STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505334	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Kirkland	10101 Northeast 120th Street Kirkland, WA 98034

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on observation, interview, and record review, the facility failed to ensure hand hygiene practices were followed for 1 of 3 staff (Staff E), failed to appropriately disinfect medical equipment for 1of 2 staff (Staff E), and failed to do proper use and disinfection/disposal of personal protective equipment (PPE-gown, gloves, face shield, N95 respirators [a device/mask designed to protect the wearer against particles and help prevent the spread of germs]) for 2 of 7 staff (Staff E & F), reviewed for infection control. In addition, the facility failed to ensure staff were fit tested (a test protocol conducted to verify that a respirator provides the wearer with the expected protection) for N95 masks for 13 of 18 staff (Staff E, F, D, G, J, K, L, M, N, O, H, I & P), reviewed for transmission based precautions (measures to prevent the spread of infection). These failures placed the residents at risk for facility acquired or healthcare-associated infection and related complications. Findings included . Review of the facility's policy titled, Hand Hygiene, revised on [DATE], showed, staff should perform hand hygiene before and after contact with the resident, after contact with visibly contaminated surfaces, objects, and surfaces in the resident's environment. Review of the facility's policy titled, Cleaning and Disinfection of Non-Critical Patient [Resident] Care Equipment, revised on [DATE], showed blood pressure cuffs (equipment used to obtain blood pressure [amount of force your blood uses to get through blood vessels]) were a none-critical item. The policy further showed, non-critical reusable patient [resident] care equipment . is cleaned daily and before and after reuse with an EPA [Environmental Protection Agency, registered products that kills microorganisms (bacterium, virus, or other organisms that can cause a disease) on surfaces]-registered hospital disinfectant . Review of the facility's policy titled, Personal Protective Equipment (PPE) for SARS-CoV-2 [virus that causes Coronavirus, a respiratory disease], revised on [DATE], showed that disposable respirators should be removed and discarded after exiting the resident's room and closing the door and performing hand hygiene after removing the respirator or facemask. The policy further showed that eye protection (including goggles or a face shield) should be removed after leaving the resident room and disinfected using an EPA-registered hospital disinfectant or discarded after use. Review of the facility's policy titled, Coronavirus (COVID 19) (SARS-CoV-2), revised on [DATE], showed to Ensure that associates [staff] are educated, trained, and have practiced the appropriate use of PPE prior to caring for a resident . (continued on next page)

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Respiratory Protection Program for COVID-19, reviewed on [DATE], showed that fit testing for staff should be done prior to being allowed to wear any tight-fitting respirator . annually .and when there are changes in the employee's physical condition that could affect respirator fit. It further showed that staff should be fit tested with the make, model, and size of respirator that they will actually wear. It showed that documentation of training and fit testing will be kept .until the next training of fit test. HAND HYGIENE On [DATE] at 11:47 AM, Staff E, Certified Nursing Assistant (CNA), was observed exiting room [ROOM NUMBER] (a COVID-19 isolation room) with soiled linen in a plastic bag and taking it to the soiled utility room. Staff E entered room [ROOM NUMBER], a non-isolation room without performing hand hygiene. DISINFECTION OF VITAL SIGN EQUIPMENT On [DATE] at 12:30 PM, Staff E was observed putting on PPE prior to entering room [ROOM NUMBER] (a COVID-19 isolation room) with vital sign equipment. Staff E exited the room at 12:40 PM and no disinfection of the vital sign equipment was observed. PROPER USE AND DISINFECTION/DISPOSAL OF PPE STAFF E Observations on [DATE] showed Staff E exited room [ROOM NUMBER] multiple times at 11:38 AM, at 11:47 AM, and at 1:00 PM. Further observation showed Staff E exited room [ROOM NUMBER] at 12:40 PM, did not disinfect/dispose their face shield, or apply a clean one, and did not change their N95 mask when exiting room [ROOM NUMBER] and room [ROOM NUMBER]. On [DATE] at 1:52 PM, Staff E stated they should have sanitized their hands prior to entering room [ROOM NUMBER]. Staff E stated that they should have disinfected the vital sign equipment using the bleach wipes that were in the hallway after resident use. Staff E stated that they were informed today [[DATE]] by facility staff [Staff A, Executive Director & Staff B, Director of Nursing] that when exiting an isolation room, they should remove their face mask and apply a new one, and disinfect their face shield using bleach wipes, or get a new face shield. Staff E further stated that they should have disinfected their face shield and applied a new face mask after exiting the isolation rooms. On [DATE] at 3:24 PM, Staff D, Registered Nurse (RN), stated that when exiting an isolation room, staff should perform hand hygiene, change their face mask, and face shield, and perform hand hygiene again. Staff D stated that hand hygiene should be performed when entering and exiting any resident room. Staff D further stated that the vital sign equipment should be disinfected before going into the resident room and after every resident interaction. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:46 PM, Staff B stated that when staff exit isolation rooms, they should perform hand hygiene, remove their mask and their face shield, either dispose of their face shield or sanitize it, and perform hand hygiene again prior to putting on a new mask and clean face shield. Staff B stated that staff should perform hand hygiene prior to entering any room. Staff B further stated that the vital sign equipment should be sanitized upon exiting the room using the disinfectant wipes on the cart. 46912 STAFF F Observation on [DATE] at 12:40 PM, showed Staff F, CNA, left room [ROOM NUMBER] (a COVID-19 isolation room) but did not dispose and change their N95 mask before going into room [ROOM NUMBER] (a COVID-19 isolation room). Staff F left room [ROOM NUMBER] and did not take off and replace their N95 mask and face shield before going into room [ROOM NUMBER] (a COVID-19 isolation room). Staff F left room [ROOM NUMBER] and went into room [ROOM NUMBER] (a COVID-19 isolation room), then went into Rooms 35 (Quarantine precautions-requiring PPE including face shield and N95 mask), 27 (a COVID-19 isolation room), 28 (Quarantine precautions), 29 (COVID-19 isolation room) and room [ROOM NUMBER] (a COVID-19 isolation room) without changing and replacing their N95 mask and/or disinfecting their face shield between rooms. On [DATE] at 1:50 PM, Staff F stated that their process for going into COVID-19 rooms was to wear a gown, gloves, face shield and N95 mask. Staff F stated that they wear the same N95 mask all day and would change it if a resident seems sicker. Staff F stated that they changed their face shield if it falls off, falls on the floor or if soiled. On [DATE] at 3:07 PM, Staff G, RN, stated that when they leave a COVID-19 room they would remove their PPE, throw away their mask and either dispose of their face shield or disinfect it. Staff G stated they put on a new N95 mask and face shield every time they leave a COVID-19 room. On [DATE] at 1:23 PM, Staff B stated they expected staff to remove their face shields and either sanitize or dispose them and change their N95 mask. Staff B further stated that they expected staff to change their face shield and N95 mask every time they leave a COVID room and that they would not expect staff to use the same N95 mask for the whole day. N95 FIT TESTING Review of the facility's untitled document showed Staff E tested positive for COVID-19 on [DATE] and had returned to work. On [DATE] at 12:54 PM, Staff E stated that they had been fit tested today [[DATE]], and did not know the reason why. Staff E stated that they did not know what mask they had been fit tested for prior to [DATE] and stated, I just popped on whatever was in the drawer of the isolation cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:26 PM, Staff B stated that everyone [staff] should be fit tested , and that staff should not be going into COVID-19 rooms until they were fit tested . Staff B stated that there should be documentation that staff were fit tested . Joint record review of Staff E's fit testing document titled, Qualitative [relating to the quality of something] Respirator Fit Test Record showed it was completed on [DATE]. Staff B stated that prior to [DATE], Staff E had not been fit tested for the masks the facility had. Staff B further stated that Staff E should not have been doing resident care for positive COVID-19 residents and that Staff E should have been fit tested for the masks the facility had in supply or have ordered the mask they had been fit tested for. Further review of an untitled facility document showed 16 staff tested positive for COVID-19 from [DATE] through [DATE]. Review of the facility's fit testing documentation binder dated 2023, showed no fit testing documentation for Staff F and Staff D. Further review of the fit testing documentation for the 16 staff who tested positive for COVID-19, showed Staff E had no fit testing documentation prior to [DATE], seven staff (Staff G, J, K, L, M, N & O) had no fit testing documentation, and three staff (Staff H, I & P) had expired fit testing documentation. In an interview and joint record review on [DATE] at 1:12 PM with Staff B, stated that fit testing was done once a year or if there's a change in weight and that everybody should be fit tested prior to going into COVID-19 positive resident rooms. Staff B stated there should be documentation of the fit testing results. Joint record review of the fit testing binder for 2023 showed no documentation that Staff F and Staff D had been fit tested for their N95 masks. Staff B stated that there was no documentation that Staff F and Staff D had been fit tested and there should have been. Further record review showed seven staff (Staff G, J, K, L, M, N & O) had no fit testing documentation and three staff (Staff H, I & P) had expired N95 fit testing. Staff B stated that the documentation should've been there, but not seeing it in there [for Staff G, J, K, L, M, N & O]. Staff B further stated that N95 fit testing should have been performed [for Staff H, I & P]. On [DATE] at 2:36 PM, Staff A stated that in an ideal situation I would want them [staff] to be fit tested prior to working with COVID-19 positive residents. Reference: (WAC) [DATE] 1(c), 5(c)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 46912 Based on interview and record review, the facility failed to designate a qualified staff person to serve as an Infection Preventionist (IP) to oversee the facility's infection prevention and control program. This failure placed the residents, staff, and visitors at risk for contracting COVID-19 (an infectious disease-causing respiratory illness) during a facility outbreak, unmet infection control issues, and lack of oversite of infection control practices. Findings included . Review of the facility document titled, Care List for Positive Individuals, dated 04/02/2024, showed 42 residents and 17 staff had tested positive with COVID-19 between the dates of 03/18/2024 and 04/01/2024. On 04/03/2024 at 12:45 PM, Staff A, Executive Director, stated that they did not have an IP at this time, but that Staff B was the interim [temporary] IP. On 04/03/2024 at 1:12 PM, Staff B stated that we don't have an IP, so I've been helping out. Staff B stated they were not IP certified. On 04/03/2024 at 2:36 PM, Staff A stated that they expected the designated IP to be certified and that Staff B was not certified. Staff A stated that Staff C, Resident Care Manager, was certified and was helping with infection control practices. On 04/03/2024 at 3:00 PM, Staff C stated that they were not acting as the facility's IP, and that Staff B was the designated IP. Staff C stated they helped with questions and some infection control tasks given to them by Staff B, but that they were not in charge of the IP role. On 04/03/2024 at 3:11 PM, when asked if the designated IP was certified, Staff A stated, it's a team effort, everyone is pitching in. No associated WAC