STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505436	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gig Harbor Health and Rehabilitation	3309 45th Street Court Northwest Gig Harbor, WA 98335

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure infection control standards were followed related to not following the Centers for Disease Control and Prevention (CDC) by implementing droplet precautions with residents suspected of having Tuberculosis (TB: an infectious disease caused by bacteria called Mycobacterium tuberculosis, primarily affecting the lungs but potentially impacting other parts of the body) for 1 of 5 residents (Resident 1), reviewed for infection control. This failure placed residents, staff and visitors at risk for possibly contracting and spreading infections. Findings included . Review of the facility's policy titled, 'Tuberculosis Screening-Nursing Facility Residents,' undated, states the definition for Tuberculosis (TB): is a disease caused by the bacterium Mycobacterium tuberculosis that is spread person-to-person through the air. TB usually attacks the lungs but can affect other parts of the body. Under the subtitle Specific Procedures/Guidance .2. (e.) The resident will immediately be placed on droplet precautions pending facility transfer per practitioner assessment and order. 3. Residents with 'suspected' and/or confirmed infectious TB may be admitted on ly if the facility is equipped with a private airborne infection isolation room . The CDC '2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings', page 17. Paragraph titled, I.B.3 (states) Modes of transmission. Several classes of pathogens can cause infection including bacteria, viruses, fungi, parasites and prions. The modes of transmission vary by type of organism and some infectious agents may be transmitted by more than one route: some are transmitted primarily by direct or indirect contact ., others by droplet ., or airborne routes (e. g. M. tuberculosis) . Resident 1 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS-an assessment tool), dated 05/23/2025, documented the resident as moderately cognitively impaired. Review of Resident 1's physician orders, dated 06/12/2025, showed Resident 1 was placed on droplet precautions related to a positive PPD test (Purified Protein Derivative- skin test, a method used to detect past or present tuberculosis infection). (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 - Few	Record review documented Resident 1 was administered the 2nd step in a 2 step PPD on 06/09/2025 and then the results were read on 06/11/2025. This result was considered positive with a 30mm (millimeter) induration (a raised hardened area at the injection site). On 06/12/2025 the provider ordered a chest x-ray to rule out TB. The results documented CONCLUSION: Patchy bilateral airspace [areas of abnormal density in both lungs, appearing scattered and irregular] and modest pleural effusions pa moderate amount of fluid buildup in the pleural space-the area between the lung and chest wall]. Pneumonia [a lung infection that inflames the alveoli-air sacs- in one or both lungs causing them to fill with fluid or pus] should be considered in the appropriate clinical setting. Recommend follow-up examination to confirm resolution of findings. Findings have improved from the comparison study. Consider reassessment for TB after resolution of the current abnormal findings. Provider ordered Levaquin (an antibiotic) 750mg (milligram) by mouth daily for pneumonia. The provider also ordered a QuantiFERON gold screening (a blood test used to screen for TB infection, including both latent and active forms). The QuantiFERON gold test was collected on 06/13/2025 and resulted on 06/16/2025. This test resulted positive. On 06/16/2025, the provider ordered another chest x-ray to rule out TB. The results were documented as CONCLUSION: Findings suggestive of pulmonary edema [a condition where fluid builds up in the lungs, specifically in the alveoli, making it difficult to breathe] with bilateral pleural effusion. Pulmonary tuberculosis cannot be confidently excluded in the setting of pulmonary opacities. Findings comparable to prior imaging of 06/12/2025. On 06/17/2025, the facility notified the local health jurisdiction (LHJ) of the possible positive TB for Resident 1. The provider then gave orders to send Resident 1 to the hospital to rule out TB. On 06/18/2025, record review showed the care plan had not been updated regarding Resident 1 possibly being positive for TB, droplet precautions initiated, or the treatment for pneumonia. On 06/25/2025, at 10:25 AM, Staff B, Registered Nurse (RN)/Infection Preventionist (IP), said she thought she spoke to the LHJ via the telephone on 06/11/2025 but could not confirm. Staff B said she emailed the LHJ on 06/17/2025 and received a response email stating the LHJ assigned to the facility was out of the office and called the number listed on the email for further instruction. Staff B had a note confirming the call on 06/17/2025. Staff B said she was not given any recommendations to follow and that she informed the LHJ she had placed Resident 1 on droplet precautions per the facility policy on 06/12/2025 and Resident 1 was sent to the hospital to rule out TB on 06/17/2025. Staff B said the care plan for Resident 1 should have been updated to include Resident 1 was suspicious of having latent or active TB and currently being treated for pneumonia. Staff B said no interventions were placed for possible exposure of TB related to staff or other residents as Resident 1 rarely left his room. Staff B said she did do monitoring for signs and symptoms of TB by verbal communication with the staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/2025 at 1:00 PM, Staff A, RN/Director of Nursing Services (DNS), said the current policy for the facility regarding TB indicated residents should be placed on droplet precautions. When asked if the precautions for TB should be droplet or airborne precautions, Staff A said usually it would be airborne precautions. Staff A said she would follow up with the Regional Nurse as to why the policy says droplet precautions. Staff A said the LHJ should have been notified on 06/11/2025 when Resident 1 had a positive PPD test and not 6 days later, on 06/17/2025. Staff A said this did not happen because they were thinking the 2nd PPD test read on 06/11/2025 was a false positive. Staff A said the LHJ was notified on 06/17/2025 after Resident 1 had a second chest x-ray that was still inconclusive to rule out TB and a positive QuantiFERON gold test was received. Staff A said the care plan should have been reviewed and updated on 06/11/2025 when Resident 1 had a positive PPD and then on 06/12/2025 after the chest x-ray results were received and Resident 1 was treated for pneumonia. Staff A said other residents should have been put on alert for possible exposure to TB and the staff that worked with Resident 1 should have been monitored to prevent spreading of the infection. Reference WAC 388-97-1320 (2)(b) .