| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | **055826** | A. BUILDING _____ B. WING _____ | **03/12/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **COUNTRY OAKS CARE CENTER** | **830 E CHAPEL ST SANTA MARIA, CA 93454** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0582<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Some | **Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.**<br><br>Based on interview and record review, the facility failed to inform three of three sampled residents (Resident 5, Resident 37, and Resident 55) of their appeal rights and protections regarding Medicare denial of covered skilled nursing service(s). This facility failure had the potential to result in them being unaware of their right to dispute the termination decision. Findings: During a review of the facility's policy and procedure (P&P) titled, Notice of Medicare Non-Coverage (NOMNC), dated 01/02/19, the P&P indicated, The facility will give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to enrollees receiving skilled nursing no later than two days before the termination of services. During a review of the facilities business record for Resident 5, the NOMNC required for services ending 01/03/20 was omitted. During a review of the facilities business record for Resident 37, the NOMNC required for services ending [DATE] was omitted. During a review of the facilities business record for Resident 55, the NOMNC required for services ending 02/11/20 was omitted. During an interview on 03/11/20, at 1:57 p.m., with a social service designee (SSD), SSD stated they did not provide NOMNC to the three sampled residents. |
| F 0623<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Some | **Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.**<br><br>Based on record review, and interview, the facility failed to ensure one of three unsampled residents (Resident 49) and the Long Term Care Ombudsman's office received a copy of the Notice of Transfer form, when transferred to an acute hospital. This failure had the potential for Resident 49 to not have access to an advocate who could inform resident 49 of their options and rights regarding discharge. Findings: During a review of the facility's policy and procedure titled, Transfer and Discharge Notice, dated December 2016, indicated, 4. A copy of the notice will be sent to the Office of the State Long-Term Ombudsman. During a review of the facility's policy and procedure titled, Transfer or Discharge, Emergency, dated August 2018, indicated, 4. d. Prepare a transfer form to send with the patient. During a concurrent interview and record review, on [DATE], at 4:01 p.m., with Licensed Nurse (LN 2), Resident Transfer and Referral Record, dated [DATE], was reviewed. The Resident Transfer and Referral Record did not indicate that the Long- Term Ombudsman's office was notified in writing. LN 2 stated, No, I can't find it anywhere. During an interview on [DATE], at 4:05 p.m., with the Director of Nursing (DON), stated, We never send anything to the resident or responsible party (RP) and on the bottom of the transfer sheet it should say that the transfer sheet was faxed to the Ombudsman office. |
| F 0625<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Some | **Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.**<br><br>Based on interview and record review, the facility failed to notify one unsampled resident (Resident 56) of the facility bed-hold and return policy. For Resident 56, this facility failure had the potential to result in being unaware a bed-hold and return could be requested. Findings: During a review of the facility's policy and procedure (P&P) titled, Bed-Holds and Returns, dated 03/2017, the P&P indicated, Prior to transfers . residents or resident representatives will be informed in writing of the bed-hold and return policy. During an interview on 0[DATE], at 10:56 a.m., with an administrator (ADM1), ADM1 stated, (Resident 56) went to the hospital over the weekend. Further stating, We couldn't fill out the bed hold form because there was no family here at the time. ADM1 continued stating, I don't want to charge for a bed-hold. (Resident 56) likes us, (Resident 56's) family likes us, (Resident 56) will be back. During an interview on 03/11/20, at 10:20 a.m., with a medical record clerk (MR), MR reviewed Resident 56's clinical record and was unable to find documentation of Resident 56 or Resident 56's representative receiving a bed-hold and return policy notification. During an interview on 03/11/20, at 10:30 a.m., ADM1 stated not providing the bed-hold and return policy notification was a choice ADM1 made, Because I have a heart. During a review of Resident 56's Interdisciplinary Progress Note (IPN), dated 03/07/20, at 10:50 p.m., the IPN indicated, Res. wife and son was at the bedside, Resident verbalized of wanting to go to the ER just to be safe. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure: 1. A comprehensive care plan was developed for one of 12 sampled residents (Resident 26). This facility failure had the potential to prevent Resident 26 from having immediate needs met. 2. A comprehensive care plan was not implemented for one of 12 sampled residents (Resident 40).This failure had the potential for Resident 40 to have a fall from bed with possible injury. Findings: 1. Review of Resident 26's clinical records on 3/12/20, at 10:33 a.m. indicated, discharge to hospital on [DATE] with readmission back to facility on 3/7/20. The Physician's admitting [DIAGNOSES REDACTED]. Also, Resident 26 was confirmed by laboratory results with infection of norovirus on [DATE] and placed on contact isolation precautions by the physician. Further record review indicated, no care plan with interventions implemented within 48 hours of readmission was found. During a concurrent interview and record review on 3/12/20 at 11:30 a.m., with Licensed Nurse 1 (LN1) indicated, care plans are usually only found in the residents' physical charts. LN1 reviewed Resident 26's physical chart and electronic health records and indicated no care plan was found. LN1 further indicated and confirmed no care plan was initiated within 48 hours of Resident 26's readmission and should have been. The facility policy and procedure titled, Care Plans - Baseline revised 12/2016 indicated, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission.<br><br>2. During a concurrent observation and interview on 3/09/2020, at 1:48 p.m., with Certified Nursing Assistant (CNA 1), observed Resident 40's lying in bed with bed elevated in high position. CNA 1 stated, It should be low. During a review of Resident 40's care plan, dated 6/10/17, the care plan indicated, Bed in lowest position.Resident 40 is on Fall Precautions. During a review of the facility's policy and procedure titled, Falls and Fall Risk, Managing, dated March 2018, indicated |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>in part Policy Statement- Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. |
| F 0658<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure services provided by the nursing facility meet professional standards of quality.**<br><br>Based on observation, interview, and record review, the facility failed to ensure standards of care were followed when administering medication to three unsampled residents (Residents 5, Resident 32, and Resident 46). This facility failure had the potential for medication errors. Findings: Review of Potter and Perry, 6th Edition, Mosby's Fundamentals of Nursing, page 847 in the section titled, Medication Administration, indicated in part, After administering a medication, the nurse records it immediately on the appropriate record form. The nurse never charts a medication before administering it. Recording immediately after administration prevents errors. During a concurrent observation and interview on 3/11/2020, beginning at 8:27 a.m., while observing medication administration, Licensed Nurse (LN 2) initialed the Medication Administration Record [REDACTED]. During a review of the facility's policy and procedure titled, Documentation of Medication Administration, dated 4/2007, indicated in part, 2. Administration of medication must be documented immediately after (never before) it is given. |
| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure medication storage was free from expired medication. This failure had the potential for residents to receive expired medication. Findings: During a review of the facility's policy and procedure titled, Storage of Medications, dated ,[DATE], indicated in part, 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biological's. All such drugs shall be returned to the dispensing pharmacy or destroyed. During a concurrent observation and interview on [DATE], at 11:25 a.m., with Licensed Nurse (LN 1), in the medication room, observed one bottle of Multivitamin with minerals expired ,[DATE] and one full box of [MEDICATION NAME] 0.5 milligrams (mg) and [MEDICATION NAME] 3 mg Inhalation solution expired ,[DATE]. LN 1 confirmed that these items<br>were expired. LN 1 stated, Yes they are expired. |
| F 0803<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.**<br><br>Based on observation, interview, and record review, the facility failed to ensure dietary staff followed recipes and menus accurately as printed when menu recipe for puree lemon cake for 3/11/20 was not followed. This failure had the potential for residents to receive inadequate and/or incorrect nutrition that could compromise their health status. Findings: During an observation and interview on 3/11/20 at 11:19 a.m., Cook 1 (CK1) pureed lemon cake for the lunch service that day. CK1 stated, cranberry juice was used in the pureed lemon cake recipe and any kind of juice may be used in the pureed lemon cake recipe. During a review of the pureed lemon cake recipe indicated, apple juice or milk shall be used per portion pureed.<br>During an interview on 3/11/20, at 11:30 a.m., CK1 reviewed recipe and confirmed the recipe for pureed lemon cake was not followed. The facility's policy and procedure titled, Pureed Diet dated 1/1/17, indicated in part, 'Mechanically altered diet' is one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physicians' order .7. Standardized recipes will be followed when pureeing food items. These can be found in the recipe book provided with each menu cycle and/or within the regular recipes provided. |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to store, prepare, and serve food in a safe and sanitary manner when: 1. A pan used in food preparation was improperly stored in an unclean area. 2. The minimum data set coordinator (MDS) did not wash hands between providing care to two of two un-sampled residents (Residents 10 and 29) during lunch. 3. Certified nurse assistant did not wash hands after touching soiled trays from lunch and before providing food to one of one un-sampled residents (Resident 10). 4. Two boxes of cereal found unsealed and open to air in the pantry storage area. 5. The door leading from the kitchen to the outside was left open with no barrier to prevent flies or rodents from entering the kitchen. 6. During food preparation a dietary aide used bare hands to mop up a spill and did not wash hands before touching a food cart. 7. Potentially hazardous foods stored in the refrigerator had no expiration dates, use by dates, and no cool down was performed to indicate foods were safe for residents to consume. 8. An entry on the facility's Cool Down Log indicated pork cooked at the dinner meal on [DATE] had an improper cool down performed on [DATE] and marked as standard met. These deficient practices had the potential to cause foodborne illness to the highly susceptible residents currently residing in the facility. According to the FDA (Food and Drug Administration) Food Code 2017, A Highly susceptible population means persons who are more likely than other people in the general population to experience foodborne disease because they are: (1) Immunocompromised; .or older adults; and (2) Obtaining food at a facility that provides services such as.health care. Findings: According to the Food and Drug Administration (FDA) Food Code 2017 in the section, Foodborne Illness Estimates, Risk Factors, and Interventions Epidemiological outbreak data repeatedly identify five major risk factors related to employee behaviors and preparation practices in retail and food service establishments as contributing to foodborne illness: improper holding temperatures, inadequate cooking, such as undercooking raw shell eggs, contaminated equipment, food from unsafe sources, and poor personal hygiene. The same document identified potentially hazardous foods included eggs, meat, and cereals and .foods prepared from ingredients at ambient temperature, such as .canned tuna. The facility policy and procedure titled Policy and Procedure dated Revision [DATE] (1), (2), (3), and unrevised dated 2017 indicated in part .once equipment is cleaned .it must be placed on a clean dry surface .hands must be washed .avoid bare hand contact with (resident) food . wash hands after picking up soiled trays .label and date foods .doors should be closed to prevent flies and rodents .do not do cleaning while food is being prepared .foods shall be labeled with day prepared and discarded on or before the 7th day .cooked foods are best cooled rapidly within 2 hours from 135F to 70F, and within 4 more hours to the temperature of approximately 41F or below. The total time for cooling from 135F to 71F should not exceed 6 hours. 1. During a tour of the kitchen on [DATE], at 11:50 a.m., a pan used in food preparation was observed sitting on top of bagged kitchen equipment touching a binder and kitchen log papers. During a concurrent observation and interview on [DATE], at 1:06 p.m., the dietary services supervisor (DSS) observed the pan still sitting on top of bagged kitchen equipment next to the kitchen door to the outside and touching a binder and papers. The DSS indicated the pan was not stored correctly and is not sanitary. 2. During a concurrent observation and interview on [DATE], at 12:25 p.m., the MDS was sitting next to and assisting Resident 29 eat lunch. The MDS got up, did not sanitize or wash hands, approached Resident 10, unwrapped a sandwich using unwashed bare hands, and handed the sandwich to Resident 10. Resident 10 took the sandwich from the MDS and began eating. The MDS returned to Resident 29, did not wash or sanitize hands, and continued to assist with lunch. The MDS agreed and confirmed hands were not sanitized or washed between providing patient care and handling prepared food and should have been. 3. During an observation on [DATE], at 12:43 p.m., the certified nurse assistant (CNA4) pick up and transported a dirty lunch tray containing left over foods with utensils to the soiled tray cart for transport back to the kitchen for washing. CNA4 did not wash hands, picked up and took a container of pudding to Resident 10. Resident 10 opened the container of pudding and began eating. CNA4 agreed and confirmed hands were not sanitized or washed after handling dirty lunch tray and before providing food to Resident 10 and should have. 4. During an observation of the facility kitchen on [DATE], at 1:06 p.m. a box of Hospitality Quick Oats (dry cereal) with an opened date of [DATE] was not sealed and was open to air inside the kitchen dry storage area. The DSS observed the opened |

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| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 2)<br>box of dry cereal confirmed and agreed the dry cereal not stored properly and should be sealed. During a visit to the facility kitchen on [DATE] at 10:04 a.m. observed an opened box of Cheerios dry cereal with an open plastic inner seal and no opened date. The DSS observed, confirmed, and agreed the box of dry cereal was undated, opened, and the inner bag was unsealed. The DSS also indicated this is a failure and the boxes of cereals should have an opened date and inner plastic lining sealed. 5. During an observation on [DATE], at 1:17 p.m., the door leading from the kitchen to the outside was open with no barrier preventing flies or rodents from entering the kitchen. The DSS observed the open door, pulled it closed, and indicated someone taking out the garbage must have forgotten to close the door. The DSS also indicated the door should not be opened because it is not sanitary and could permit flies and rodents to enter the kitchen. 6. During an observation on [DATE], at 11:24 a.m., the dietary aide 1 (DA1) touch and transport a dirty bucket and mop with bare hands from the kitchen dirty utility room to where food preparation was taking place. DA1 then moved the cart back to the dirty utility room, wrung the mop out with a mechanical wringer, and carried the mop to a spill of white liquid in the food preparation area. DA1 then used unwashed hands to move a kitchen cart of prepared lunch foods away from spill, and mopped up a small spill of white liquid. DA1 agreed and confirmed mopping should not have been performed while food preparation was in process. DA1 further agreed and confirmed gloves should have been worn and the cart of lunch foods should not have been touched with dirty hands. 7. During an interview on [DATE], at 2:52 p.m., the DSS indicated, there were no facility cool down logs because the facility does not save or serve left-over cooked foods and discards all left over foods. During an observation with the DSS on [DATE], at 2:59 p.m. inside the kitchen refrigerator, in separate covered plastic containers dated [DATE] the following was observed: left-over turkey with condensation inside of lid, left-over turkey without condensation on inside of lid, egg salad (using in house boiled eggs), cooked chocolate cake, cooked dietetic lemon cake, and three peeled boiled (in house) eggs in a bowl covered with plastic wrap. In addition, there was a covered plastic container of cooked jello dated [DATE], and two unpeeled boiled (in house) eggs in a bowl covered with plastic wrap dated [DATE]. The above refrigerated foods had no labels indicating a use by or expired date and no cool down times and temperatures found on the facility Cool Down Log for Potentially Hazardous Foods (PHF). During a concurrent interview, observation, and record review on [DATE], at 3:09 p.m. cook (CK2) observed the two containers of left-over turkey inside of the kitchen refrigerator and indicated was notified by the cook who prepared the turkey a proper cool down was performed and the turkey was ok to use for residents' dinner meal on [DATE]. CK2 reviewed the cool down log and confirmed no cool down entries for cooked turkey found on the log. CK2 stated .If I get the ok to use it (a food item) I use it. If not ok, I dump it. During an observation, interview, and record review with the DSS on [DATE] at 3:18 p.m. observed inside the kitchen refrigerator ready to serve to residents: 8 un-dated egg sandwiches and one container of left-over tuna salad. The DSS observed the food items, indicated and confirmed the boiled eggs are cooked in the kitchen and the tuna and egg salads were prepared on [DATE] during lunch preparation. The DSS reviewed the facility's Menu Alternates dated 2017 and confirmed egg and tuna salad sandwiches are available to residents daily. 8. During a record review with the DSS on [DATE] at 3:04 p.m., the facility's Winter Menu indicated pork was served for the dinner meal on [DATE]. Further review of the menu indicated pork was not served on [DATE]. Review of the facility's Cool Down Log for Potentially Hazardous Foods (PHF) (herin called log) dated [DATE] indicated a cool down procedure was performed on pork. The log indicated the following times and temperatures for the cooling down process of pork: initial temperature 180 degrees, the two-hour temperature 139 degrees, the four-hour temperature 119 degrees, the six-hour temperature 50 degrees, and the 'Standard Met Yes or No' indicated cool down was properly performed and marked 'yes=ok'. During an interview and record review on [DATE] at 5:02 p.m. the DSS reviewed and confirmed the facility Cool Down Log for Potentially Hazardous Foods (PHF) indicated the safe cool down procedure is within 2 hours from 135F to 70F; and within a total of 6 hours from 135F to 41F or less. The DSS further indicated and confirmed the facility Cool Down Log for Potentially Hazardous Foods (PHF) had no entries for any of the left-over foods in the kitchen refrigerator, the pork cool down was performed improperly, and only the left-over tuna had a label indicating a use by date. The DSS also indicated the expectation is foods in the refrigerator should have expiration or use by dates and proper cool down procedures should be performed on any PHF and entered onto the log. During an interview on [DATE] at 6:08 p.m. the registered dietician (RD) indicated she was not aware facility cooked boiled eggs, stored and used cooked left-over foods, and did not perform and log in cool down times and temperatures. The RD also indicated facility risks were not addressed and should have been. |
| F 0865<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Have a plan that describes the process for conducting QAPI and QAA activities.**<br><br>Based on observation, interview, and record review, the facility failed to identify systemic issues with their infection prevention and control program. This facility failure had the potential to affect the health of the residents, visitors and staff. Findings: During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 08/2016, indicated, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. During an interview on 03/12/20, at 4:06 p.m., with an assistant administrator (ADM2), ADM2 stated they were not aware, but should have been aware of the systemic deficient practices related to the infection prevention and control program. Cross-reference F880 and F881. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to implement their infection prevention and control program in the areas of: 1. Coordination and oversight, 2. Surveillance, 3. Data analysis, 4. Outbreak management, 5. Prevention of infection, and 6. Monitoring employee health and safety. These facility failures had the potential to place residents, visitors and staff at increased risk of infections. Findings: During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 08/2016, the P&P indicated, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals. Coordination and Oversight. The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist). Surveillance. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. Data Analysis. Data gathered during surveillance is used to oversee infections and spot trends. Outbreak Management. Outbreak management is a process that consists of. preventing the spread to other residents. reporting the information to appropriate public health authorities. Prevention of Infection. Important facets of infection prevention include. ensuring that they adhere to proper techniques and procedures. following established general and disease specific guidelines. Monitoring Employee Health and Safety. those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment. The facility provides personal protective equipment, checks for its proper use. 1. During an interview on 03/12/20, at 8:20 a.m., with a licensed nurse (LN3), LN3 stated, they are the infection preventionist (a nurse specially trained to make sure healthcare workers and residents are doing all the things they should to prevent infections), LN3 revealed they had been working the night shift and teaching certified nursing assistant classes, stating, It makes it hard to do the infection preventionist job. Adding both administrators (ADM, ADM1), the assistant administrator (ADM2) and director of nursing (DON) were aware LN3 was not able to perform the duties of the infection preventionist (IP). During an interview on 03/12/20, at 8:47 a.m., DON indicated they have an infection preventionist certificate and had been attending the infection control meetings. DON stated, No, they have not been performing the infection preventionist duties while LN3 had been working the night shift. During an interview on 03/12/20, at 4:06 p.m., ADM2 stated they were not aware, but should have been aware, of deficient practices related to the infection prevention and control program. 2. During an interview on 03/12/20, at 8:20 a.m., LN3 was unable to locate any surveillance (monitoring) data and stated, It's been at least a year, since the last handwashing surveillance took place. 3. During an interview on 3/12/20, at 8:25 a.m. LN3 indicated, when antibiotics being ordered for a resident, the nurse completes the Individual Infection Report (IIR) form. LN3 stated, At least six months, since LN3 followed up on the incomplete IIRs. 4. During an interview on 03/12/20, at 8:30 a.m., LN3 stated, It has been years, since they last reported any communicable (contagious) diseases to public health. LN3 was not able to recall any communicable diseases that are required to be reported. LN3 stated, We did have a list, but I can't say the last time I saw it. At least a year ago. LN3 indicated, she was aware Resident 26 was diagnosed with [REDACTED]. 5. a. During a review of the facility's policy and procedure (P&P) titled, Norovirus Prevention and Control, dated 10/2011, the P&P indicated, Place residents on Contact Precautions (level of personal protection used when near a |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 3)<br>resident or their items when they have an infection caused by germs that can be spread by touching) in a single occupancy room, if possible, when symptoms are consistent with norovirus gastroenteritis. During a review of Resident 26's Physician Orders, dated 03/09/20, the physician order [REDACTED]. During an observation on 0[DATE], starting at 10:12 a.m., in room [ROOM NUMBER] (a three bed room), certified nursing assistants (CNA2 and CNA3) were providing bedside care to Resident 26 in the bed farthest from the hallway door and restroom. The other two beds were occupied. After giving Resident 26 a bed bath, CNA2 carried the bucket of dirty bed bath water to the room fivr (5) resident bathroom, emptied the water, and got paper towels from the dispenser. CNA2 dispensed paper towels wearing contaminated gloves. CNA3 carried Resident 26's dirty linen past the other two resident beds to the dirty linen bucket located in the hallway. CNA3 opened the door wearing contaminated gloves. CNA2 was observed to open the privacy curtain between the resident beds while wearing contaminated gloves. CNA2 and CNA3 completed care and left the room without disinfecting the bathroom or the door knob. During a concurrent observation and interview on 0[DATE], starting at 10:42 a.m., with DON, in the hallway outside of resident room five (5), a sign was posted indicating, Contact Precautions, Private room is desirable. If not available, cohort residents with similar infection. DON stated, Resident 43 does use the bathroom in resident room [ROOM NUMBER] where the contaminated bed bath water from Resident 26 was discarded. DON further stated, I guess we didn't think that one all the way out. DON further stated, Yes, they did observe the laundry worker deliver a white shirt to a resident after it had brushed over the white bucket containing the contaminated dirty linen from Resident 26.<br><br>b. During an observation, record review, and interview on 3/09/20 at 4:09 p.m. the tubing attached to Resident 8's portable [MED]gen concentrator used for administering breathing treatments was not dated. Resident 8's Physician order [REDACTED]. Certified nursing assistant (CNA1) observed the undated tubing, and indicated the tubing is not dated and should be dated. c. During an observation and interview on 3/09/20 at 4:11 p.m. certified nurse assistant (CNA5) exited room three (3) wearing vinyl gloves and did not remove gloves, sanitize hands, and entered room four (4). CNA5 confirmed, and indicated did not remove gloves or sanitize hands after exiting room three (3) and before entering room four (4) and should have removed the gloves and sanitized hands between resident rooms. d. During a record review and observation on [DATE] at 12:01 p.m. physician's orders [REDACTED]. Contact isolation precaution signage is outside of Resident 26's door alerting staff and visitors to put on personal protective equipments (PPE) before entering Resident 26's bed area. Resident 26 occupies a shared room and bathroom with two other residents not on contact isolation for norovirus. The bathroom contains a single unlined open to air trash can. During an observation and interview on [DATE] at 12:23 p.m., the certified nurse assistant (CNA3) removed soiled PPE after providing care to Resident 26 and placed the soiled PPE into the shared trash can. CNA3 removed the trash can from Resident 26's bathroom, carried the trash can through the facility, and disposed the contents into an outside trash barrel. CNA3 re-entered the facility and did not sanitize, clean, and line the trash can with a plastic liner before placing the trash can back into Resident 26's shared bathroom. CNA3 confirmed placing soiled PPE into Resident 26's shared trash can, carried it without a covering through the facility, and did not clean or sanitize the trash can before replacing into the shared bathroom. CNA3 indicated this is the process followed and then I wash my hands. e. During an observation and interview on 3/12/20 at 11:56 a.m., two water pitchers found on nursing station counter by the sink and blocking access to the soap dispenser. Certified nurse assistant (CNA5) observed the two water pitchers at nursing station counter by the sink, blocking access to the soap dispenser, confirmed the two water pitchers are dirty and should not be stored at the nursing station. CNA5 further indicated dirty water pitchers are customarily placed in this spot until all the clean pitchers from dietary are provided to residents but should not be because it is not sanitary. 6. During a concurrent observation and interview on 03/12/20, at 10:38 a.m., with a laundry supervisor (LW2), at the outside laundry closet, LW2 was observed wearing the PPE provided to them by the facility. A reusable apron covering chest and hips and single use disposable gloves covering hands and wrists. Both arms were noted to be exposed. LW2 stated, We have never used heavy duty gloves. LW2 further stated, they have never used gowns that protect their arms from exposure while sorting dirty laundry. During a review of the facility's policy and procedure (P&P) titled, Standard Precautions (level of personal protection used for all residents) dated 12/2007, the P&P indicated, Linen a. Handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments. |
| F 0881<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Implement a program that monitors antibiotic use.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to implement its policy and procedure regarding antibiotic use for one sampled resident (Resident 25) and two unsampled residents (Residents 37 and 50). This facility failure resulted in a lack of data to assist the practitioner in prescribing antibiotics and had the potential to result in avoidable harm associated with unnecessary antibiotic use. Findings: During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship - Review and Surveillance (close supervision) of Antibiotic Use and Outcomes, dated 12/2016, the P&P indicated, Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form . The information gathered will include: a. Resident name and medical record number; b. Unit and room number; c. Date symptoms appeared; d. Name of antibiotic (see approved surveillance list); e. Start date of antibiotic; f. Pathogen (bacterium, virus, or other microorganism that can cause disease) identified (see approved surveillance list); g. Site of infection; h. Date of culture (growing microorganisms in a lab to determine the type of organism); i. Stop date; j. Total days of therapy; k. Outcome; and l. Adverse events (unexpected medical problem). During a review of the Monthly Infection Log (MIL), dated 01/2020, the MIL indicated: a. Resident 25 was treated for [REDACTED]. b. Resident 37 was treated for [REDACTED]. c. Resident 50 was treated for [REDACTED]. During an interview on 03/12/20 at 8:20 a.m., with an infection preventionist nurse (certified in methods to prevent infections) (LN3), LN3 stated the nurses have not been completing the antibiotic surveillance tracking form titled, Individual Infection Report. LN3 further stated, It has been at least six months, since LN3 last followed up on the reports. LN3 indicated, working the night shift and teaching certified nursing assistant classes, Makes it hard to do the infection preventionist job. LN3 additionally stated, both administrators (ADM, ADM1), the assistant administrator (ADM2) and director of nursing (DON) were aware LN3 was not able to perform their duties as the facility infection preventionist. |