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	175403	A. BUILDING _____ B. WING _____	12/14/2021

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #164098. This 2567 was electronically sent to the facility on 12/16/2021.	F 000		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		

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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available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 27 residents. Based on record review and interview, the facility failed to display the actual hours worked on the daily nursing staffing sheets on a daily basis, for the 27 residents who reside in the facility.

Findings included:

- Review of the facility's "Daily Staffing Sheets", for the past 90 days, revealed the section for the actual nursing hours worked, lacked completion.

On 12/9/21 at 02:00 PM, Administrative Nurse D stated, the facility staff failed to complete the nursing staff sheets with the actual nursing hours worked, as they should have been.

The facility policy for "Posting Daily Nurse Staffing Form" dated 2018, included: The total number of hours of each position is posted at the entrance to the health center and will be kept current during each day by revising the form as staffing and census change.

The facility failed to properly complete the daily nursing staffing sheets to include the actual hours the nursing staff worked, for the residents of the facility.

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F 880	Continued From page 2	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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; §483.80(a)(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;	F 880		

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F 880	Continued From page 3 (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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: The facility reported a census of 27 residents. Based on observation, interview, and record review, the facility failed to ensure staff provided environmental cleaning in a sanitary manner to prevent the spread of infection, failed to ensure pet vaccinations remained up to date for resident's cat, failed to ensure the water temperature in the laundry remained at least 160 degrees Fahrenheit to ensure sanitary laundering	F 880		

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of resident linen.

Findings included:

- Observation, on 12/08/21 at 08:28 AM, revealed housekeeping staff VV and WW changing resident bed linen. Staff VV with gloves on changed the bed linen in a resident room, came out of the room, with the same gloves on, went into another resident room and changed the bed linen, and with the same gloves on wheeled the dirty linen cart into the resident room, placed the dirty linen in the cart, removed her gloves, performed hand hygiene and wheeled the cart out of the room.

Interview, on 12/08/21 at 11:00 AM, with Administrative Nurse D, revealed she would expect staff to change gloves and perform hand hygiene upon exit of each resident room when changing bed linen.

The facility failed to provide a policy related to this issue.

The facility failed to ensure staff provided changing of resident bed linen cleaning in a sanitary manner to prevent the spread of infection.

- Observation, on 12/09/21 at 07:53 AM, revealed Housekeeping staff V cleaning a resident room. Staff V donned gloves and obtained a sanitary wipe and proceeded to wipe the toilet flush handle, then wearing the same gloves and with the same wipe, Staff V started to wipe the resident's shelf containing the resident's knick knacks. Surveyor GG questioned staff V if

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F 880	Continued From page 5	F 880		

the toilet flusher was a dirty surface and the shelf a clean surface, and staff V concluded she should change her gloves and provide hand hygiene and changed her gloves and obtained a new wipe. Staff V continued with cleaning surfaces in the resident's room. Observation revealed staff V obtained the toilet bowl cleaning products, lifted the toilet seat lid, and squirted the cleaning agents, in the bowl, returned the cleaning product to her cart, then with the same gloves, obtained a scrubber for the resident's sink and proceeded to clean the resident's sink. Surveyor GG advised staff V that her gloves were considered contaminated from the contact with the toilet bowl. Staff V agreed and doffed these gloves, performed hand hygiene and then donned gloves and threw the sink scrubber away. Observation continued as staff V cleaned the toilet seat lid and surface, and with the same gloved hands and same sanitizing wipe, then cleaned the toilet riser's hand rails.

Interview, on 12/08/21 at 11:00 AM, with Administrative Nurse D, revealed she would expect staff to change gloves and perform hand hygiene when in contact with a dirty surface, before contact with a clean surface.

The facility policy "Donning and Doffing Disposable Gloves," revised 08/2020, instructed staff to change gloves and perform hand hygiene when moving from soiled contaminated area of care to clean areas of care.

The facility failed to provide housekeeping services to a resident room in a sanitary manner to prevent the spread of infection.

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- Observation, on 12/09/21 at 10:01 AM, revealed a temperature log in the laundry room with temperatures logged as 162 degrees Fahrenheit, the log lacked temperature documentation from 12/06/21, 12/07/21, 12/08/21 and 12/09/21. Interview at that time with Laundry staff W, revealed laundry staff obtained the water temperature from the gauge on the water line going to the noncommercial washing machine. Laundry staff W stated the washing machines used hot water for sanitizing laundry and the bags used for isolation laundry dissolved in water at a temperature of 160 degrees Fahrenheit. Staff W stated laundry staff use a graph to determine what setting to use for various types of laundry and the detergent, softener and bleach were dispensed automatically, and whites were sanitized at 160 degrees temperatures. Staff W stated maintenance checked the water temperature in the hand washing sink. Interview with Maintenance staff UU, revealed he did not check the water temperature in the washing machines.

Observation, on 12/09/21 at 10:30 AM, revealed maintenance staff U, obtained a water temperature from the hot water line leading to the commercial washing machines as 147.5 degrees Fahrenheit. Staff W stated the water temperature should be above 160 degrees.

Interview, on 12/09/21 at 11:00 AM, with Maintenance staff U, revealed the hot water tank temperature had been inadvertently turned down to below 160 degrees. Maintenance staff U did not know how long the water temperature's thermostat was in this position.

The facility policy "Laundry Protocol," undated,

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F 880	Continued From page 7 instructed staff to prevent the spread of infections by hot water washing included water temperatures exceeding 160 degrees for 24 minutes. The maintenance/environmental service department instructed to routinely inspect maintain and document hot water temperatures on the washers at 160 degrees. The facility failed to ensure adequate hot water sanitation of resident laundry to prevent the spread of infections. - Observation on 12/07/21 at 08:30 AM, revealed resident (R)10 personal cat lived in his room and facility staff provided a litter box and feeding to the pet. Review of the pet's vaccination records revealed the last date of vaccinations as November 2, 2018, November 16, 2018, November 24, 2018 and November 24, 2018. Interview, on 12/09/21 at 11:00AM, with Administrative staff A, confirmed the vaccines were not renewed since 2018. The facility "Pet Policy," dated January 2019, instructed staff that all animals must be examined by the veterinarian and certified as healthy with all recommended immunizations. The facility failed to ensure one resident's cat had current vaccinations to prevent the spread of infection.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		

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F 881	Continued From page 8 §483.80(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: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: The facility reported a census of 27 residents. Based on interview and record review, the facility failed to ensure nursing staff followed the principles of antibiotic stewardship proactively to ensure antibiotic use in a safe and effective manner to prevent unnecessary side effects of antibiotics and development of antibiotic resistance in the residents of the facility. Findings included: - Review of the "Antibiotic Stewardship Log," revealed the facility lacked the use of an assessment tool (for antibiotic appropriateness) at the initiation of antibiotic therapy. The facility reviewed antibiotic appropriateness at the completion of the antibiotic. Furthermore, the facility lacked periodic review of antibiotic use by physician and compilation of organisms/resistive organisms in the facility. Review of the "Antibiotic Stewardship Log," for September 2021, revealed an entry for resident (R)10 with a urinary tract infection due to benign prostate hyperplasia (non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections) with a culture result of E coli (a type of	F 881		

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bacteria) and a Physician's Order for Keflex (an antibiotic) 500 (mg) milligrams, three times a day for seven days, and then Cipro 250 mg, twice a day, for seven days, due to resident still had symptoms per the notation on the log.

Review of the "Antibiotic Stewardship Log," for October 2021, revealed R10 developed burning discomfort and cloudy, odorous urine had a culture result of E coli, and the "Physician's Order" for Cephalexin (an antibiotic) 500 mg, for seven days. With the indication the resident had the same infection from September 2021 with continuation of symptoms.

Review of the "Antibiotic Stewardship Log," for November 2021, revealed an entry for resident R10, with a urinary tract infection with a culture result of E-coli (a type of bacteria) and a "Physician's Order," dated 11/12/21 instructed staff to administer Cephalexin (an antibiotic) 500 milligrams (mg) three times a day for seven days, then staff to administer Cipro (an antibiotic) 250 mg, daily, for urinary tract infection prevention.

Interview, on 12/07/21, at 11:00 AM, with Administrative Nurse D, revealed the facility lacked an assessment tool, for nursing staff to utilize at the initiation of the antibiotics, at this time but would initiate the McGeer's Criteria (a systematic guide for antibiotic use based on criteria for specific infections which included culture sensitivity to antibiotic prescribed.) Administrative Nurse D confirmed the facility did not periodically review antibiotic use by physician or compile data for the occurrence rate of organisms/resistive organisms in the facility. Administrative Nurse D stated the facility did not compile a separate report of the number of

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antibiotics used for prophylaxis.

Interview, on 12/08/21 at 10:43 AM, with Licensed Nurse (LN) G, revealed she lacked training in use of criteria/guides for antibiotic initiation, but followed the prompts in the electronic medical record for infection documentation.

Interview, on 12/08/21 at 11:15 AM with LN H, revealed she was not familiar with a tool for use prior to initiation of an antibiotic.

Interview, on 12/14/21 at 11:00 AM with Administrative Nurse D revealed the pharmacist identified the R10's prophylactic (for prevention) use of antibiotic in November 2021, and the physician wrote a benefit statement that included prostatic hypertrophy and urinary retention but failed to identify the risks of antibiotic use.

The facility policy "Antibiotic Stewardship Program" reviewed 4/2021, instructed staff to promote the appropriate use of antibiotics while optimizing the treatment of infections to reduce the possible adverse events associated with antibiotic use. The policy instructed the Administrative Nurse to monitor antibiotic usage patterns and report the number of antibiotics prescribed and provide a separate report for antibiotics that did not meet criteria for active infection.

The facility failed to proactively monitor initiation of antibiotics and failed to monitor antibiotic use patterns by prescribers to ensure antibiotics were used in a safe and effective manner to prevent unnecessary side effects of antibiotics and antibiotic resistance.