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PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated (complaint) survey was conducted 10/8/19 through 10/10/19. One complaint was investigated during the survey. Significant corrections are required for compliance with the 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 3 resident reviews: Two current resident reviews (Resident's #1 and #2) and 1 closed record review (Residents #3).	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction.	
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690	The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated. F690 1. Resident #3 no longer resides at the nursing facility. 2. Current residents' records were reviewed for the past 30 days to ensure any change of condition was identified and addressed appropriately.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wardell Birch | TITLE: Administrator | (X6) DATE: 10/28/2019

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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and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on a complaint investigation, clinical record review, staff and family interview, the facility staff failed to assess, monitor and treat an identified problem on 6/8/19 based on Resident #3's symptomology of continued vaginal pain, as well as evidence from the results of a urine analysis on 6/10/19 which pointed to signs of a Urinary Tract Infection (UTI). The resident was transported the local emergency department (ED) on 6/14/19 with diagnosis of severe sepsis and septic shock.

The findings included:

Resident #3 was admitted to the nursing facility on 12/12/17 with diagnoses that included fractured tibia, high blood pressure, stroke, generalized muscle weakness and calculus in the bladder. The resident was discharged to the local hospital on 6/14/19 with a diagnoses of severe sepsis and septic shock.

Resident #3's most recent operational Minimum Data Set (MDS) assessment prior to discharge

3. Licensed staff will be re-educated on documentation and the INTERACT process. A review of residents' change of condition will be conducted in morning meeting 5 times a week.

4. Random audits of residents' change of condition will be completed 2 times per week for 90 days. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance.

5. Compliance Date: 11/1/2019

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was dated 5/3/19. The resident was coded with a score of nine out of a possible 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was moderately impaired with the cognitive skills necessary for daily decision-making. The resident was assessed to require extensive assistance of two staff for bed mobility and bathing. She was coded to require extensive assistance of two staff for dressing, toileting and personal hygiene. The resident was bedbound and did not ambulate or use a wheelchair. Resident #3 was assessed to require supervision (cueing and oversight) with set up for eating. Resident #3 was coded as always incontinent of bowel and bladder. The resident was not assessed to have a UTI within the last 30 days.

The care plan revised on 11/29/18 identified pain as one of the resident's focus areas. The goal set for the resident by the staff was that the resident would maintain adequate level of comfort as evidenced by no signs/symptoms of unrelieved pain or distress, or verbalizing satisfaction with level of comfort. Some of the approaches the staff would implement to accomplish this goal included evaluate characteristics and frequency/pattern of pain and evaluate what makes the patient's pain worse and ensure care needs are met.

The following nurse's notes is a chronology from 6/8/19 to discharge 6/14/19 with applicable interviews:

-6/8/19 at 12:38 a.m., Licensed Practical Nurse (LPN) #1 (11/7) entered a Situation Background Assessment Recommendation (SBAR) indicated the resident complained of pain in her knees.

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Upon assessment, no signs of dislocation or fracture noted. The Nurse Practitioner (NP#1) was called and gave orders for ibuprofen 600 milligrams (mg) by mouth (po) every eight hours as needed.

An interview was conducted with LPN #1 on 10/10/19 at 11:25 a.m. She stated she called the NP to inform her of the resident's complaints of bilateral knee pain and thought it was different from the resident's normal complaints of general pain.

-6/8/19 at 11:42 p.m., LPN #2 (3/11 shift) entered "Resident continues to complain of pain in her vaginal area. Order received from (NP#1's name) this evening for UA/C&S (urine analysis culture and sensitivity) related to pain. Staff will continue to monitor resident." No further assessment was conducted based on the resident's symptoms to include vital signs.

*Resident #3 had a routine scheduled physician's order dated 12/22/18 for Tylenol extra strength tablet 500 mg po at 9:00 a.m., 1:00 p.m. and 7:00 p.m. for generalized pain.

A phone interview was conducted with NP #1 on 10/10/19 at 11:15 a.m. Although NP #1 gave an order for the ibuprofen, she stated she does not routinely order pain medication without knowing more about what type of BLE pain the resident was experiencing to find out the cause. She stated the nurse should have been more descriptive. She also stated, "I was called by a nurse stating the resident was having groin pain and not vaginal pain nor was I told that the pain had been continuing and from what timeframe. I ordered a UA/C&S suspicious of bladder

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problems, but nothing about the call led me to believe the situation was emergent. I may have had her evaluated if I knew it was vaginal pain." (Urinary tract infections don't always cause signs and symptoms, but when they do they may include:
-A strong, persistent urge to urinate
·A burning sensation when urinating
·Passing frequent, small amounts of urine
·Urine that appears cloudy
·Urine that appears red, bright pink or cola-colored - a sign of blood in the urine
·Strong-smelling urine
·Pelvic pain, in women - especially in the center of the pelvis and around the area of the pubic bone.
https://www.mayoclinic.org/diseases-conditions/urinary-tract-infection/symptoms-causes/syc-20353447).

-6/14/19 at 2:02 p.m., LPN #3 indicated that Certified Nursing Assistant (CNA) #1 informed her that the resident had not voided during the 7/3 shift. LPN #3 called the physician and obtained an order to straight catheterize the resident and leave in place if urinary retention is greater than 100 cubic centimeters (cc). The nurse's note indicated the urinary output was less than 20 cc's with a white milky discharge and foul odor

LPN #3 was interviewed on 10/9/19 at 11:37 a.m. According the LPN she was the assigned nurse on 6/14/19 for the 7/3 shift. She stated the resident was fine and did not look any different from the previous day nor had the night shift nurse reported any physical/medical issues, complaints or problems. She stated she was not in any acute signs of distress on the 7/3/ shift and was administered her scheduled Tylenol. She

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stated at around 1:30 p.m., the Resident Representative informed her Resident #3 was complaining of vaginal pain, but she had just administered Tylenol at 1:00 p.m. She stated at 2:00 p.m., the CNA came to inform her the resident had not voided during the shift. She stated she called to inform the on call physician/nurse practitioner and received orders to strait catheterize the resident and leave catheter in place for urine output greater than 100 cc, but the output was only 20 cc. She said, upon catheterization the resident possessed a strong foul order with a white milky discharge. She stated she knew a U/A and C&S had been drawn and the results were pending.

-6/14/19 at 3:51 p.m., LPN #2 indicated the resident had low oxygen saturation of 82% (normal is 95-100-https://www.mayoclinic.org/symptoms/hypoxemia/basics/causes/sym-20050930), low blood pressure=80/49, respiratory rate=22, pulse=64 and temperature=98.2. "Resident alert, lethargic, not talking, but able to talk." EMS (911) was called and the resident was placed on "oxygen 2 liters/minute via nasal cannula continuously, every shift face mask applied (sic) until paramedics arrived."

A phone interview was conducted on 10/9/19 at 5:40 p.m. with LPN #2 who entered the nurse's note on 6/8/19 at 11:42 p.m. and the nurse's note on 6/14/19 at 3:51 p.m. The LPN stated she called the physician on 6/8/19 due to the resident's continued vaginal pain. When asked how long had the resident had the vaginal pain, she responded, "On and off." She stated she knew she performed an assessment of the resident's abdomen, bowel sounds and vital

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signs, but failed to document the assessment. She stated, "I would have done all that before I called the physician so they would have this information, knowing they would need it. Maybe it is on the vital sign sheet for that day." The Director of Nursing (DON) searched and was not able to provide any additional assessment or vital signs documentation. LPN #2 stated, "When I got the urine sample it was Saturday (6/8/19) and I was told no urine samples could go out STAT, so it was placed in the refrigerator until normal lab pick up on Monday (6/10/19)."

During continuation of the aforementioned interview, LPN#2 said on 6/14/19, a little after her shift started on 3/11, CNA #1 asked her to assess Resident #3 because she "did not look well." The LPN stated, the resident's blood pressure was very low, she was lethargic and her O2 saturation levels were very low. LPN #2 stated she placed an oxygen mask on the resident and called 911. She stated the 7/3 nurse (LPN #3) did not report anything unusual about the resident at shift change.

A phone interview was conducted with the facility's laboratory company on 10/9/19 at 4:05 p.m. They stated they a UA could have been ordered stat with a phone call to them and a pick up would be made within 2-3 hours and taken to the contracted hospital/facility for processing with results the next day, 6/9/19. They stated that would offer an opportunity for the medical team whether or not to treat.

An interview was conducted with Certified Nursing Assistant's (CNA) #1 and #2 on 10/9/19 at 3:00 p.m. CNA #1 stated she was frequently assigned to Resident #3, but on the evening of

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6/14/19, the day the resident was sent to the hospital, she had the resident across the hall. The CNA stated, "It was not unusual for me to check on the resident and when I went to see her she was really not herself. I could see her from across the hall though. She had taken off all her clothes, was lethargic, sweating and disoriented and did not respond to me as she normally did. She had been going down for about a week, not wanting to feed herself and was hardly drinking anything. I went to the nurse that I knew would go immediately and check on her, (LPN #2's name) and she went in right away to assess (the resident's name)." CNA #1 stated she had been telling the nurses about a week that the resident was not eating well nor drinking, but felt they were not doing anything about it. When asked if she utilized the facility's "Stop and Watch Early Warning Tool" which would validate all the times she told the nurse, she stated, "No, I just told them, but I guess I should have." During the interview, CNA #2 said she worked every other weekend and was assigned the resident on the 6/14/19 for the 3/11 shift and validated the condition the resident was in as described by CNA #1.

During clinical record review, NP #2 progress notes dated 6/11/19 indicated Resident #3 was being seen for lab follow up and issues with abdominal pain. The U/A revealed positive nitrates and positive leukocytosis with urine culture and sensitivity pending. The notes indicated "Started on Cipro 250 (antibiotic) mg q (every) 12 H (hours) until urine C&S results ...Urine analysis for infection." The U/A laboratory report dated 6/10/19 revealed cloudy urine, positive nitrates (negative=normal), 2+ leukocytes (negative=normal), 3+ blood (negative=normal),

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Red blood and white blood cells were TNTC (too numerous to count, 0-2=normal). Review of the physician orders and the Medication Administration Record (MAR) did not evidence Cipro orders. On 10/9/19 at 1:00 p.m., the Director of Nursing (DON), Unit I and II Managers searched the electronic medical record (EMR) as well as the paper chart and could not locate evidence of cipro orders.

On 10/9/19 at 3:45 p.m., a phone interview was conducted with NP#2. The NP stated on 6/11/19 she wrote an order for cipro 250 mg (po) by mouth every 12 hours times 7 days based on the U/A lab results of nitrates, leukocytes and her symptomology of vaginal pain. She said, "I know I wrote the order and intended to treat the resident with an antibiotic until the C&S results came in because the U/A indicated infection. I can't say what happened to the order and can't be responsible for what the nurses failed to do."

The pharmacy shipping manifest forms reviewed from 6/11-14/19, did not evidence that Cipro was delivered the nursing facility for Resident #3. The Urine C&S report sent to the facility was dated 6/14/19 (resident had been transported to the local ED and admitted to the hospital) resulted in two organisms: 1. Greater than 100,000 CFU/ML proteus mirabilis 2. Greater than 100,000 CFU/ML providencia stuartII. NP #2 noted on the Urine C&S report that she saw the report on 6/17/19 and to start Bactrim DS one by mouth every 12 hours times 14 days.

On 10/9/19 at 4:10 p.m., interviews were conducted with the Interim Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and current Unit Manager I and II. They

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searched through the paper chart, telephone orders and the Electronic Medical Director (EMS) and could not locate the orders for Cipro that the NP#2 stated she wrote to be started on 6/11/19. The DON stated all she knew was that she received a call from the nurse to inform her the resident was sent out to the hospital the evening of 6/14/19. The Interim Administrator who was also a Registered Nurse stated it was her experience based on the results of the U/A on 6/10/19 and the resident's symptoms of vaginal pain that an antibiotic be administered prophylactically, and it was also in keeping with their protocol.

On 10/10/19 at 12:17 p.m., a phone interview was conducted with the Resident Representative (RR). She stated she was informed by the hospital that the resident was in severe septic shock based on the resident's symptoms and the lab results. She stated she was told to consider hospice.

On 6/14/19 at 4:47 p.m., according to the emergency department (ED) documentation, Resident #3 presented with altered mental status and hypoxia (lack of sufficient oxygen, that can cause cellular injury to major organs-Elsevier: Pathophysiology, McCance &Huether, 2014), vital signs were BP=99/58; P=92; T=97.7 degrees; RR=24. The RR relayed to the ED physician that the resident had been declining over the past few days. The ED physician documented that the services he provided to the patient were to treat and/or prevent clinically significant deterioration that could result in the failure of one or more body systems and/or organ systems due to septic shock.

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The lab findings revealed the following abnormalities that supported severe sepsis and septic shock:
-BUN (Blood urea nitrogen)=103 (7.0-18mg/DL=normal)
-Crt (creatinine)=2.76 (0.6-1.3 mg/DL)
-BUN/Crt ratio=37 (12-20=normal)
-Alkaline phosphatase=179 (45-117 U/L=normal)
-Blood Serum WBC (White Blood Cell)=27.1 (4.6-13.2=normal)
-Blood serum RBC (Red Blood Cell)=3.36 (4.20-5.30 M/UL)
-Blood serum Hgb/Hct=9.3/28.0 (Hgb-12.0-16.0g/dl=normal/Hct-35.0-45.0 %=normal)
-Blood serum ABS. Neutrophils=24.7 (1.8-8.0 K/UL=normal)
-Blood serum lactic Acid=2.46 (0.40-2.00 mmol/L=normal)

The RR requested that Resident #3 be placed on comfort care with no aggressive treatments and discharged to hospice services within the hospital. The resident expired on 6/17/19 at 7:12 p.m. under hospice care.

The nursing facility's policy and procedures titled Loeb Minimum Criteria for Initiation of Antibiotics dated 2001 indicated treatment would be warranted in resident's without indwelling urinary catheter if they exhibited acute dysuria (exhibited by Resident #3) or fever greater than 100 degrees Fahrenheit and at least one of the following:
-New or worsening urgency
-Frequency
-Suprapubic pain (Resident #3's complaint)
-Gross hematuria
-Costovertebral angle tenderness

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The facility's Interact Tool dated 2014 indicated the algorithm for resident change in condition included the CNA, other direct care staff or family alerts the LPN or Registered Nurse (RN) and a Stop and Watch early warning tool would be completed as supporting evidence that the LPN/RN were notified of the change in condition. The LPN/RN would complete an evaluation, process the SBAR form and nurse's note and notify the physician for further guidance.

Septic shock is a serious condition that occurs when a body-wide infection leads to dangerously low blood pressure. Any type of bacteria can cause septic shock. Toxins released by the bacteria or fungi may cause tissue damage. This may lead to low blood pressure and poor organ function. Some researchers think that blood clots in small arteries cause the lack of blood flow and poor organ function. The body has a strong inflammatory response to the toxins that may contribute to organ damage. Septic shock can affect any part of the body, including the heart, brain, kidneys, liver, and intestines. Symptoms may include a high or very low temperature, little or no urine, low blood pressure, rapid heart rate, restlessness, agitation, lethargy or confusion and or decreased mental status. Septic shock has a high death rate. The death rate depends on the cause of the infection, how many organs have failed, and how quickly and aggressively medical therapy is started (https://medlineplus.gov/ency/article/000668.htm).