DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495126 | A. BUILDING _____ B. WING _____ | C 03/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WADDELL NURSING AND REHAB CENTER | 202 PAINTER ST GALAX, VA 24333 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 03/07/17 through 03/09/17. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 135 certified bed facility was 118 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 6 closed record reviews (Residents #22 through #27).

F 226 SS=D 483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

483.12
(b) The facility must develop and implement written policies and procedures that:

(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

(2) Establish policies and procedures to investigate any such allegations, and

(3) Include training as required at paragraph §483.95,

483.95
(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also

F 000 This Plan of Correction will serve as the facility's allegation of compliance with the requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of the plan of correction is in response to the CMS 2567 for the survey and does not constitute an agreement or admission by Waddell Nursing and Rehab Center of the truth of the facts alleged or correctness of the conclusions stated in the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal laws. Waddell Nursing and Rehab Center contends that it was in substantial compliance with the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, Waddell Nursing and Rehab Center submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully complete in all areas as of April 21, 2017.

F 226
1) Employee records for #10 were checked and verified by the facility Administrator on 3/9/17 and confirmed that the employee's criminal background check has been checked and received on 11/2/16 and verifications retained in the employee's personnel file.
2) All employee records were reviewed by the Human Resources Assistant and Administrator completed on 3/20/17 and all employee records were found to be completed.
3) In-service education of the policy was completed with the Human Resources Assistant on 3/20/17 by the Administrator and DON.
4) All employees were provided a copy of the facility Abuse Policy on 3/22/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lawn B Wardell | TITLE: administrator | (X6) DATE: 5/24/17

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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| F 226 | Continued From page 1<br>provide training to their staff that at a minimum educates staff on-<br><br>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, and the Code of Virginia, the facility staff failed to obtain a criminal background check for 1 of 20 newly hired employees. (Employee #10).<br><br>The findings included:<br><br>The surveyor reviewed 20 newly hired employees' files for completeness on 3/8/17 along with the human resource director. It was noted by the surveyor that a newly hired employee, which will be identified as Employee #10 on the form titled "Criminal Record Check" which was hired on 8/8/16 as a registered nurse. The criminal background check was completed on 11/2/16 on this employee. The human resource director stated to the surveyor "this nurse worked for another one of our facilities that was owned by the same corporation that we are in. The employee worked in North Carolina then came here to work."<br><br>According to the policy titled "Abuse, Neglect, and Misappropriation of Property Reporting Policy" | F 226 | 5) The policy was discussed with the Human Resources Assistant that prior to or no later than the date of hire, a criminal background check will conducted and the results will be placed into the employee's personnel record. Employees with negative screening will not be hired.<br>6) The facility Administrator will conduct a review weekly of new employee records with the Human Resources Assistant at the weekly staffing meeting.<br><br>4/21/17 | |

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| F 226 | Continued From page 2<br>that was given to the survey team leader at the start of the survey on 3/7/17 stated the following under Section VI Protection:<br>"...A. Criminal background checks are completed on all employees ..."<br>Also in the policy titled "Resident Abuse" under Section 4, Response, the following was noted by the surveyor:<br>"...V. Conduct a criminal background check in accordance with State law and facility policy ..."<br><br>The administrative team was notified of the above documented findings on 3/8/17 at 3:25 pm in the conference room.<br><br>No further information was provided to the surveyor prior to the exit conference on 3/9/17. | F 226 | | |
| F 309 SS=D | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25<br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. | F 309 | 1) The attending physician for Resident #11 was contacted on 3/9/17 that ordered pain medications for resident #11 was administered but the facility failed to do a pain assessment and that no non-pharmacological intervention had been attempted prior to administration of pain medication. The attending physician for Resident #15 was contacted on 3/9/17 that no pre-dialysis assessment was completed before Resident #15 left for dialysis.<br>2) A 100% review of resident charts was conducted by the professional nursing staff completed on 3/14/17 and found no residents who were ordered pain medication had not first been attempted a non- | |

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| F 309 | Continued From page 3 | F 309 | | |

(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for 2 of 27 residents (Resident #11 and Resident #15).

The findings included:

1. The facility staff failed to complete pain assessments and failed to offer non-pharmacological interventions for pain prior to pain medication administration for Resident #11.

The clinical record of Resident #11 was reviewed 3/7/17 through 3/9/17. Resident #11 was admitted to the facility 7/24/14 with diagnoses that included but not limited to pain, anemia, hypothyroidism, hyperlipidemia, major depressive disorder, anxiety, transient cerebral ischemic attack, insomnia, hypertension, gastroesophageal reflux disease, contracture left arm and trigger finger, left ring finger.

Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/13/17 assessed the resident with a cognitive summary score of 03 out of 15.

pharmacological intervention and the resident on dialysis's record indicate a pre and post-dialysis assessment.

3) In-service education will be provided on 4/12/17 by the Director of Staff Development for the professional nursing staff addressing proper procedures for attempting non-pharmacological interventions for residents on pain medication and pre-dialysis assessments, following CMS Guidelines and facility policy.
4) The unit nurse supervisor during their shifts will monitor all residents for adherence to the facility policy concerning non-pharmacological interventions and pre and post-dialysis assessment. The unit nurse supervisor will print and use the E-Mar reminders and will have results scanned into the electronic medical record and also a check list for pre and post-dialysis will be placed into a hard binder and retained by the DON.
5) The ADON, DON and / or designee will conduct a weekly review of 25% of all residents for adherence to the facility policy and practice. Identified areas of concern will be communicated to the facility administrator for development of an appropriate action plan as determined by the

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| F 309 | Continued From page 4<br>Resident #11 was assessed without delirium, psychosis, or behaviors that were directed at others. Section G Functional Status assessed the resident to require extensive assistance of 2 people for bed mobility, transfers, and toileting. Section J Health Conditions and specifically Section J0100 Pain Management assessed that resident had received a scheduled pain medication regimen, had not received prn (as needed) medication or was offered and declined, and received non-medication interventions for pain during the look back period.<br><br>Resident #11's current comprehensive care plan created on 5/17/16 with revisions beginning 1/16/17 did not include a care plan that identified pain as a focus area.<br><br>The February 2017 physician order sheet and March 2017 physician order sheet included an order that read "Ultram tablet 50 mg (milligrams) Give 1 tablet by mouth as needed for pain bid (twice a day)." The February 2017 medication administration records (MARs) were reviewed. Resident #11 received prn (as needed) pain medications three (3) times in February 2017 on 2/8/17 at 1917 (7:17 p.m.), 2/12/17 at 1630 (4:30 p.m.) and 2/27/17 at 2046 (8:46 p.m.). The March 2017 medication administration records were reviewed. Resident #11 received Ultram 50 mg on 3/1/17 at 19:51 (7:19 p.m.) and on 3/4/17 at 2139 (9:39 p.m.)<br><br>The February 2017 progress notes did not reveal evidence that a pain assessment had been done or that any non-pharmacological interventions had been done prior to medication administration on 2/8/17, 2/12/17 and 2/27/17. | F 309 | facility administrator, DON and ADON. Findings will be discussed and reviewed by the Quality Assurance – QAPI Committee. | 4/21/17 |

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The 2/8/17 19:17 progress note read "Ultram tablet 50 mg give 1 tablet by mouth as needed for pain BID." There was no pain assessment prior to the administration of the Ultram or the use of non-pharmacological interventions prior to the administration of Ultram.

The follow-up note dated 2/8/17 at 20:54 (8:54 p.m.) read "Effective."

The 2/12/17 at 1630 (4:30 p.m.) note read "Ultram tablet 50 mg give 1 tablet by mouth as needed for pain BID resident request for feet pain." There was no pain assessment prior to the administration of the Ultram or the use of non-pharmacological interventions prior to the administration of Ultram.

The follow-up note dated 2/12/17 at 17:34 (5:34 p.m.) read "Effective."

The 2/27/17 at 20:46 (8:46 p.m.) note read "Ultram tablet 50 mg give 1 tablet by mouth as needed for pain BID resident request for leg pain." There was no pain assessment prior to the administration of the Ultram or the use of non-pharmacological interventions prior to the administration of Ultram.

The follow-up note dated 2/27/17 at 23:41 (11:41 p.m.) read "Effective."

The March 2017 progress notes did not reveal evidence that a pain assessment had been done or that any non-pharmacological interventions had been done prior to medication administration on 3/1/17 or 3/4/17.

The 3/1/17 19:51 (7:51 p.m.) progress note read

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| F 309 | Continued From page 6 | F 309 | | |

"Ultram tablet 50 mg give 1 tablet by mouth as needed for pain BID." There was no pain assessment prior to the administration of the Ultram or the use of non-pharmacological interventions prior to the administration of Ultram.

The follow-up note dated 3/1/17 at 20:45 (8:45 p.m.) read "Effective."

The 3/4/17 21:39 (9:39 p.m.) progress note read "Ultram tablet 50 mg give 1 tablet by mouth as needed for pain BID." There was no pain assessment prior to the administration of the Ultram or the use of non-pharmacological interventions prior to the administration of Ultram.

The follow-up note dated 3/4/17 at 22:04 (11:04 p.m.) read "Effective."

The surveyor interviewed the staff development licensed practical nurse on 3/8/17 at 8:22 a.m. The staff development L.P.N. stated the facility had not yet put into place non-pharmacological interventions for pain. She stated "It's in the development stage."

The failure of the facility to assess Resident #11 for pain and to not offer/use non pharmacological interventions prior to medication administration was discussed in the end of the day meeting on 3/8/17 at 3:25 p.m. with the administrative staff.

The surveyor requested the policy on pain from the director of nursing on 3/9/17 at 9:00 a.m.

The surveyor and the staff development L.P.N. reviewed the electronic clinical record for pain assessments since the facility began using the electronic system (approximately one year) on

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3/9/17 and was able to locate only one after the resident sustained a fall.

The surveyor reviewed the facility policy on pain management and pain protocol on 3/9/17. The policy read in part: "A pain evaluation will occur on admission to the facility, at each quarterly review, whenever significant change in condition and with any onset of new pain.
1. The interdisciplinary team will establish a care plan to identify the goals of the pain program and the care plan will be reviewed and updated as needed.
2. The nurse will evaluate the nonverbal resident and/or the resident with dementia for nonspecific signs and systems (sic) that could reflect pain.
3. Since the policy is to utilize the pain flow record, it is not necessary to duplicate the documentation of the response of the medication on the back of the MAR (medication administration record).
4. The information on the pain flow record will identify: a. Location of the pain. b. Pain intensity. c. Pain quality. d. Onset and duration of the pain e. Aggravating factors f. Accompanying symptoms.
5. The resident will be assessed for pain at regular intervals. The physician will be notified of ineffective pain management as needed."

No further information was provided prior to the exit conference on 3/9/17.
2. The facility staff failed to provide dialysis documentation for Resident #15.

Resident #15 was admitted to the facility on 2/10/17 with the following diagnoses of, but not limited to heart failure, diabetes, diabetes, respiratory failure, and Stage 5 Kidney Disease.

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Resident #15 was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/17/17 as having a BIMS (Brief Interview for Mental Status) as having a score of 15 out of a possible score of 15. Resident #15 was coded as requiring extensive assistance of 1 to 2 staff members for dressing, bathing and personal hygiene.

Resident #15's clinical record was reviewed by the surveyor on 3/9/17. The dialysis assessment was not present in the clinical record for when the resident left the building for dialysis on the following dates: 3/6/17, 2/17/17, and 2/13/17.

The director of nursing was notified of the above documented findings on 3/9/17 at approximately 9:30 am in the conference room. The surveyor asked the director of nursing what was the protocol the nurses were to follow regarding when a resident went to dialysis. The director of nursing stated "The nurses are to assess the resident before and after the resident goes to dialysis and then chart them in the clinical record." The director of nursing also provided the surveyor with a copy of a policy titled "End Stage Renal Dialysis Services. In this policy the following was stated: "...The resident will receive an assessment and evaluation prior to the transportation to the dialysis..."

On 3/9/17 at approximately 9:45 am, the survey notified the administrative team of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 3/9/17.

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| F 431 | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, | F 431 | |

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| F 431 SS=D | Continued From page 9<br>LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals.<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate,accessory and cautionary instructions, and the expiration date when applicable.<br><br>(h) Storage of Drugs and Biologicals.<br>(1) In accordance with State and Federal laws, | F 431 | 1) Resident #20 eye drops and Resident #21 Levemir insulin was dated on 3/8/17 as being opened.<br>2) All pharmacy storage areas were checked on 3/8/17 for unlabeled medication and none were found. The Pharmacy Consultant conducted a review of the pharmacy storage areas on 3/21/17 and none were found.<br>3) The professional nursing staff charge nurses will monitor Monday – Wednesday and Friday their respective pharmacy storage areas for unlabeled medication and will replace as necessary any found medication that is unlabeled.<br>4) In-service education will be provided on 3/31/17 by the Director of Staff Development for the professional nursing staff addressing proper procedures for labeling medication.<br>5) The DON, ADON and pharmacy consultant will conduct at least monthly monitoring of the pharmacy storage areas for unlabeled medications and will replace as necessary any unlabeled medication. The pharmacy consultant will present findings to the Quality Assurance – QAPI Committee for necessary monitoring and follow up. | 4/21/17 |

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the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to date medications when opened for 2 of 27 residents (Resident #20 and Resident #21).

The findings included:

1. The facility staff failed to date eye medications when opened for Resident #20.

The surveyor and registered nurse #1 checked the medication cart 1 on the first floor on 3/8/17 at 10:25 a.m. The surveyor observed an opened bottle of Lumigan 0.01% eye drops with directions for Resident #20 that read to give 1 drop into both eyes at bedtime. The bottle was open; however, the surveyor found no date when opened recorded on the bottle. Registered nurse #1 checked the bottle and stated she saw no date recorded.

The surveyor interviewed R.N. #1. R.N. #1 was

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asked when bottles were to be dated. R.N. #1 stated bottles were supposed to be dated when opened and stated the Lumigan eye drops were not.

The surveyor interviewed the director of nursing on 3/8/17 at 11:15 a.m. The surveyor asked the DON when medications should be dated. The DON stated medications should be dated when opened. The DON stated the carts were checked 3/7/17 and no issues found. The surveyor requested the facility policy on labeling and dating medications.

The surveyor reviewed the facility policy titled "Storage and Expiration of Medication, Biologicals, Syringes and Needles" on 3/8/17. The policy read in part "5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."

The surveyor informed the administrative staff of the concern with dating medications when opened in the end of the day meeting on 3/8/17 at 3:25 p.m. and again on 3/9/17 at 10:15 a.m.

No further information was provided prior to the exit conference on 3/9/17.

Resident #20 was admitted to the facility 2/1/14 with diagnoses that included but not limited to glaucoma, Vitamin B12 deficiency, anemia, dementia without behavioral disturbances, hypertension, and major depressive disorder.

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Resident #20's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/24/17 assessed the resident with a cognitive summary score of 12 out of 15.

Resident #20's current physician orders for 3/8/17 read in part "Lumigan Solution 0.01% Instill 1 drop in both eyes at bedtime for glaucoma."

2. The facility staff failed to date an opened vial of Resident #21's Levemir insulin.

The surveyor and licensed practical nurse #2 checked the medication cart 2 on the first floor on 3/8/17 at 10:40 a.m. The surveyor observed an opened bottle of Levemir insulin with Resident #21's name and with directions for administration (Levemir 20 units at bedtime). The bottle did not have a date located on the bottle or the packaging. L.P.N. #2 checked for the date and stated she was unable to find one. She was asked when bottles/vials of medications should be dated. She stated "When opened."

The surveyor interviewed the director of nursing on 3/8/17 at 11:15 a.m. The surveyor asked the DON when medications should be dated. The DON stated medications should be dated when opened. The DON stated the carts were checked 3/7/17 and no issues found. The surveyor requested the facility policy on labeling and dating medications.

The surveyor reviewed the facility policy titled "Storage and Expiration of Medication, Biologicals, Syringes and Needles" on 3/8/17. The policy read in part "5. Once any medication or biological package is opened, Facility should

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follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."

The surveyor informed the administrative staff of the concern with dating medications when opened in the end of the day meeting on 3/8/17 at 3:25 p.m. and again on 3/9/17 at 10:15 a.m.

No further information was provided prior to the exit conference on 3/9/17.

Resident #21 was admitted to the facility 5/8/13 and readmitted 11/21/16 with diagnoses that included but not limited to type 2 diabetes mellitus, Vitamin B12 deficiency, anemia, Vitamin D deficiency, hyperlipidemia, unspecified psychosis, bipolar disorder, major depressive disorder, anxiety, and Parkinson's disease.

Resident #21's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/27/17 assessed the resident with a cognitive summary score of 13 out of 15.

Resident #21's current physician orders dated 3/8/17 read in part "Levemir Solution 100 unit/ml (milliliter) (Insulin Detemir) Inject 20 unit subcutaneously at bedtime for IDDM (insulin dependent diabetes mellitus)."

F 431

F 441 SS=E 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS

F 441

(a) Infection prevention and control program.

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

F 441

1. The SDC (staff development coordinator) reviewed and completed the infection control tracking form on 3/10/17 to address the resolution date of resident infections. Resident #19 in room 128-D was removed from isolation on 3/9/17. Resident #10 was removed from isolation on 3/9/17.
2. All facility infection control logs for the pat 6-month was reviewed by the SDC and Administrator and were found to be completed on 3/10/17. No residents on facility review conducted on 3/10/17 were found to be in isolation.
3. All facility staff will be in-serviced by 4/12/17 concerning proper infection guidelines and facility policy, including monitoring visitors and sitters to current infection control / isolation procedures as address by the signage at the resident's room.
4. The unit nurse supervisor during their shifts will monitor proper placement of infection control isolation signage and adherence to proper infections control practices.
5. The SDC will present the infection control monitoring log at the monthly Quality Assurance Committee meeting for review and completion by the committee members.
6. The Administrator and DON will conduct a weekly facility rounds review for compliance with proper infection control practices. Identified areas of concern will be communicated to the facility administrator for development

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| F 441 | Continued From page 15<br>least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure an effective infection control program in regards to tracking of infections and for 2 of 27 Residents, Residents #19 and #10.<br><br>The findings included.<br><br>1. The infection control tracking form provided to the surveyor by the facility was incomplete. The facility had failed to indicate if the infections were resolved or were ongoing. | F 441 | of an appropriate action plan as determined by the facility administrator, DON, and ADON as appropriate. Findings will be discussed and monitor by the Quality Assurance – QAPI Committee.<br><br>4/21/17 | |

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On 03/07/17 during the entrance conference the ADON (assistant director of nursing) was provided a list of items that would be required for the survey. The infection control line list/tracking form was one of the items requested.

The facility provided the surveyor with copies of their infection control tracking form on 03/08/17 for November 2016-March 2017. However, the document provided to the surveyor was incomplete. Under the column titled "Date Resolved" the document failed to identify if the infection had been resolved or was ongoing for the majority of the Residents listed.

On 03/08/17 at approximately 9:35 a.m. the SDC (staff development coordinator) provided the survey team with a copy of their infection control policy. This policy read in part "It is the policy of this facility to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection...This facility will have an effective infection prevention and control program which incorporates, but is not limited to, the following components...Surveillance, including process and outcome..."

On 03/08/17 at approximately 8:20 a.m. the surveyor interviewed the SDC during this interview the SDC verbalized to the surveyor that she had not followed up on some of the infections.

The administrative team was notified of the above in a meeting with the survey team on 03/09/17 at approximately 10:15 a.m.

No further information regarding this issue was

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provided to the survey team prior to the exit conference.
2. The facility staff failed to post infection control signage on Resident #19's door.

Resident #19 was readmitted to the facility on 3/4/17 with the following diagnoses of, but not limited to anemia, high blood pressure, malnutrition, anxiety disorder, insomnia, respiratory failure and acute kidney failure. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/8/17 as having a BIMS (Brief Interview Mental Status) score of 15 out of a possible sore of 15. The resident was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing.

During the initial tour on 3/7/17 at 12:45 pm, licensed practical nurse (LPN #1) made rounds with the surveyor on the 500 hallway. Upon going by room 128 D, the LPN #1 gave the surveyor a verbal report of Resident #19 had an infection of MRSA in the leg wound. The surveyor noted that there was no infection control signage on the resident's door or on the isolation cart that was sitting beside the resident's door.

The surveyor made another observation on 3/8/17 at 8:30 am, to room 128 D and there was no infection control signage on the resident's door on the isolation cart beside of the resident's room. Again, at 2:30 am, there was no signature on resident's door on 128 D or on the isolation cart sitting beside the resident's door. The surveyor also observed on 3/9/17 at 8:35 am, the surveyor again observed no infection control signature on the door of 128 D or on the isolation cart sitting

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beside the door.

The surveyor requested a copy of the infection control policy from Registered nurse (RN) #1 which was provided to the surveyor on 3/8/15/at 9:35 am. (RN) #1 provided the surveyor a copy of the policy titled "Infection Control" which stated the following: " ...Pertinent signage will be posted on resident's door ..."

On 3/9/17 at approximately 9:45 am, the surveyor notified the administrative team of the above documented of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 3/9/17.
3. The facility staff failed to ensure visitors followed infection control guidelines for Resident #10.

The clinical record of Resident #10 was reviewed 3/7/17 and 3/8/17. Resident #10 was admitted to the facility 8/29/16 and readmitted 11/13/16 with diagnoses that included but not limited to urinary tract infection with Escherichia coli (ESBL-extended-spectrum ?-lactamases), pulmonary embolus and deep vein thrombosis, symbolic dysfunctions, Alzheimer's disease, hypertension, gout, dementia without behavioral disturbances, and right hip fracture.

Resident #10's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/18/17 assessed the resident with a cognitive summary score of 09 out of 15 in Section C Cognitive Summary.

Resident #10 was observed on 8/7/17 at 2:00 p.m. At the entrance to Resident #10's room, the

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surveyor observed a 3 drawer cart and a sign on top of the cart that read "Contact Isolation". The surveyor did as instructed on the card which was to wear a gown and gloves. The surveyor knocked on the door and a visitor opened the door. The sitter was observed without any type of personal protective equipment.

Resident #10 was observed again on 3/8/17 at 8:05 a.m. The 3 drawer cart with the signage was still in place. The surveyor donned the gown and gloves as instructed on the card and entered Resident #10's room. The surveyor observed the same visitor as on 3/7/17 without any type of PPE. She stated she was the "sitter" and stayed with Resident #10 from 7:00 a.m. to 3:00 p.m. Monday through Friday. The surveyor asked the sitter if she had been told about Resident #10's isolation and the sitter responded "Should I be wearing the gown and gloves?"

The surveyor reviewed Resident #10's clinical record. Resident #10 had orders dated 3/6/17 1502 (3:02 p.m.) that read "Contact Isolation-UTI (urinary tract infection) ESBL positive."

The progress note dated 3/6/17 1510 (3:10 p.m.) read "Resident placed on Contact Isolation for UTI-ESBL positive RP (responsible party) notified."

The surveyor interviewed licensed practical nurse #2 on 3/8/17 at 8:10 a.m. L.P.N. #2 stated she educated the family and the sitter about infection control but had failed to document any of the education. The surveyor called the responsible party on 3/8/17 but was unable to reach the family.

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The surveyor requested the facility policy on infection control with a focus on visitor education from the staff development licensed practical nurse on 3/8/17 at 9:00 a.m.

The surveyor reviewed the facility policy titled "Companion or Sitter Policy-Nursing Home/Assisted Living Facility" on 3/8/17. "Requirements: The companion or sitter must meet the following requirements. 6. Attend facility orientation and training requirements on appropriate policies governing HIPPA, Infection Control, resident and companion or sitter safety and follow such policies."

The surveyor also reviewed the infection control policy for the facility titled "Infection Control." The infection control policy read in part under "Preventing Spread of Infection "1. When it is determined that a resident needs isolation to prevent the spread of infection, this facility will isolate the resident." "Facility Components of Infection Prevention and Control Program" read in part "Provide education, including training in infection prevention and control practices, to ensure compliance with facility requirements as well as State and federal regulation." Contact Precautions read "Contact precautions require the use of appropriate PPE, including a gown and gloves upon entering the room. Cart holding supplies (PPE) will be stationed outside of room." Resolving Protocols read in part "ESBL will be cleared after 3 negative cultures are obtained." "The facility will inform any transportation agent (i.e. ambulance attendants, funeral home, etc.,) if the resident has an infection and the type."

The surveyor interviewed the staff development/licensed practical nurse on 3/8/17 at

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| F 441 | Continued From page 21<br>8:25 a.m. on infection control. SD L.P.N. stated that when the facility identified a resident who needed isolation, a sign was posted for family, visitors and staff. The staff explains to the family, visitor, or staff the reason for the isolation. The surveyor interviewed the staff development L.P.N. again on 3/9/17 at 7:30 a.m. SD L.P.N. stated L.P.N. #2 stated she had provided education to the sitter but had failed to document the education. SD L.P.N. stated she took responsibility for the lack of follow-up. SD L.P.N. stated that was part of her follow-up to go back and make sure staff had documented their education to the family/visitors. She stated she just got busy and hadn't done it and then stated that if wasn't documented, it wasn't done. The surveyor also requested the education about the sitter to meet the requirements in the facility "Companion or Sitter Policy." SD L.P.N. stated she didn't have that information.<br><br>The surveyor informed the administrative staff of the concern with infection control during an end of the day meeting on 3/8/17 at 3:25 p.m. and again on 3/9/17 at 10:15 a.m.<br><br>No further information was provided prior to the exit conference on 3/9/17. | F 441 | | |
| F 502 SS=D | 483.50(a)(1) ADMINISTRATION<br><br>(a) Laboratory Services<br><br>(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br>This REQUIREMENT is not met as evidenced by: | F 502 | 1) Resident #9 attending physician was contacted on 3/9/17 and made aware that the facility had drawn the TCP3 for November 2016 and the CBA and BMP for August 2016, but the results were not in the medical record, and the attending physician gave no new orders. | |

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| F 502 | Continued From page 22<br>Based on staff interview and clinical record review, the facility staff failed to obtain a physician's ordered laboratory test for 2 of 27 residents, Residents #9 and #6.<br><br>The findings included.<br><br>1. For Resident #9 the facility staff failed to obtain physician ordered laboratory test CBC (complete blood count), a BMP (basic metabolic panel), and T3 (Thyroid test).<br><br>Resident # 9 was admitted to the facility on 11/1/13. Resident #9's diagnoses include but are not limited to: elevated blood pressure, dementia, anxiety disorder, diabetes, and thyroid disorder.<br><br>A review of Resident #9's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 2/14/17, the facility staff assessed the resident to usually understand and to be understood and as having problems with short and long term memory.<br><br>On 3/8/17, a review of Resident #9's clinical record revealed that the physician had given orders for the laboratory test, TCP3 (Thyroid Stimulating Hormone with T3) to be done yearly, CBC, and BMP to be obtained every three months (May, August, November, and February).<br><br>A review of Resident 9's electronic clinical record for the results of the lab tests was done. However, the results for the August 2016, CBC and BMP, and the yearly T3 for November 2016, was not located in the clinical record.<br>On 3/9/17 at 8:55am, LPN #3 was asked to assist in locating the labs. After looking she reported to the surveyor "they were not found". | F 502 | 2) The professional nursing staff reviewed on 3/10/17 100% of resident records for missing laboratory tests and found none.<br>3) The facility has implemented a new laboratory tracking policy which will provide daily alert and scheduled tracking information for laboratory testing and receipt of laboratory results. The unit secretary will monitor the tracking information daily and will prepare the appropriate laboratory paper work to then be acknowledged by the charge nurse. The RN Unit Supervisor will monitor 100% of resident charts for completion of scheduled and physician ordered laboratory tests for recorded results.<br>4) The DON and ADON will monitor daily the alert tracking and trending section of the electronic health record and will conduct a 25% review of resident records for necessary laboratory result. The DON will present findings to the Quality Assurance - QAPI Committee for necessary monitoring and follow up. | 4/21/17 |

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On 3/9/17 at approximately 10:15 am, during a meeting with the administrator, director of nurses and the assistant director of nurses, the missing lab results were discussed.

Prior to exit on 3/9/17, no further information was provided to the surveyor related to the labs that were not obtained.
2. The facility staff failed to obtain a physician ordered laboratory tests for Resident #6.

Resident #6 was admitted to the facility 9/4/15 with the following diagnosis of, but not limited to high blood pressure, dementia, thyroid disorder, anxiety disorder, obesity, diabetes, low sodium, high cholesterol, and psychotic disorder. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/28/17 scored the resident as having a BIMS (Brief Interview for Mental Status, an assessment protocol) of 0 out of a possible score of 15. Resident #6 was also coded as requiring total dependence of 2 staff members for dressing, personal hygiene and bathing.

The surveyor conducted a clinical record review of Resident #6's chart on 3/7/17. In performing this review, the surveyor noted that the physician had ordered a CBC, BMP, and a TPC3 every year in September."

The surveyor could not find the results of these labs in the electronic medical record.

Registered nurse (RN) #1 was interviewed by the surveyor on 3/7/17. The surveyor asked if these above documented findings had been performed

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| F 502 | Continued From page 24<br>as ordered by the physician. RN #1 stated "I don't know but I will look into this for you."<br><br>The administrative team was notified of the above documented findings by the surveyor on 3/7/17 at 3:25 pm.<br><br>RN #1 returned to the surveyor on 3/8/17 at approximately 9 am and stated that she could not find out why these labs were not drawn.<br><br>No further information was provided to the surveyor prior to the exit conference on 3/9/17. | F 502 | | |
| F 504 SS=E | 483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN<br><br>(a) Laboratory Services<br><br>(2) The facility must-<br><br>(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review the facility staff failed to obtain a physician's order prior to obtaining a laboratory test for 5 of 27 Residents, Residents #5, #8, #1, #6, and #11<br><br>The findings included:<br><br>1. For Resident #5 the facility staff failed to obtain a physician's order prior to obtaining a BMP (basic metabolic panel). | F 504 | 1) The attending physicians for residents #5, #8, #1. #6 and #11 were contacted on 3/9/17 and advised that Residents #5 BMP, #8 CBC and BMP, #1 Microalbumbin, #6 HgbA1C, and #11 CMP laboratory tests were performed without physician orders. No new orders or change of orders were provided by the attending physicians.<br>2) A 100% review of resident charts was conducted by the professional nursing staff completed on 3/10/17 and found no residents with non-physician ordered laboratory tests.<br>3) The facility has implemented a new laboratory tracking policy which will provide daily alert and scheduled tracking information for laboratory testing and receipt of laboratory results. The unit secretary will monitor the tracking information daily and will prepare the appropriate | |

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Resident #5 was admitted to the facility on 07/25/16 and readmitted on 12/14/16. Diagnoses included but not limited to anemia hypertension, hip fracture, Alzheimer's disease, chronic obstructive pulmonary disease, constipation, and cataracts.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/28/16 coded the Resident as 10 out of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #5's clinical record was reviewed on 03/07/16. It contained a laboratory report for a BMP dated 08/26/16. The surveyor could not locate a physician's order for this lab test.

The surveyor asked the staff development nurse if she could locate the physician's order. The staff development nurse provided the surveyor with a copy of an order which indicated the test was to be completed on 09/01/16. Staff development nurse stated that the lab had completed the test on 08/26/16 by mistake, but had also completed it again on 09/01/16.

The concern of the missing physician's order was discussed with the administrative team during a meeting on 03/08/17 at approximately 1525.

No further information was provided prior to exit.

2. For Resident #8 the facility staff failed to obtain a physician's order prior to obtaining a CBC (complete blood count) and a BMP (basic metabolic panel).

Resident #8 was admitted to the facility on

laboratory paper work to then be acknowledged by the charge nurse. The RN Unit Supervisor will monitor 100% of resident charts for completion of scheduled and physician ordered laboratory tests for recorded results.

4) The DON and ADON will monitor daily the alert tracking and trending section of the electronic health record and will conduct a 25% review of resident records for necessary laboratory result. The DON will present findings to the Quality Assurance - QAPI Committee for necessary monitoring and follow up.

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11/20/14 and readmitted on 05/24/16. Diagnoses included but not limited to hypertension, diabetes mellitus, hyperlipidemia, multiple sclerosis, anxiety, depression, chronic obstructive pulmonary disease, dysphagia, gastroesophageal reflux disease, myasthenia gravis, end stage renal disease, and cataracts.

The most recent MDS (minimum date set) with an ARD (assessment reference date) of 02/04/17 coded the Resident as 15 out of 15 in section C, cognitive patterns. This is a quarterly MDS.

Resident #8's clinical record was reviewed on 03/07/17. It contained a laboratory report for a CBC and BMP dated 09/16/16. The surveyor could not locate a physician's order for these labs. The surveyor asked the staff development nurse if she could locate the missing order, and she could not.

The concern of the missing physician's order was discussed with the administrative team during a meeting on 03/08/17 at approximately 1525.

No further information was provided prior to exit.
3. The facility staff failed to obtain a physician order prior to obtaining a laboratory test on Resident #1.

Resident #1 was readmitted to the facility on 12/21/16 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, dementia, Parkinson's Disease, anxiety disorder and depression. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/4/17 with a BIMS (Brief Interview for Mental Status, an assessment tool used) with a score of 3 out of a

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possible score of 15. Resident #1 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene.

The surveyor conducted a clinical record review of Resident #1's chart on 2/23/17. In performing this review, the surveyor noted there was a result in the chart dated on 6/14/16 for a Microalbumbin. There was no physician order noted in the clinical record for this laboratory test.

The administrative team was notified of the above documented findings on 3/8/17 at 3:35 by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 3/9/17.

4. The facility staff failed to obtain a physician order prior to obtaining a laboratory test for Resident #6.

Resident #6 was admitted to the facility on 9/4/15 with the following diagnoses of, but not limited to anemia, coronary artery disease, high blood pressure, diabetes arthritis, dementia, anxiety disorder, and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/2/8/17 the resident was coded as having a BIMS (Brief Interview for Mental Status, an assessment protocol) score of 0 out of a possible score of 15. Resident #6 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and bathing.

The surveyor conducted a clinical record review of Resident #6's clinical record on 3/7/17. In performing this review, the surveyor noted there

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was a result in the chart dated on 8/22/16 for a HgbA1C. There was no physician order noted in the clinical record for this laboratory test.

The administrative team was notified of the above documented findings on 3/8/17 at 3:25 pm.

No further information was provided to the surveyor prior to the exit conference on 3/9/17.

5. The facility staff failed to obtain a physician order prior to obtaining a laboratory test for Resident #11.

The clinical record of Resident #11 was reviewed 3/7/17 through 3/9/17. Resident #11 was admitted to the facility 7/24/14 with diagnoses that included but not limited to pain, anemia, hypothyroidism, hyperlipidemia, major depressive disorder, anxiety, transient cerebral ischemic attack, insomnia, hypertension, gastroesophageal reflux disease, contracture left arm and trigger finger, left ring finger.

Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/13/17 assessed the resident with a cognitive summary score of 03 out of 15. Resident #11 was assessed without delirium, psychosis, or behaviors that were directed at others.

The surveyor reviewed the laboratory section of the clinical record on 3/7/17. The results of a comprehensive metabolic panel dated 6/27/16 were found. However, the surveyor was unable to locate a physician order for the laboratory test.

The surveyor discussed the issue with the staff development licensed practical nurse on 3/8/17 at

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8:22 a.m. The staff development L.P.N. stated she would check the lab request form to see what lab test was marked. 8:45 a.m. SD LPN informed the surveyor that a BMP (basic metabolic panel) was marked on the lab request form but she had no idea why the contracting laboratory completed a CMP in addition to a BMP. The surveyor asked if the nursing staff compared the physician order to the lab tests obtained. She stated yes. SD LPN also stated the admissions nurse was currently doing laboratory audits that were started in November 2016. SD LPN stated there was no way to schedule laboratory tests in the current electronic record unless it was ordered every x amount of months. She stated "You can't track labs in the electronic record like you can on paper."

The surveyor informed the administrative of the concern with obtaining laboratory tests without a physician order in the end of the day meeting on 3/8/17 at 3:25 p.m.

No further information was provided prior to the exit conference on 3/9/17.