COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

June 27, 2017

Ms. Karen Pohl, Administrator
Newport News Nursing & Rehab
12997 Nettles Drive
Newport News, VA 23602

RE: Newport News Nursing & Rehab
Provider Number 495340

Dear Ms. Pohl:

An unannounced standard survey, ending June 15, 2017, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Five complaints were investigated during the survey. One complaint was substantiated, with deficiencies. One complaint was substantiated, with no deficiencies. Three complaints were unsubstantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Elizabeth Hudnall, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).
- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,
- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Elizabeth Hudnall

Elizabeth Hudnall, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman
Joann Atkins, Dmas (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495340	A. BUILDING _____ B. WING _____	C 06/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT NEWS NURSING & REHAB	12997 NETTLES DRIVE NEWPORT NEWS, VA 23602

(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
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 06/13/17 through 6/15/17. Five complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements.

The census in this 102 certified facility was 95 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents #1 through 16) and 7 closed record reviews (Residents #17 through 23).

Preparation and submission of this plan of correction does not constitute and admission, or agreement by the provider, of the truth or the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under State and Federal law.

F 157 SS=D 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

F 157

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

1. Resident #1 physician was notified of the urine analysis results. Resident #21 was discharged from the facility on 2-3-2017
2. A quality monitoring tool was completed on 6-27-2017 to identify any resident's with an order for an urinalysis and to identify any resident who have had a change in condition in the last 30 days .
3. Director of nursing or designee educated staff on policy and procedure for notifying physician of urine analysis results and notifying responsible party on change of conditions.
4. The director of clinical services or designee to monitor Nurses notes, SBAR's and physician orders daily and a quality monitor to be performed3 times per week for 4 weeks on each shift to ensure compliance with Notification of physician and responsible party and then 1 time weekly for one month then quarterly thereafter. The results of the quality monitoring to be discussed at QAPI meeting for review , analysis and further recommendations.
5. A.O.C. is July 18,2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Pohl	Executive Director	6/30/17

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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(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and facility policy review, the facility staff failed to notify the physician of a condition that would require a need to commence a medical treatment to deal with a medical problem for 1 resident (Resident #1) and failed to notify the Resident Representative of a change in condition for 1 resident (Resident #21) in the survey sample of 23 residents.

1. The facility staff failed to notify the physician regarding the results of a Urine Analysis/Culture and Sensitivity that had resulted in a urinary tract

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infection that required immediate physician intervention for Resident #1.

2. The facility staff failed to notify the Resident Representative of a change in condition requiring physician intervention for Resident #21.

The findings include:

1. Resident #1 was admitted to the nursing facility on 6/21/16 with diagnoses that included but was not limited to osteoporosis, chronic pain, joint stiffness and high blood pressure.

The most recent Minimum Data Set (MDS) was a Significant Change in Status assessment dated 6/9/17 and coded the resident with a score of 3 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the skills for daily decision making. The resident required extensive assistance from two staff for bed mobility and transfers. She required extensive assistance of one staff for locomotion on and off the unit, dressing, eating and personal hygiene. The resident was totally dependent on two staff for bathing. The resident was assessed frequently incontinent of bowel and bladder.

The care plan dated 2/9/17 identified Resident #1 had a Urinary tract Infection and antibiotics were initiated on 2/10/17. Isolation precautions were initiated due to *ESBL infection in the urine.

*ESBL (Extended Spectrum Beta-Lactamase) are Gram-negative bacteria that produce an enzyme; beta-lactamase that has the ability to break down commonly used antibiotics, such as penicillins and cephalosporins and render them ineffective

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for treatment.
www.health.gov.nl.ca/health/publichealth/cdc/.../extended_spectrum_hcp.pdf

Extended-spectrum beta-lactamase-producing bacteria require contact isolation practices necessary within a health care facility to prevent the spread of these bacteria, which can potentially cause life-threatening infections. Recommendations from the Centers for Disease Control and Prevention are discussed, including isolation practices utilized at a multihospital health care system.
https://www.ncbi.nlm.nih.gov/pubmed/21160300

The nurse's notes dated 2/10/17 2:29 a.m. indicated "MD aware of results from UTI, gave order for IVANZ 1 Gram with lidocaine every day (QD) X (times) 7 days and she is to be on isolation-urine contains ESBL in the urine."

The Nurse's notes dated 2/10-19/17 indicated the *IVANZ IM (Intramuscular) was administered daily and the resident was maintained on contact precautions. The last dose of antibiotic was administered on 2/19/17 and contact precautions were discontinued 2/19/17.

*IVANZ/Ertapenem injection is used to treat certain serious infections, including pneumonia and urinary tract, skin, diabetic foot, gynecological, pelvic, and abdominal (stomach area) infections, that are caused by bacteria. Ertapenem is in a class of medications called carbapenem antibiotics. It works by killing bacteria. Ertapenem injection comes as a powder to be mixed with liquid to be injected intravenously (into a vein) or intramuscularly (into a muscle). It is also may be given once or twice a

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day intramuscularly for up to 7 days. The length of treatment depends on the type of infection being treated.

On 6/13/17 and 6/14/17 the lab results could not be located in the electronic record, or in the physician's communication binders.

On 6/14/17 around 1:00 p.m., the Director of Nursing (DON) stated she had to call the laboratory company to obtain a copy of the UA/C&S. Upon review of the results, it indicated the urine sample was collected on 1/31/17 and reported to the facility on 2/2/17 that resulted in a Urinary Tract Infection (UTI) *Escherichia Coli, ESBL resistance due to Extended Spectrum B-Lactamase. There were no nurse's notes to validate action on this abnormal lab result until 2/10/17. The DON stated she would have to investigate why the delay in treatment and delay in initiating contact precautions for ESBL in the urine.

*Escherichia coli (E. coli), a type of bacteria commonly found in the gastrointestinal (GI) tract carried in feces (http://www.mayoclinic.org/diseases-conditions/urinary-tract-infection/basics/causes/CON-20037892)

On 6/15/17 at approximately 10:00 a.m., the DON presented further information regarding the delay in treatment for the UTI: "On 2/1/17 at 12:15 p.m., the lab called and spoke to Licensed Practical Nurse (LPN) #1 to report urine result of ESBL/Ecoli of urine. On 2/2/17 at 11:03 a.m., the lab called the facility and no pick up reported by the lab. Lab reported they got a voicemail. On 2/2/17 sensitivity of urine was faxed by the lab to

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the facility X3 after lab had called the facility. Lab had no name of the nurse that requested the information. On 2/10/17 orders were obtained for the ESBL infection in the Urine for INVANZ solution 1 gram IM at hour of sleep times 7 days. Isolation was discontinued on 2/20/17." The DON stated it was the labs protocol to call all critical and abnormal labs results over that need a physician's immediate attention. The DON stated she spoke to LPN #1 and it was determined she failed to follow through on contacting the physician to inform him of the abnormal labs and obtain further orders. The DON stated it was the lab that was reaching out for action by the nursing staff and physician. She stated it was her expectation that the nurse immediately call the physician to inform him of any abnormal labs for immediate attention, write on the lab slip, the physician was called with date and time, any orders and place in the perspective physician's communication binder. The DON stated, none of the above was done and it appeared the lab made contact with the physician. She stated failure of the LPN to call the physician with the abnormal labs delayed treatment for at least 8 days and immediate isolation precautions for an organism that could be spread to other residents.

On 6/15/17 at 12:30 p.m., the DON stated she called Resident #1's physician to see if she remembered anything about why the delay in treatment for the ESBL infection, and to see if she had any progress notes as to why she ordered the UA/C&S; the physician had no progress notes and could not recall why she ordered the urine sample.

The facility's Policies and Procedures subject: "Change in Resident Condition" with effective

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date of 11/30/14 read, in part:

Policy: The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as possible.

Procedure:...The Physician/Family/Responsible Party will be notified as soon as possible include but not limited to significant change, accident/incident, change in treatment, transfer, D/C (discharge)...Notification of the Physician and agent/surrogate/ contact person of a significant change in status shall routinely occur during the shift in which it occurs.

On 6/15/17 at 3:00 p.m., during the pre-exit meeting with the Administrator and the DON, no further information was provided to the survey team.
2. The facility staff failed to notify the Resident Representative of a change in condition requiring physician intervention for Resident #21.

During a complaint investigation the complainant alleged the facility staff failed to notify the Responsible Representative (RR) of a change in condition that occurred on 2/2/17.

Resident #21 was admitted to the facility on 12/16/16 for skilled services. The resident's diagnoses include, but were not limited to recent history of a brain aneurysm (1) status post clipping, subsequent functional quadraplegia (2), tracheostomy (3) and sacral pressure ulcer.

The admission MDS (Minimum Data Set) with an assessment reference date coded the resident as

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having long and short term memory deficits. The resident was coded as receiving applications of dressings, oxygen and trach care.

The Progress Notes dated 2/2/17 and timed for 11:08 pm, read in part: "...CNA (Certified Nurse Aide) noticed that patient was warm to touch. Upon checking vitals: Temp 101.6, BP 141/80, pulse 140 and blood sugar 136...Called on call (name). At 11:15 pm, the nurse then documented, "Will put in all orders per (name of Nurse Practitioner/ NP)."

The NP ordered a stat chest X-ray, complete blood count, and a rapid flu swab.

The complainant alleged that on 2/3/17 she and other family had visited with the resident and left before 3:45 pm. During that time the new unit manager came into the resident's room and introduced herself. The complainant stated she expressed concerns of the sacral wound odor. The unit manager informed her that the resident's vital signs were going to be taken, due to the resident having had a fever the night before. The RR was asked by the unit manager if someone had called to notify her of this, she stated no.

There was no documentation in the clinical record to indicate the Responsible Representative was notified of the resident's change in condition on the night of 2/2/17 that required physician notification and change in treatment. At 3:45 pm on 2/3/17 after the lab results were received, orders were obtained to send the resident out for an Emergency Room evaluation, at which time the RR was notified. The resident was admitted to the hospital.

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On 6/15/17 the Director of Nursing was interviewed. The above findings was shared. She was asked if the facility staff should have notified the RR of the resident's change in condition the night of 2/2/17. The DON nodded her head "yes" and stated, "It was a change in condition".

The facility's Policies and Procedures subject: "Change in Resident Condition" with effective date of 11/30/14 read, in part:

Policy: The Clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as possible.

Procedure:...The Physician/Family/Responsible Party will be notified as soon as possible include but not limited to significant change, accident/incident, change in treatment, transfer, D/C (discharge)...Notification of the Physician and agent/surrogate/ contact person of a significant change in status shall routinely occur during the shift in which it occurs.

The above findings was shared with the Administrator, the Director of Nursing and the Corporate Nurse during a pre-exit meeting conducted on 6/15/17 at 1:30 pm.

1. Aneurysm-Localized abnormal dilatation of a blood vessel, usually an artery due to an congenital defect or weakness of the vessel. (Source-Taber's Cyclopedic Medical Dictionary, Edition 20.)
2. Quadraplegia-Paralysis of all four extremities.

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F 157	Continued From page 9 (Source-Taber's Cyclopedic Medical Dictionary, Edition 20.) 3. Tracheostomy- The surgical opening of the trachea to provide and secure an airway. (Source-Taber's Cyclopedic Medical Dictionary, Edition 20.)	F 157		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 164	1. Registered nurse #2 was educated on 6-16-2017 on the policy of providing privacy. 2. Any resident of the facility has the potential to be affected. 3. Director of nursing or designee educated staff on policy and procedure for providing privacy. 4. The director of clinical services or designee to monitor staff providing privacy and a quality monitor to be performed 3 times per week for 4 weeks on each shift to ensure compliance with providing privacy, 1 time weekly for one month then quarterly thereafter. The results of the quality monitoring to be discussed at QAPI meeting for review, analysis and further recommendations. 5. A.O.C. is July 18,2017	

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(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review the facility staff failed to provide privacy during the provision of care for 1 of 23 residents in the survey sample, Resident #3.

The facility staff failed to close the door completely and pull the privacy curtain during a dressing change for Resident #3.

The findings included:

Resident #3 was admitted to the facility on 8/29/16 with diagnosis to include, but not limited to; a stage III pressure ulcer to the right outer ankle (1).

The current MDS (Minimum Data Set) with an assessment reference date of 4/5/17 coded the resident as scoring a 13 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact.

The physician's orders dated 6/5/17 included a treatment to cleanse the right outer ankle pressure ulcer with normal saline, apply silver

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F 164	Continued From page 11 hydrogel and a protective dressing once a day. The right ankle dressing change observation was conducted on 6/14/17 at 3:30 pm. The nurse was Registered Nurse #2. The resident was sitting in a wheelchair, the nurse failed to close the resident door completely and failed to pull the privacy curtain. The resident's roommate was in bed. After the dressing change the nurse was interviewed. The observation of failing to provide privacy with closing the door and curtains was shared. The nurse stated, "Yes", when asked if the resident should have been provided privacy. The above observation was shared with the Administrator, the Director of Nursing and the Corporate Nurse during a pre-exit meeting conducted on 6/15/17 at 1:30 pm. A policy was requested for the provision of privacy during care. The Corporate Nurse stated the facility did not have a policy and provided a blank Performance Improvement audit titled "Dignity & Privacy" revised 3/2014. Question #13 read, Is resident's privacy maintained when doctor, nurse, or staff provide care, or others visit. 1. Stage III Pressure Ulcer-Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. (Source: MDS Version 3.0)	F 164		
F 167 SS=D	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to-	F 167		

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(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and

(g)(11) The facility must--

(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.

(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and

(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

(iv) The facility shall not make available identifying information about complainants or residents.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interview, the facility staff failed to post the past three years of survey results conducted by Federal or State surveyors.

The findings included:

During the General Observations of the facility on 06/13/17 through 06/15/17 the facility staff failed to have a posting and make the results of the past three years survey results readily accessible

1. Survey results for the past three years survey were made readily accessible on 6-16-2017 and notice is posted in facility.
2. Any resident of the facility has the potential to be affected.
3. Staff educated on 6-16-2017 that survey results For the past three years must be readily accessible and posted and on location of the survey results.
4. The executive director or designee to monitor that the posting is readily accessible and posted in facility and a quality monitor to be performed 3 times per week for 4 weeks on each shift to ensure compliance with survey results being readily accessible and posted 1 time weekly for one month then quarterly thereafter. The results of the quality monitoring to be discussed at QAPI meeting for review, analysis and further recommendations.
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F 167	Continued From page 13 to residents and the public. A review of the survey results book identified by the facility, contained one year of survey results. There were no notice of where the most recent past three years of the Federal survey results could be located for examination. During an interview on 06/15/17 at 1:25 P.M. with the Administrator, she stated I have not been here but for a few months. The Administrator searched for about 20 minutes to produce three years of back survey results. When told the survey results did not include the posting of where the past three years survey results could be found, she stated, "I will need to look through the files." The facility staff failed to have the survey results of the past three years posted for examination.	F 167		
F 226 SS=E	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,	F 226		

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F 226	Continued From page 14 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on employee personnel file reviews, staff interview and facility document review the facility staff failed to implement their abuse prohibition policy and procedures for screening of new hires. The findings included: On 6/14/17 five (5) newly hired employee personnel files were reviewed. For two employees the criminal background checks (CBC) were not obtained prior to orientation as follows: 1. CNA (Certified Nurse Aide) hired on 3/27/17-CBC screening was done on 6/14/17. 2. Registered Nurse (RN) hired on 4/11/17-CBC screening was done on 6/13/17. The four newly hired employees licensure verification was not obtained prior to orientation as follows:	F 226	1. Director of human resources educated on 6-16-2017 on the policy and procedure the abuse prohibition for screening of new hires. 2. Any resident of the facility has the potential to be affected. 3. Quality monitoring tool was completed on all new hires in last 30 days To ensure compliance with policy and procedure on prescreening new hires . 4. The executive director or designee to monitor that all new hires will have prescreening done per policy and a quality monitor to be performed 3 times per week for 4 weeks on each shift to ensure compliance with all new hires having prescreening completed 1 time weekly for one month then quarterly thereafter. The results of the quality monitoring to be discussed at QAPI meeting for review , analysis and further recommendations. 5. A.O.C. is July 18,2017	

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F 226	Continued From page 15 1. Licensed Practical Nurse (LPN) hired on 5/23/17 not verified until 5/27/17. 2. CNA hired on 3/13/17 not verified until 3/17/17 3. CNA hired on 4/11/17 not verified until 6/14/17 4. RN hired on 4/11/17 not verified until 5/27/17 An interview was conducted with the Human Resource Coordinator (HRC) on 6/14/17 at 1:30 pm. She stated she was fairly new to the facility and had noted in May (2017) that some of the employee files did not contain the required screening. She stated the hire date is the date of orientation. She stated that that the offer of a job is contingent on the screening to include CBC and licensure/ registry verification prior to hire. The facility's Resident Abuse Policy and Procedure with a revision date of 2/1/17 read, in part: Screening- Persons applying for employment with a The Company facility will be screened for a history of abuse, neglect, or mistreating residents to include: Criminal Background check (VA specific; after hire, during orientation). Abuse check with appropriate licensing board and registries, prior to hire. Verify license or registration prior to hire. The above findings was shared with the Administrator, the Director of Nursing and the Corporate Nurse on 6/15/17 at 1:30 pm.	F 226		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility	F 309		

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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.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
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.

(l) 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 clinical record review, staff interview and facility policy review, the facility staff failed to obtain orders to treat a known infection for 1 of 23 residents (Resident #1) in the survey sample.

Resident #1's Urine analysis/culture and

1. Resident #1 does not currently have any signs or symptoms of a urinary tract infection and does not require isolation.
2. A quality monitoring tool was completed on 6-27-2017 to identify any resident that has had a diagnosis of urinary tract infection requiring isolation in last 30 days.
3. Director of clinical services or designee educated staff on policy and procedure of isolation and initiation of treatment.
4. The director of clinical services or designee to monitor that all new hires will have prescreening done per policy and a quality monitors to be performed 3 times per week for 4 weeks on each shift to ensure compliance with initiation of treatment and need for isolation
1 time weekly for one month then quarterly thereafter.
The results of the quality monitoring to be discussed at QAPI meeting for review, analysis and further recommendations.
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sensitivity report indicated a Urinary Tract Infection (UTI) that required Antibiotic therapy and isolation precautions. The resident did not start treatment until 8 days later.

The findings include:

Resident #1 was admitted to the nursing facility on 6/21/16 with diagnoses that included but was not limited to osteoporosis, chronic pain, joint stiffness and high blood pressure.

The most recent Minimum Data Set (MDS) was a Significant Change in Status assessment dated 6/9/17 and coded the resident with a score of 3 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the skills for daily decision making. The resident required extensive assistance from two staff for bed mobility and transfers. She required extensive assistance of one staff for locomotion on and off the unit, dressing, eating and personal hygiene. The resident was totally dependent on two staff for bathing. The resident was assessed frequently incontinent of bowel and bladder.

The care plan dated 2/9/17 identified Resident #1 had a Urinary tract Infection and antibiotics were initiated on 2/10/17. Isolation precautions were initiated due to *ESBL infection in the urine.

*ESBL (Extended Spectrum Beta-Lactamase) are Gram-negative bacteria that produce an enzyme; beta-lactamase that has the ability to break down commonly used antibiotics, such as penicillins and cephalosporins and render them ineffective for treatment.
www.health.gov.nl.ca/health/publichealth/cdc/.../e

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xtended_spectrum_hcp.pdf

Extended-spectrum beta-lactamase-producing bacteria require contact isolation practices necessary within a health care facility to prevent the spread of these bacteria, which can potentially cause life-threatening infections. Recommendations from the Centers for Disease Control and Prevention are discussed, including isolation practices utilized at a multihospital health care system.
https://www.ncbi.nlm.nih.gov/pubmed/21160300

The nurse's notes dated 2/10/17 2:29 a.m. indicated "MD aware of results from UTI, gave order for IVANZ 1 Gram with lidocaine every day (QD) X (times) 7 days and she is to be on isolation-urine contains ESBL in the urine."

The Nurse's notes dated 2/10-19/17 indicated the *IVANZ IM (Intramuscular) was administered daily and the resident was maintained on contact precautions. The last dose of antibiotic was administered on 2/19/17 and contact precautions were discontinued 2/19/17.

*IVANZ/Ertapenem injection is used to treat certain serious infections, including pneumonia and urinary tract, skin, diabetic foot, gynecological, pelvic, and abdominal (stomach area) infections, that are caused by bacteria. Ertapenem is in a class of medications called carbapenem antibiotics. It works by killing bacteria. Ertapenem injection comes as a powder to be mixed with liquid to be injected intravenously (into a vein) or intramuscularly (into a muscle). It is also may be given once or twice a day intramuscularly for up to 7 days. The length of treatment depends on the type of infection

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being treated.

On 6/13/17 and 6/14/17 the lab results could not be located in the electronic record, or in the physician's communication binders.

On 6/14/17 around 1:00 p.m., the Director of Nursing (DON) stated she had to call the laboratory company to obtain a copy of the UA/C&S. Upon review of the results, it indicated the urine sample was collected on 1/31/17 and reported to the facility on 2/2/17 that resulted in a Urinary Tract Infection (UTI) *Escherichia Coli, ESBL resistance due to Extended Spectrum B-Lactamase. There were no nurse's notes to validate action on this abnormal lab result until 2/10/17. The DON stated she would have to investigate why the delay in treatment and delay in initiating contact precautions for ESBL in the urine.

*Escherichia coli (E. coli), a type of bacteria commonly found in the gastrointestinal (GI) tract carried in feces (http://www.mayoclinic.org/diseases-conditions/urinary-tract-infection/basics/causes/CON-20037892)

On 6/15/17 at approximately 10:00 a.m., the DON presented further information regarding the delay in treatment for the UTI: "On 2/1/17 at 12:15 p.m., the lab called and spoke to Licensed Practical Nurse (LPN) #1 to report urine result of ESBL/Ecoli of urine. On 2/2/17 at 11:03 a.m., the lab called the facility and no pick up reported by the lab. Lab reported they got a voicemail. On 2/2/17 sensitivity of urine was faxed by the lab to the facility X3 after lab had called the facility. Lab

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had no name of the nurse that requested the information. On 2/10/17 orders were obtained for the ESBL infection in the Urine for INVANZ solution 1 gram IM at hour of sleep times 7 days. Isolation was discontinued on 2/20/17." The DON stated it was the labs protocol to call all critical and abnormal labs results over that need a physician's immediate attention. The DON stated she spoke to LPN #1 and it was determined she failed to follow through on contacting the physician to inform him of the abnormal labs and obtain further orders. The DON stated it was the lab that was reaching out for action by the nursing staff and physician. She stated it was her expectation that the nurse immediately call the physician to inform him of any abnormal labs for immediate attention, write on the lab slip, the physician was called with date and time, any orders and place in the perspective physician's communication binder. The DON stated, none of the above was done and it appeared the lab made contact with the physician. She stated failure of the LPN to call the physician with the abnormal labs delayed treatment for at least 8 days and immediate isolation precautions for an organism that could be spread to other residents.

On 6/15/17 at 12:30 p.m., the DON stated she called Resident #1's physician to see if she remembered anything about why the delay in treatment for the ESBL infection, and to see if she had any progress notes as to why she ordered the UA/C&S; the physician had no progress notes and could not recall why she ordered the urine sample.

On 6/15/17 at 3:00 p.m., during the pre-exit meeting with the Administrator and the DON, no further information was provided to the survey

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F 309	Continued From page 21 team. The facility did not have a policy and procedure titled "Physician Orders."	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review and facility document review the facility staff failed to provide Activities of Daily Living assistance to maintain good personal hygiene for 1 of 23 residents in the survey sample, Resident #15.

The facility staff failed to provide assistance with showers for Resident #15 consistent with the Resident Centered Plan of Care.

The findings included:

Resident #15 was admitted to the facility on 6/7/14 with diagnoses to include, but not limited to chronic obstructive pulmonary disease (COPD) (1).

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 5/24/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. The resident was coded as requiring physical help in part of bathing activity, to include

1. Resident #15 was showered on 6-16-2017.
2. A quality monitoring tool was completed on 6-27-2017 to identify any resident that has not a shower in last 30 days.
3. Director of clinical services or designee educated staff on policy and procedure of providing activities of daily living assistance to maintain good personal hygiene.
4. The director of clinical services or designee to monitor that all new hires will have prescreening done per policy and a quality monitors to be performed 3 times per week for 4 weeks on each shift to ensure compliance with residents receiving assistance with activities of daily living to maintain good personal hygiene. 1 time weekly for one month then quarterly thereafter.
   The results of the quality monitoring to be discussed at QAPI meeting for review, analysis and further recommendations.
5. A.O.C. is July 18,2017

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full-body bath/shower.

The Person Centered Plan of Care identified the resident had both actual and potential ADL Self Care Performance Deficits related to several medical issues to include COPD. The resident was unable to shower and dress without supervision. The goal was that the resident will receive staff support with all ADLs as needed through the next review date of 8/30/17. One of the interventions listed was to provide the resident with assistance to bathe daily and PRN (as needed). The plan of care had entries of the resident's refusal of showers on four occurrences in 2016, the last one on 10/11/ 2016, and one refusal for 2017 on 3/17/17.

During a resident Group Interview conducted on 6/14/17 at 11:15 am, the group was asked if the staff assisted them with their ADL's. Resident #15 stated she had not been offered assistance to shower in over a week. She stated she normally receives assistance with showers twice a week and recently had not been offered one.

The shower schedule was reviewed. Resident #15's showers were scheduled on Tuesdays and Fridays during the 7-3 shift.

A follow up interview with the resident in private was conducted on 6/14/17 at 4:30 pm., at the resident's bedside. The resident stated she was not sure when her shower days were scheduled and her last shower was sometime last week. She stated this was due to lack of staff. The resident was asked if she had refused a shower last week or yesterday and stated, "No, I was not offered one".

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Review of the clinical record documentation failed to evidence the resident's refusal of a shower or that a shower was offered/ provided as stated by resident. The resident was scheduled to have been offered and provided assistance with a shower Tuesday 6/6/17, Friday 6/9/17 and Tuesday 6/13/17.

On 6/15/17 at approximately 1:00 pm., the Registered Nurse #2 unit manager was interviewed. The above findings was shared. She stated she was fairly new to the facility. She stated she had just found out today that if a resident refuses a shower the CNAs are to fill out a pink Skin Observation Sheet and document the refusal on it, the pink sheet is then handed to the charge nurse. She stated the charge nurse then documents the refusal in the clinical record.

On 6/15/17 at 1:20 pm, the 7-3 shift CNA (Certified Nurse Aide #2) who was assigned to care for the resident yesterday (Tuesday) was interviewed over the phone. She was asked if the resident was assisted with a shower yesterday and stated "No". The CNA stated she had last assisted the resident with a shower on the weekend of 6/3-6/4/17. The CNA stated the resident had refused a shower yesterday. When asked if she had reported this refusal to the charge nurse she stated, "Probably not".

The above findings was shared during the pre-exit meeting conducted on 6/15/17 at 1:30 with the Administrator, the Director of Nursing and the Corporate Nurse in attendance.

1. COPD-Chronic airflow obstruction. (Source

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F 312	Continued From page 24 Taber's Cyclopedic Medical Dictionary, Edition 20).	F 312		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interview, the facility staff failed to consistently record temperatures for the hot water Hydrocollator machine and ensure recorded temperatures were within the manufacture's recommended range.	F 323	1. Hydrocollator thermostat was calibrated on 6-16-2017. A quality monitor tool was put in place on 6-16-2017. 2. All resident's have the potential to have been affected. 3. Director of therapy services or designee educated staff on 6-16-2017 on policy and procedure of care and use of hydrocollator and temperature logs to be completed daily. 4. The director of rehab services or designee to monitor Temperature logs daily and a quality monitor to be performed 3 times per week for 4 weeks on each shift to ensure compliance with temperature logs and temperature being within range 1 time weekly for one month then quarterly thereafter. The results of the quality monitoring to be discussed at QAPI meeting for review , analysis and further recommendations. 5. A.O.C. is July 18,2017	

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The findings included:

The facility staff failed to consistently record temperatures for the hot water Hydrocollator machine and ensure recorded temperatures within the manufacture's recommended range of 65 -165 Fahrenheit degrees.

During the environmental observations of the facility on 6/15/17 at 9:02 P.M. inconsistent temperatures were being recorded.
A review of the Rehabilitation Services monthly Hydrocollator Temperature/Cleaning Log indicated the following: For the month of January 2017 temperatures were recorded on the following dates: January 3, 5, 9, 10, 12, 13, 16, 17, 19, 23, 24, 25, 30 and 31.
For the month of February 2017 temperatures were recorded on the following dates: February 1, 2, 3, 6, 7, 8, 13, 14, 16, 21, 22, 23, and 27.
For the month of March 2017 no temperatures were recorded.
For the month of April 2017 temperatures were recorded on the following dates: April 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, and 27.
For the month of May 2017 temperatures were recorded on the following dates: May 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18.
For the month of June 2017 temperatures were recorded on the following dates: June 1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14.

A manufacture's guideline last updated 9/06/16 indicated: "Heating Unit has a built in adjustable thermostat which ranges between 65 and 165 F, and is certified to UL Standards."

A review of the temperature logs indicated recorded temperatures higher than 165 degrees

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F 323	Continued From page 26 F: January 2017 - January 3 - 170-F, and January 25 - 170-F. February 2017 - February 1, 2, 3, 6, 7, 8, 16, 22, and 23 (168-F); February 13 and 14 (166-F). April 2017 - April 3, 4, 5, 6, 7, 10, 12, 13, 14, 18, 19, 20, (170-F; April 11, 21 (169-F); April 17 (167-F). June 2017 - June 1, 2, 3, 5, 6, 7, 8, 11, 12, 13, 14 (170). June 9, 10 (169-F). During an interview on 6/15/17 at 9:37 A.M., the Rehabilitation Director stated, "We take the temperatures on the days in which we use the Hydrocollator machine." When asked if staff utilized the Hydrocollator on weekends he stated, "Yes." When asked had the temperature gauge been calibrated for accuracy he stated, "No". The facility staff failed to consistently record temperatures and maintain temperatures within manufacture's guidelines.	F 323		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. 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	F 441		

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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 least restrictive possible for the resident under the circumstances.

(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

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified

1. Registered nurse #2 and LPN # 2 were educated on 6-16-2017 On policy and procedure of handwashing as per the CDC guidelines
2. All resident's have the potential to have been affected.
3. Director of clinical services or designee educated staff on policy and procedure on handwashing as per the CDC guidelines.
4. The director of clinical services or designee to conduct a random observation of RN/ LPN handwashing procedure and a quality monitor to be performed 3 times per week for 4 weeks on each shift to ensure compliance with handwashing 1 time weekly for one month then quarterly thereafter. The results of the quality monitoring to be discussed at QAPI meeting for review, analysis and further recommendations.
5. A.O.C. is July 18,2017

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under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, and clinical record review the facility staff failed to implement acceptable standards of hand hygiene to prevent exposure to potentially pathogenic organisms during the provision of care for 4 of 23 residents in the survey sample, Residents #3, 6, 1 and 5.

1. The facility staff failed to practice proper hand hygiene technique and infection control practices during a dressing change observation for Resident #3.

2. The facility staff failed to practice proper hand hygiene technique and infection control practices prior to and after providing trach care for Resident #6.

3. The facility staff failed to provide contact isolation precautions for Resident #1.

4. The facility staff failed to practice proper hand hygiene technique during wound care for Resident #5.

The findings included:

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1. Resident #3 was admitted to the facility on 8/29/16 with diagnosis to include, but not limited to; a stage III pressure ulcer to the right outer ankle (1).

The current MDS (Minimum Data Set) with an assessment reference date of 4/5/17 coded the resident as scoring a 13 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact.

The physician's orders dated 6/5/17 included a treatment to cleanse the right outer ankle pressure ulcer with normal saline, apply silver hydrogel and a protective dressing once a day.

The right ankle dressing change observation was conducted on 6/14/17 at 3:30 pm. The nurse was Registered Nurse (RN) #2. The resident was sitting in a wheelchair. Prior to removal of the dressing the nurse placed all dressing supplies on a vinyl chair. The nurse then put on gloves, while opening a 4 x 4 gauze dressing the tube of silver hydrogel and the spray bottle of normal saline fell to the floor. The nozzle to the normal saline spray fell off. The nurse then picked these items off the floor and stated, "It's okay it's not open (the hydrogel tube)". She placed the spray nozzle back on the normal saline bottle and sprayed some out into the roommate's trash can to see if it was still working. The nurse then washed her hands for a count of 5 seconds and then put on two pair of gloves. The nurse then took the resident's right tennis shoe off, touching the sole with her gloved hands and then cleansed the wound with the normal saline and 4 x 4 gauze. The nurse then removed the first layer of gloves and completed the dressing change. The nurse then removed the gloves, washed her

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hands for a count of 6 seconds, and then assisted the resident to the toilet. After the resident was done, the nurse put on gloves and wiped the residents buttocks with toilet paper. The nurse then assisted the resident to wash hands. The nurse then removed her gloves and washed her hands for a count of 4 seconds and assisted the resident back into the room. Immediately afterwards she placed on gloves to assist the roommate, Resident #6.

The facility policy titled "Hand Washing Technique" with a revision date of 6/1/15 read, in part:
7. Rub hands together vigorously for 15-20 seconds, generating friction to on all surfaces of the hands and fingers. Friction removes more surface organisms than either soap or water...

The above observation was shared with the Director of Nursing on 6/15/17 prior to the pre-exit meeting.

A pre-exit meeting was conducted on 6/15/17 at 1:30 with the Administrator, the Director of Nursing and the Corporate Nurse in attendance. They indicated that they had recently conducted hand washing training and audits with staff in May (2017).

(1). Stage III Pressure Ulcer-Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. (Source:MDS Version 3.0)

2. The facility staff failed to implement proper hand washing technique and infection control

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practices prior to and after providing trach care for Resident #6.

Resident #6 was admitted to the facility on 7/22/16 with diagnoses to include, but not limited to chronic respiratory failure with tracheostomy (2).

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 3/1/17 coded the resident as scoring a 12 out of a possible 15 for the Brief Interview of Mental Status, indicating the resident's cognition was moderately impaired. Under Section O. Special Treatments, Procedures and Programs the resident was checked off as having received tracheostomy care to include oxygen and suctioning.

On 6/14/17 the nurse (RN #2) was observed assisting the resident's roommate (Resident #3)with toileting, to include wiping the resident's buttocks with toilet paper and gloves on. Afterwards the nurse removed her gloves she washed her hands for a count of 4 seconds and assisted the roommate out of the bathroom. The nurse then immediately put on gloves to tend to Resident #6 who required repositioning and trach suctioning. During the repositioning the resident was mouthing words, the nurse then placed her gloved left Index finger over the opening of the trach tube to aide the resident to speak. After repositioning, the nurse removed the gloves, washed her hands for a count of 5 seconds and then put on a pair of green gloves from the suction kit. She then used the left gloved hand to turn on the suction machine and then placed her left gloved index finger over the resident's trach once more to aide the resident to speak. After

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suctioning the resident, the nurse removed her gloves and washed her hands for a count of 6 seconds before leaving the resident's room.

The facility policy titled "Hand Washing Technique" with a revision date of 6/1/15 read, in part:
7. Rub hands together vigorously for 15-20 seconds, generating friction to on all surfaces of the hands and fingers. Friction removes more surface organisms than either soap or water...

The above observation was shared with the Director of Nursing on 6/15/17 prior to the pre-exit meeting.

A pre-exit meeting was conducted on 6/15/17 at 1:30 with the Administrator, the Director of Nursing and the Corporate Nurse in attendance. They indicated that they had recently conducted hand washing training and audits with staff in May (2017).

(2). Tracheostomy-The surgical opening of the trachea to provide and secure an open airway. (Source: Taber's Encyclopedic Medical Dictionary, Edition 20)

3. Resident #1 was admitted to the nursing facility on 6/21/16 with diagnoses that included but was not limited to osteoporosis, chronic pain, joint stiffness and high blood pressure.

The most recent Minimum Data Set (MDS) was a Significant Change in Status assessment dated 6/9/17 and coded the resident with a score of 3 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which

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indicated the resident was severely impaired in the skills for daily decision making. The resident required extensive assistance from two staff for bed mobility and transfers. She required extensive assistance of one staff for locomotion on and off the unit, dressing, eating and personal hygiene. The resident was totally dependent on two staff for bathing. The resident was assessed frequently incontinent of bowel and bladder.

The care plan dated 2/9/17 identified Resident #1 had a Urinary tract Infection and antibiotics were initiated on 2/10/17. Isolation precautions were initiated due to *ESBL infection in the urine.

*ESBL (Extended Spectrum Beta-Lactamase) are Gram-negative bacteria that produce an enzyme; beta-lactamase that has the ability to break down commonly used antibiotics, such as penicillins and cephalosporins and render them ineffective for treatment.
www.health.gov.nl.ca/health/publichealth/cdc/.../extended_spectrum_hcp.pdf

Extended-spectrum beta-lactamase-producing bacteria require contact isolation practices necessary within a health care facility to prevent the spread of these bacteria, which can potentially cause life-threatening infections. Recommendations from the Centers for Disease Control and Prevention are discussed, including isolation practices utilized at a multi-hospital health care system.
https://www.ncbi.nlm.nih.gov/pubmed/21160300

The nurse's notes dated 2/10/17 2:29 a.m. indicated "MD aware of results from UTI, gave order for IVANZ 1 Gram with lidocaine every day (QD) X (times) 7 days and she is to be on

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isolation-urine contains ESBL in the urine."

The Nurse's notes dated 2/10-19/17 indicated the *IVANZ IM/Ertapenem (Intramuscular) was administered daily and the resident was maintained on contact precautions. The last dose of antibiotic was administered on 2/19/17 and contact precautions were discontinued 2/19/17.

*IVANZ/Ertapenem injection is used to treat certain serious infections, including pneumonia and urinary tract, skin, diabetic foot, gynecological, pelvic, and abdominal (stomach area) infections, that are caused by bacteria. Ertapenem is in a class of medications called carbapenem antibiotics. It works by killing bacteria. Ertapenem injection comes as a powder to be mixed with liquid to be injected intravenously (into a vein) or intramuscularly (into a muscle). It is also may be given once or twice a day intramuscularly for up to 7 days. The length of treatment depends on the type of infection being treated.

On 6/13/17 and 6/14/17 the lab results could not be located in the electronic record, or in the physician's communication binders.

On 6/14/17 around 1:00 p.m., the Director of Nursing (DON) stated she had to call the laboratory company to obtain a copy of the UA/C&S. Upon review of the results, it indicated the urine sample was collected on 1/31/17 and reported to the facility on 2/2/17 that resulted in a Urinary Tract Infection (UTI) *Escherichia Coli (E.Coli), ESBL resistance due to Extended Spectrum B-Lactamase. There were no nurse's notes to validate action on this abnormal lab

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result until 2/10/17. The DON stated she would have to investigate why the delay in treatment and delay in initiating contact precautions for ESBL in the urine.

*Escherichia coli (E. coli), a type of bacteria commonly found in the gastrointestinal (GI) tract carried in feces (http://www.mayoclinic.org/diseases-conditions/urinary-tract-infection/basics/causes/CON-20037892)

On 6/15/17 at approximately 10:00 a.m., the DON presented further information regarding the delay in treatment for the UTI: "On 2/1/17 at 12:15 p.m., the lab called and spoke to Licensed Practical Nurse (LPN) #1 to report urine result of ESBL/Ecoli of urine. On 2/2/17 at 11:03 a.m., the lab called the facility and no pick up reported by the lab. Lab reported they got a voicemail. On 2/2/17 sensitivity of urine was faxed by the lab to the facility X3 after lab had called the facility. Lab had no name of the nurse that requested the information. On 2/10/17 orders were obtained for the ESBL infection in the Urine for INVANZ solution 1 gram IM at hour of sleep times 7 days. Isolation was discontinued on 2/19/17." The DON stated it was the lab's protocol to call all critical and abnormal labs results over that need a physician's immediate attention. The DON stated she spoke to LPN #1 and it was determined she failed to follow through on contacting the physician to inform him of the abnormal labs and obtain further orders. The DON stated it was the lab that was reaching out for action by the nursing staff and physician. She stated it was her expectation that the nurse immediately call the physician to inform him of any abnormal labs for immediate attention, write on the lab slip, the

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physician was called with date and time, any orders and place in the perspective physician's communication binder. The DON stated, none of the above was done and it appeared the lab made contact with the physician. She stated failure of the LPN to call the physician with the abnormal labs delayed treatment for at least 8 days and immediate isolation precautions for an organism that could be spread to other residents.

On 6/15/17 at 12:30 p.m., the DON stated she called Resident #1's physician to see if she remembered anything about why the delay in treatment for the ESBL infection, and to see if she had any progress notes as to why she ordered the UA/C&S; the physician had no progress notes and could not recall why she ordered the urine sample.

On 6/15/17 at 3:00 p.m., during the pre-exit meeting with the Administrator and the DON, no further information was provided to the survey team.

The facility staff stated they followed the Centers for Disease Control and Prevention: "For ESBL/ECOLI infection use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks."
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf

4. The facility staff failed to practice adequate hand hygiene during wound care for Resident #5.

Resident #5 was admitted to the nursing facility

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on 12/27/16 with diagnoses that included but not limited to Alzheimer's disease, anemia, chronic kidney disease and was on Hospice.

The Annual Minimum Data Set assessment dated 5/8/17 coded the resident with short and long term memory and moderately impaired in the skills needed for daily decision making. The resident was coded to have one *Stage III pressure ulcer and one *Unstageable pressure ulcer.

*Stage III pressure ulcer has full thickness loss. Subcutaneous fat may be visible but bone, tendon or muscle. Sough (soft dead yellow/tan tissue) may be present, but does not obscure the depth of tissue loss. May include undermining and tunneling (http://www.npuap.org/).

*Unstageable pressure ulcer has slough or Eschar (hard black dead adherent tissue) that is known, but unable to stage due to slough or eschar (http://www.npuap.org/).

During observation of Resident #5's wound care that was conducted on 6/14/17 at 3:00 p.m., Licensed Practical Nurse #2 washed her hands three times during the process of wound care. During these observations of hand washing/hand hygiene, she held her hand under the water with soap for approximately 3-4 seconds and turned off the faucet with the same paper towel she used to dry her hands.

On 6/15/17 at 3:00 p.m., during the pre-exit meeting with the Administrator and the DON. The DON stated she expected the standard be implemented regarding handwashing to include hold the hands under water, rubbing hands

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F 441	Continued From page 38 vigorously to exhibit friction for at least 15-20 seconds and another paper towel used to turn off the faucet.	F 441		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to ensure that the 300 unit doors were in good repair and the laundry room and dryer room were free of lint and debris. The findings included: During the environmental observations at 9:37 A.M. on 6/15/17 the following rooms on the Rosewood Unit were observed to have sharp jagged edge doors: Rooms 318, 323, 325, 327, 328 and 339. The Laundry dryer room was observed to have an outside vent which was clogged with lint and debris. The vent door was observed to be open and exposed to the outside. The dryer area was observed to have large amounts of lint, trash and	F 465	1. The dryer outside vent has been cleaned and is free from lint and debris and the missing or chipped tiles were replaced on 6-15-2017. The doors 318,323,325,327,328 and 339 will be replaced. 2. Any resident of the facility has the potential to be affected. Maintenance staff cleaned the outside vent and a quality monitoring tool to be utilized to check vent daily and all doors in center have been checked for sharp edges and quality monitoring tool to be used for checking doors for sharp edges. 3. The maintenance director or designee to complete quality monitor to be performed 3 times per week for 4 weeks on each shift to ensure compliance with vent being free from lint and debri and also doors to be checked for sharp edges1 time weekly for one month then quarterly thereafter. The results of the quality monitoring to be discussed at QAPI meeting for review , analysis and further recommendations. 4. A.O.C. is July 18,2017	

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F 465	Continued From page 39 debris. The washer area was observed to have large amounts of lint, trash and debris. The front of washer #1 and #2 was observed to have chipped and missing tiles. During an interview with the laundry room staff, she was asked when the last time the dryer and washer area had been cleaned and she stated, "Two months ago." The facility staff failed to ensure resident doors were in good repair and the laundry area was clean and free of debris.	F 465		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514	1. A quality monitoring tool was completed to validate missing documentation for last 30 days was done 6-26-2017. 2. Any resident of the facility has the potential to be affected. 3. The director of clinical services or designee to complete quality monitoring tool to be performed 3 times per week for 4 weeks on each shift to ensure compliance with missing documentation 1 time weekly for one month then quarterly thereafter. The results of the quality monitoring to be discussed at QAPI meeting for review , analysis and further recommendations. 4. A.O.C. is July 18,2017	

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(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to maintain a complete and accurate medical record for 1 of 23 residents in the survey sample, Resident #10.

The facility staff failed to complete the documentation on the Treatment Administration Record (TAR) for treatments ordered for Resident #10.

The findings included:

Resident #10 was admitted to the facility on 4/17/17. Diagnoses for Resident #10 included but not limited to, high blood pressure, cancer, and blindness.

The most recent Minimum Data Set with an assessment reference date of 5/5/17, coded Resident #10 with a score of 9 out of possible 15 on the Brief Interview for Mental Status (BIMS), indicating Resident #10 was moderately impaired in the skills needed for daily decision making.

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On 5/14/17, the facility provided a copy of the Treatment Administration Record for April 2017, May 2017 and June 2017, as requested. Review of these records found several incomplete documentation of treatment orders on the following dates and times:

A. April 2017 Treatment Administration Record:

Cleanse peg (1) site with soap and water daily, apply clean dry dressing qd (daily) every day shift - missed documentation on 4/19 at 9:00 am

PEG tube - change syringe daily every night shift - missed documentation on 4/19 night shift

Barrier Cream to buttocks with each incontinent episode each shift as prevention - missed documentation on 4/19 day shift; 4/17 and 4/23 evening shift

Enteral (2) - Check for placement every shift by auscultation (3) and aspiration - missed documentation on 4/9 evening shift

Enteral - Elevate head of bed as per policy every shift - missed documentation on 4/19 day shift; 4/9, 4/13, 4/17, 4/23 evening shift

Oral care frequently every shift - missed documentation on 4/23 evening shift

Pressure reducing mattress check every shift adequate condition every shift - missed documentation on 4/23 evening shift

Stool sample/specimen every shift - missed documentation on 4/19 day shift; 4/17, 4/23, 4/25,

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4/26, 4/28 evening shift; 4/18 and 4/26 night shift

Wheelchair cushion check every shift for proper condition - missed documentation on 4/23 evening shift.

B. May 2017 Treatment Administration Record:

Cleanse peg site with soap and water daily, apply clean dry dressing qd (daily) every day shift - missed documentation on 5/5 and 5/9 at 9:00 am

Barrier Cream to buttocks with each incontinent episode each shift as prevention - missed documentation on 5/5 and 5/9 day shift; 5/6, 5/9 and 5/30 evening shift

Enteral - Check for placement every shift by auscultation and aspiration - missed documentation on 5/5 and 5/9 day shift; 5/6, 5/9 and 5/30 evening shift

Enteral - Elevate head of bed as per policy every shift - missed documentation on 5/5 and 5/9 day shift; 5/6, 5/9, and 5/30 evening shift

Oral care frequently every shift - missed documentation on 5/5 and 5/9 day shift; 5/6, 5/9 and 5/30 evening shift

Pressure reducing mattress check every shift adequate condition every shift - missed documentation on 5/5 and 5/9 day shift; 5/6. 5/9 and 5/30 evening shift

(Brand name) heels bilaterally - missed documentation on 5/30 day shift

Turn and position frequently every 1-2 hours

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F 514	Continued From page 43 every shift - missed documentation on 5/30 evening shift Wheelchair cushion check every shift for proper condition - missed documentation on 5/5 and 5/9 day shift; 5/6, 5/9 and 5/30 evening shift. C. June 2017 Treatment Administration Record: Cleanse peg site with soap and water daily, apply clean dry dressing qd (daily) every day shift - missed documentation on 6/12 night shift Cleanse sacrum (4) with NS (Normal Saline) apply (name of medication) and cover with dry dressing change daily and PRN (5) one time a day - missed documentation on 6/2 at 10:00 am PEG tube - change syringe daily every night shift - missed documentation on 6/12 night shift Barrier Cream to buttocks with each incontinent episode each shift as prevention - missed documentation on 6/2 day shift; 6/12 night shift. Enteral - Check for placement every shift by auscultation and aspiration - missed documentation on 6/2 day shift; 6/12 night shift. Enteral - Elevate head of bed as per policy every shift - missed documentation on 6/2 day shift; 6/12 night shift. Oral care frequently every shift - missed documentation on 6/2 day shift; 6/12 night shift. Pressure reducing mattress check every shift adequate condition every shift - missed documentation on 6/2 day shift; 6/12 night shift.	F 514		

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(Brand name) heels bilaterally - missed documentation on 6/2 day shift; 6/12 night shift.

Turn and position frequently every 1-2 hours every shift - missed documentation on 6/2 day shift; 6/12 night shift.

Wheelchair cushion check every shift for proper condition - missed documentation on 6/2 day shift; 6/12 night shift.

On 6/14/17 at 12:00 pm, (Registered Nurse) RN #1, Nurse Manager, was interviewed and discussed the incomplete documentation on the Treatment Administration Records. She stated that, as Nurse Manager, she expected the nurses to complete the TARs 100%. When asked who was responsible for making sure the documentation was 100% complete, she stated that Nurse Managers are responsible, validated by the DON (Director of Nursing). She stated that TARS are monitored for completion at the end of day shift before the nurses leave and the following day for the evening and night shift. She stated, "Nurses are supposed to document. It is basic nursing."

On 6/15/17 at 8:20 am, an interview was conducted with the DON in regards to the facility process to ensure completion of documentation on the TARs. She stated that nurses were expected to check for the "green light" (in the electronic medical record, green light means that documentation has been signed off) at the end of each shift. She stated that in the morning meeting, she and the clinical staff attending would check all the records for completion and would call the nurses back to fill in the incomplete

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documentation. According to the DON, the electronic medical records have been audited on an ongoing basis and had seen some improvement in nursing documentation.

On 6/15/17 at 10:00 am, the facility Administrator provided a copy of the policy and procedure titled "Daily Skilled Nursing Progress Note" effective 11/30/14 with a revision date of 4/14/17. Completion of the Treatment Administration Record was not addressed in this policy. The facility did not have any other policy that addressed documentation, according to the Regional Director of Clinical Services.

The Administrator, DON and the Regional Director of Clinical Services were made aware of these findings on 6/15/17 at approximately 1:30 pm, no further information was provided.

Definition:

(1) Enteral - of, relating to, or affecting the intestines
(Source: http://c.merriam-webster.com/medlineplus/enteric)

(2) Auscultation - Auscultation is usually done using a tool called a stethoscope. Health care providers routinely listen to sounds of the body.
(Source: https://medlineplus.gov/ency/article/002226.htm)

(3) Peg tube - tube through the skin and the stomach wall. It goes directly into the stomach.
(Source: https://medlineplus.gov/ency/article/002937.htm)

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F 514	Continued From page 46 (4) Sacrum - The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. (Source: medlineplus.gov -> Medical Encyclopedia) (5) PRN - Latin pro re nata - as needed; as the circumstances require-used in writing prescriptions. (Source: http://c.merriam-webster.com/medlineplus/prn)	F 514		