Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125041	A. BUILDING: ______ B. WING ______	03/18/2016

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2016 APR 27 A 10:52
STATE OF HAWAII

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILIHA HEALTHCARE CENTER	1814 LILIHA STREET HONOLULU, HI 96817

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4 000	11-94.1 Initial Comments A State relicensure survey was conducted from 3/15 - 3/18/16. At the time of entrance, the resident census was 89.	4 000	**4 148 Nursing Services** Corrective actions Taken:	
4 148	11-94.1 -39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to have nursing staff sufficient in number/qualifications and adequately staff the facility to meet the nursing needs of the residents. Findings include: Cross reference to tag 4 149. In an interview with Resident #7 on the morning of 3/15/16 at 10:00 A.M., the resident was asked if he thought the facility was adequately staffed. The resident responded, "Absolutely not!" Further query to determine which shifts, the Resident #7 responded, "All shifts, 24-7." The resident reported waiting long periods of time for staff to respond to his call light. The resident had a diagnosis of quadriplegia and required extensive to total assistance with Activities of Daily Living (ADLs). Resident #7 stated the worst shift was night shift (11:00 P.M. to 7:00 A.M.)	4 148	1. Consultants assisted facility staff in performing staffing analysis based on CMS criteria. DON assigned additional staff to work on 11-7 shift to provide more adequate staff supervising resident's needs. 2. Staff, residents, and families will be informed of the staffing changes into staffing needs. 3. Nursing staff are monitoring and documenting resident behaviors and also add on their 24 hour report which is reviewed by IDT. 4. DON and ADON will monitor call light response time by asking residents and family input and completing call light response observation audits at least weekly. Findings will be reported to QAPI committee for proper action.	4/14/16 4/29/16 4/11/16 & ongoing 4/22/16 & ongoing

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nicomedes G. Santos, NHA | TITLE: Administrator | (X6) DATE: 4/27/16

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4 148	Continued From page 1 when there was only 2 Certified Nurses Aides, CNAs, for the entire 1st floor (45 beds, 44 filled during the survey period). He further stated the evening shift (3:00 P.M. to 11:00 P.M) was staffed with 4 CNAs while the day shift (7:00 A.M. to 3:00 P.M0 had the most, with 6 CNAs. Resident #7 stated that he had problems with Resident #47 wandering into his personal space. He stated the staff were slow to respond when problems with the roommate occurred. Observations of Resident #47 over the survey period found him wandering into residents' personal spaces and occasionally getting agitated. The facility did not provide adequate supervision for him to avoid and prevent future incidents of resident to resident altercations. An interview with a night shift CNA on the morning of 3/18/16 found she worked at the facility for 10 years. The CNA reported from the time of employment, the facility always staffed with only 2 CNAs for night shift on each floor. The surveyor provided a scenario where she and the other CNA were busy caring for a dependent resident when Resident #7 calls for assistance because Resident #47 is coming into his space and touching his things and getting agitated when Resident #7 corrects his behavior. The CNA responded, "We answer his call light; Turn it off; and tell him he has to wait because we're busy." "He's okay. He can wait." An interview with Resident #140's spouse on the afternoon of 3/15/16 revealed that she didn't think there was enough staff to care for residents. She stated, "I told my husband, go [bowel movement] in your diaper. That's their job to clean you up." Resident #140's spouse reported the resident waited longer than reasonable for assistance.	4 148	Identification of other residents Affected: All residents have the potential to be affected. System Change to Ensure Deficient Practice will not recur. 1. Facility hired more nursing staff to fill up open positions. Scheduled additional staff on 11-7 shift to have 3 nurse's aides on each floor or as determined by resident need. 2. DON, ADON and SS will continue to monitor residents and family concerns regarding the care provided and discuss findings during IDT and QAPI meetings. 3. Residents with wandering behaviors will be assessed and care plans updated per new IDT process to determine root causes and identify effective interventions 4. Administrator will communicate all QAPI findings and recommendations to upper management for their consideration and approval.	4/29/16 & ongoing 4/22/16 & ongoing 4/29/16 & ongoing 4/29/16 & ongoing

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4 148	Continued From page 2 She was unable to provide actual times the resident has to wait. At the time of survey, the facility's census was 89 residents (44 on first floor, 45 on second floor). A review of the staffing schedule for 3/1/16 - 3/31/16 found that day shift included 4 Registered Nurses, RNs, (2 assigned as administrative [MDS] nurses) and 12 Certified Nurses Aides, CNAs. Evening shift included 2 RNs and 8 CNAs. Night shift included 2 RNs and 4 CNAs. An interview with the Director of Nursing, DON, on the morning of 3/18/16 revealed, "Yes, I agree we have inadequate staffing. It's been this way since I started working here (over 20 years ago)." The DON stated that the staff is required to be attentive to all residents but it becomes difficult when their bed census is 92 and sometimes only have 4 CNAs and 2 RNs (night shift) for the entire facility. The surveyor shared that a few residents and a family member complained of long wait times for staff assistance. The DON was asked how she monitors/audits call light response times. She stated that while at the nurses station, she will randomly see how long the staff takes to answer call lights/alarms. The facility's call light system did not have a program which allowed staff to get a printout of response times. The DON stated she does not have a monitoring system for call light response times. The DON further agreed that she does not have adequate staffing to be able to supervise all residents.	4 148	Monitoring System Change to Ensure Deficient Practice will not Recur: 1. Unannounced call light response audits will be completed on all shifts at least weekly. Findings will be reviewed to identify resident concerns regarding call light response and trends related to identified concerns. 2. QAPI committee will evaluate monthly Quality Indicators which reflects the quality of care provided. Cross-reference to Plan of Corrections 4 149 Page 4 - 8	4/22/16 & ongoing 4/29/16 & ongoing
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following:	4 149		

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4 149	Continued From page 3 (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on observations, medical record review and staff interviews, the facility failed to provide adequate supervision and ongoing evaluation/monitoring to ensure quality resident care for one resident, Resident #47, of 4 residents reviewed for accidents in the Stage 2 sample. Findings include: An interview with Resident #7 on the morning of 3/15/16 revealed that his roommate, Resident #47, often came into his space. According to Resident #7, Resident #47 comes into his space and adjusts the air conditioner and turns the channels on his personal TV. Resident #7's bed	4 149	**4 149 Nursing Services** Corrective actions Taken: 1. Consultants assisted facility leadership in performing staffing analysis based on CMS criteria. DON assigned additional staff to work on 11-7 shift to provide supervision to promote resident safety. 2. New QAPI (Quality Assurance Performance Improvement) IDT (Interdisciplinary team) meeting process initiated and performed Resident #47 assessment to analyze root causes of behaviors. The IDT developed interventions based on the behavior root causes for the resident's symptoms. 3. New interventions for resident #47 were incorporated in the plan of care and communicated to care givers.	4/14/16 4/6/16

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4 149	Continued From page 4 was closest to the window (where the air conditioner was located) and Resident #47's bed was immediately next to him in a 4-bed bedroom. Resident #7 further stated that Resident #47 becomes agitated and confrontational when Resident #7 asks him to stop touching his items. Resident #7 stated that Resident #47 will put up a fist and come toward him in his bed. During the interview with the surveyor, Resident #47 came into #7's space and began staring at Resident #7. Resident #7 stated to #47, "I'm talking here. Please leave." Resident #47 had an angry look on his face but turned and walked back to his bed. Resident #7 stated, "Yes, I feel worried. I can't do much." When asked if he thought the facility was sufficiently staffed, Resident #7 stated, "Absolutely not." A review of Resident #7's Minimum Data Set, MDS, with Assessment Reference Date, ARD, of 3/8/16, found a Brief Interview for Mental Status (BIMS) score of 15/15 (completely alert and oriented to person, place, and time). The MDS noted he had a diagnosis of quadriplegia. His MDS further indicated that he required either extensive assistance or was totally dependent, requiring 1 and sometimes 2 person assistance for: bed mobility; transfer; dressing; eating; toilet use; personal hygiene; and bathing. Resident #47's room was the last room, furthest away from the nurses station. An observation of Resident #47 on the morning of 3/15/16 at approximately 11:30 A.M. found him sitting on a chair in the hallway near his room. A staff member was seated next to him while she charted on a computer. After 10 minutes, Resident #47 independently ambulated back to his bed. Lunch was delivered to the unit at approximately 12:05 P.M. Resident #47	4 149	4. Updated interventions were communicated to all staff taking care of resident #47.	4/6/16
			5. In response to incompatibility concerns from Resident #7, a reassessment of behaviors led to seeking permission from all involved parties, and resident #47 was moved to another room.	4/5/16
			6. This result of room change and other new interventions are thus far effective. Resident #47 sleeping better, more engaged in activities, in better mood. Resident #7, the former roommate, reports he is no longer concerned about resident #47. Resident #47's new roommates report not distress.	4/11/16
			7. DON, Administrator will continue to monitor effectiveness of new approaches for resident #47 and reassess, adding new approaches where needed.	4/15/16 & ongoing

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4 149	Continued From page 5 ambulated to the dining room and ate his lunch there. When he was done, he independently returned to his room. Staff were busy assisting with the lunch meal. Throughout the rest of the lunch meal, Resident #47 independently ambulated back and forth from his room to the hallway, to the dining room and back to his room. Along the way staff would see the resident but no one staff member was assigned to supervise him. Observation of Resident #47 on the afternoon of 3/16/16 found him wandering along the hallway, to his room, and into the dining room. He independently wandered around without direct supervision by staff members. Observation of Resident #47 on the morning of 3/17/16 found a Certified Nurses Aide, CNA, following him around. She was sitting with him in the dining room and when he got up to walk down the hallway, she followed him. At approximately 2:00 P.M. the CNA was seated with him and provided him with ice cream. A review of Resident #47's medical record found he was admitted to the facility on 8/15/15. He had a strong history of aggression. According to the medical record, the resident had been incarcerated in the past for attacking a staff member at a facility he previously resided at. His diagnoses included: Cerebrovascular Accident (CVA) with left sided weakness; [redacted] Dementia with behavior disturbance; Insomnia; and hypertension. When the resident has difficulty sleeping, he wanders at night and will stand at the bedside of other residents and stare at them, startling them. While in this facility, Resident #47 displayed several major episodes of aggression. On	4 149	Identification of other residents Affected: 1. Nursing and SS will identify all residents with socially disruptive or physically intrusive behaviors. System Change to Ensure Deficient Practice will not recur. 1. For all presidents with wandering behaviors, a comprehensive IDT, including direct care giver assessment of root causes for behavior will be updated. The IDT will identify appropriate interventions, update the plan of care, and communicate new approaches to staff. 2. The IDT process will involve all disciplines and direct care staff for their input, and where possible, resident/family input. 3. Department heads began twice-daily meetings focusing on the POC progress, discuss trends and apply QAPI principles (root cause analysis etc.) to identified concerns. Input from direct care givers is actively sought and documented.	4/11/16 4/6/16 & ongoing 4/6/16 & ongoing 4/6/16

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4 149	Continued From page 6	4 149		
	9/17/15 at approximately 9:20 P.M., Resident #47 allegedly hit a female resident on the back of her head. The staff did not witness the incident. According to the incident report, the female resident was seated near the door to her room while the CNA prepared the toilet for her. The female resident stated that Resident #47 struck her on the back of head while he was walking by. The female resident stated she didn't think Resident #47 knew what he did. No injuries were noted. The facility's investigation indicated the nursing staff was neglectful by not closely monitoring the whereabouts of Resident #47.		4. Facility is hiring more nursing staff and will add a staff member to night shift to assure adequate supervision of residents.	4/1/16 & ongoing
			5. ADON will review the wandering behavior monitor log and report findings to QAPI committee for further action.	4/22/16
			Monitoring System Change to Ensure Deficient Practice will not recur:	
	Another documented incident occurred between Resident #7 and Resident #47 on 9/10/15 during night shift. The night shift CNA was attempting to turn Resident #7 when Resident #47 shouted to turn off the light. Resident #47 moved toward the CNA and threatened to hit her so she turned the light off. At that time, Resident #7 requested to speak with the Licensed Nurse, who went over to him. Resident #7 informed the Licensed Nurse that if they [staff] cannot speak with Resident #47, then he will be the one to speak with him because "God told him to". While Resident #7 was speaking with the Licensed Nurse, Resident #47 interrupted and said, "Shut up." They exchanged more words and the Licensed Nurse was able to finally get Resident #47 to return to his own space. The Licensed Nurse provided Resident #47 with his prn Trazodone.		1. IDT will be conducting audits and interviews of concerned residents and families. Findings will be shared to all department heads during daily IDT meetings.	4/7/16 & ongoing
			2. The QAPI committee will review the results of the audits and develop interventions based on audit findings.	4/12/16 & ongoing
			3. DON will review all resident supervision needs and adjust the staffing level as necessary.	4/22/16
	Finally, an incident occurred on the morning of 8/9/15 with Resident #47 and another male resident. When staff arrived, they found Resident #47 seated on the bed of the male resident. The male resident was on the floor facing the wall and grasping Resident #47's right arm. Resident #47 stated, "he hit me first so I hit him back five times		4. Administrator and DON will review audit reports regularly to identify and address potential non-compliance.	4/22/16

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4 149	Continued From page 7 on his face." No injuries were noted. The facility's investigation indicated the nursing staff was neglectful for not closely monitoring Resident #47. On the afternoon of 3/17/16 at approximately 2:05 P.M., the CNA assigned to Resident #47 was interviewed. The CNA stated, "We have to follow him because he wanders into everyone's rooms. All rooms are females except his room and the room right next door. We have to distract him, provide a snack, and redirect him." She further stated the staff and female residents were afraid of him because he was known to get aggressive and combative with other residents. She also stated that he can be irritating to other residents because he wanders into their rooms. The CNA stated he has improved and hasn't shown aggression lately. She further indicated the staff and female residents were no longer afraid of him. The CNA stated they were required to monitor his behaviors every 30 minutes and document it. The CNA said it's sometimes difficult to monitor him because they get busy with other residents. An interview with night shift CNA on the morning of 3/18/16 revealed she worked in the facility over the past 10 years. She stated since she started, the facility always staffed the night shift with 2 CNAs for each floor. The 1st floor had 45 beds and 44 were filled during the survey period. The 2nd floor had 47 beds and 45 were filled during the survey period. Both floors maintained 2 CNAs for each floor on night shift. The night shift CNA reported that Resident #47 sometimes experienced insomnia and had a history of aggression and wandering into other residents' rooms. The surveyor brought up the fact that Resident #47 is known to have insomnia and will	4 149	5. Facility will encourage residents and families to utilize our facility grievance program and use the program to investigate and resolve issues to resident and family satisfaction whenever possible. 6. The facility will address and respond to the grievance submitted in a timely manner, considering all party's rights, comfort and care.	4/11/16 & ongoing 4/11/16 & ongoing

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4 149	Continued From page 8 wander into residents rooms and stand over them at the bedside and stare at them, startling them. The CNA reported that she knew Resident #47 would stand over Resident #7's bed at night. When asked how they respond, she stated that Resident #7 is capable of using his call light. The surveyor then questioned what happens if both night shift CNAs were busy with other residents. She replied, "We would answer his call light and tell him to wait. He can wait." When asked if the staffing was adequate for night shift, the CNA responded, "It's okay." An interview with the Director of Nursing, DON, on the morning of 3/18/16 revealed that managing care for Resident #47 has been challenging. She stated that they continue to monitor his behaviors. She realizes that Resident #47 has been physically aggressive to other residents in the recent past. She realizes that he requires close supervision and that she does not have enough staff to dedicate one on one supervision to any resident in the facility. The psychiatrist comes to the facility to see Resident #47 and has made adjustments to his medications which has helped the resident. The DON further indicated that she constantly reminds staff to closely monitor Resident #47 at least every 30 minutes. She says that since the facility is unable to adequately staff the facility, it's difficult to manage and supervise residents with behavioral disturbances. The DON stated that hiring additional staff is not possible with their current budget.	4 149	**4 159 Storage and Handling of Food** Corrective actions Taken 1. Maintenance staff fixed the floor tiles in the dishwashing room. Floor and wall tiles was scrubbed well to remove any mildew and dust. 2. Broken water spray nozzle was replaced. 3. Nursing staff checked expiration dates of other food and drink in the refrigerator. Expired Greek yogurt found in the refrigerator was discarded.	3/25/16 3/21/16 3/18/16
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions.	4 159		

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4 159	Continued From page 9 (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to provide sanitary conditions for the dishwashing area and storage area for cooking utensils and drinking jugs in the kitchen. The facility also failed to safely procure food in resident snack refrigerator. Findings include: Observation on 3/14/2016 of the dishwashing area noted a broken tile area was visible with cement dust and tile dust accumulating. A hose like tap hanging on a hook beside a sink was leaking onto the floor. Water was accumulating in the broken tile area. The entire floor area was wet from the leaking tap. Beside the broken tile area was a shelved alcove area that stored cooking utensils and drinking jugs. Inspection of the residents' refrigerator on the 2nd floor nursing unit found it contained a Greek yogurt with an expiration date of Jan 30 2016. These findings in the kitchen dishwashing area and expired yogurt were confirmed by the kitchen manager and staff during the observations.	4 159	Identification of other residents Affected: All residents can be affected. System Change to Ensure Deficient Practice will not recur. 1. Refrigerator Check log was revised to include checking the temperature, cleaning and checking expiry dates of food items stored. 2. Temperature of the refrigerator and freezer will be checked and recorded twice a day. 3. Night shift nursing staff will check expiry dates of food and clean the refrigerator daily. Write comments and sign the log. 4. All food and drinks will be labeled indicating the date opened or expiration date. 5. Food and drink is good for 3 days from date it was opened except for milk which is 24 hours. All expired or unlabeled food will be discarded immediately.	1. 4/1/16 2. 4/1/16 & ongoing 3. 4/1/16 & ongoing 4. 4/1/16 & ongoing 5. 4/1/16 & ongoing

	Completion Date
Continuation of 4 159 Storage and Handling of Food	
6. Dietary staff will clean the kitchen and dishwashing room floor daily. Will report broken equipment to maintenance staff to have it fixed or replaced immediately.	4/1/16 & ongoing
7. General cleaning of the unit will be done at least every month.	4/29/16 & ongoing
Monitoring System Change to Ensure Deficient Practice will not recur:	
1. Dietary manager or designee will check the refrigerators in the unit every morning to make sure it is clean and food items are not expired. Result of the audit will be reported to QAPI committee for further action.	4/1/16 & ongoing
2. Day shift nursing staff will also check the refrigerator making sure nothing is overlooked.	4/1/16 & ongoing
3. Dietary manager and maintenance supervisor or designees will conduct their environmental rounds daily and report their findings to QAPI committee.	4/15/16 & ongoing

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4 184	Continued From page 10	4 184	**4 184 Pharmaceutical Services**	
4 184	11-94.1-46(a) Pharmaceutical services (a) Each facility shall employ a licensed pharmacist, or shall have a written contractual arrangement with a licensed pharmacist, to provide consultation on methods and procedures for ordering, storing, administering, disposing, and recordkeeping of drugs and biologicals, and provisions for emergency service. This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to ensure 1 (Resident #63) of 5 sampled residents has adequate indication for the use of medications. Findings include: On 3/15/16 at 11:00 A.M. a record review was done for Resident #63. The physician's order for March 2016 notes the following order: melatonin 3 mg. tablet, 1 tab at bedtime; trazodone 25 mg., 1 tab at bedtime; celexa 10 mg. daily; and prazosin 1 mg. twice daily. Further review on the morning of 3/17/16 found a discontinued order for celexa 10 mg., 1.5 tabs daily for diagnosis of anxiety. Subsequent order (dated 2/23/16) notes celexa, 10 mg. daily. Further record review done on 3/17/16 at 9:15 A.M. found there is no documentation in the order for the diagnosis related to the use of celexa, trazodone and prazosin. Resident #63 was admitted to the facility on 5/1/15 with admitting diagnoses of cerebro vascular accident; coronary artery disease; peripheral vascular disease with right leg vascular bypass; hypertension; hyperlipidemia; atrial fibrillation; blindness, NOS; hard of hearing; anxiety (nocturnal 10/27/15); and dementia	4 184	Corrective actions Taken: 1. Attending physician reviewed the medications of resident #63 on 3/15/16 and ordered to reduce the dose of Trazodone at HS. 2. Diagnosis/indication for use of Celexa, Trazodone and Prazosin was reviewed with the physician; same is now clearly documented on the medical record. 3. Geri Psych physician came for a follow up visit on 3/30/16 to reassess appropriate use of medications for resident conditions. 4. Geri Psych physician talked to resident's son about his plan to reduce the medications that resident is taking. Risk/benefits of various treatment approaches discussed. Son prefers to maintain resident #63 on the current low dosage of existing set of medications rather than use larger doses or antipsychotics.	3/15/16 3/30/16 3/30/16 3/30/16

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4 184	Continued From page 11 (vascular or mixed) with behavioral disturbances/psychosis 10/27/15. A review of the Care Area Assessment for significant change with an assessment reference date of 2/24/16 notes the resident triggered due to the use of antidepressant related to underlying anxiety, dementia with behavioral disturbance and psychosis. Resident #63 was also noted to have disorganized thinking with episodes of sluggishness and sleepiness as well as refusing care; however, trazodone is used at bedtime and celexa for the management of the resident's mood and behavior issues. On 3/17/16 at 9:30 A.M. an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). A concurrent review of the physician's order was done with the DON and inquired about the use of two antidepressants (celexa and trazodone). The DON confirmed that a diagnosis for the use of trazodone was not documented in the order; however, the trazodone is being used for insomnia. Further queried the DON regarding the use of two medications (trazodone and melatonin) to aide in sleeping, the DON responded the trazodone was ordered 10/2015 and was not effective so melatonin was added to the order on 11/2015. Further inquired regarding the use of celexa for anxiety, the DON reported the physician is indicating the resident has anxiety, its depression with anxiety. The DON clarified the resident has sun downing in the afternoon and throughout the night she is awake, she will get out of bed and go to the bathroom and dining room. The ADON reported the behavior Resident #63 exhibits include yelling/calling out loudly and getting out of bed and going to the bathroom frequently. The ADON	4 184	Identification of other residents Affected: 1. Residents with psychoactive medications will be reviewed by facility, and pharmacy consultant. RCA is used to identify causes of behavior and corresponding effective interventions. Missing elements (appropriate diagnosis/ indication, status of appropriate dose reduction, non-pharm approaches) will be evaluated and changes made where needed. System Change to Ensure Deficient Practice will not Recur: 1. DON, ADON, Administrator and Consultant met with licensed nurses on 4/6/16. Reviewed with them the components of correct physician order. 2. Nurses were advised to always clarify diagnosis when receiving new orders and when doctors come on-site for routine visits. 3. DON/ADON is auditing physician orders to determine our compliance. Result of the audit is being reported to the QAPI committee.	4/22/16 & ongoing 4/6/16 4/6/16 4/7/16 & ongoing

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4 184	Continued From page 12 reported the monitoring of the behavior is provided to the geriatric psychiatrist. On 3/18/16 at 8:15 A.M. an interview was conducted with the Licensed Nurse (LN). The LN reported the trazodone addresses the resident's restlessness, yelling and inability to sleep. The LN confirmed a diagnosis was not provided for the use of trazodone and prazosin. The LN was asked whether anxiety is a diagnosis. The LN confirmed anxiety is not a diagnosis. The LN reviewed the original physician order for the use of prazosin and confirmed there is no identified diagnosis related to the use of prazosin. The facility failed to provide the indication for the use of trazodone, prazosin and celexa. Also, the facility failed to evaluate the use of both melatonin and trazodone for insomnia.	4 184	4. DON/ADON and Administrator will review Physician Order Sheets to make sure all medication orders have appropriate diagnosis or indication for use. **Monitoring System Change to Ensure Deficient Practice will not recur:** 1. Licensed nurses are reviewing the Physician Order Sheet before the end of the month will include checking medication orders to make sure there is a diagnosis or indication for use. 2. Licensed nurses receiving physician orders towards the end of the month will transcribe the orders on the current physician order sheet and POS for the following month. 3. DON/ADON will continue to review physician orders to make sure compliance is maintained. 4. Consultant pharmacist will be checking medications to assure appropriate diagnosis or indication for use is in place and will include it in her monthly report.	4/22/16 & ongoing 4/29/16 & ongoing 4/29/16 & Ongoing 4/15/16 & ongoing 4/29/16 & ongoing
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure medications were not kept beyond their expiration dates. Findings include: Observation of the second floor medication storage room on the morning of 3/18/16 at approximately 9:15 A.M. found several expired medications:	4 197		

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4 197	Continued From page 13 1) One vial of Influenza vaccine which was opened on 11/26/15. An interview of the Licensed Nurse on the second floor found the vial was good for 3 months and therefore it should have been discarded on 2/26/16. 2) One vial of Procrit 10,000 U/mL expired February 2016. 3) Two bottles of Lactulose Solution 10 gm/15 mL expired 9/22/15. A facility policy was requested of the Director of Nursing on the morning of 3/18/16 at approximately 9:30 A.M. At the time of exit on 3/18/16, the policy was not provided to the survey team.	4 197	**4 197 Pharmaceutical Services** 1. Nursing staff checked the medication storage room on both floors. Expiration dates of medications and supplies were checked 2. Expired medications were discarded in accordance with facility policy on Destruction of Medications. **CONTINUED ON NEXT PAGE**	3/18/16 3/18/16
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to protect a high number of residents from gastrointestinal illness by failing to practice transmission based precautions, and failing to thoroughly investigate the outbreak of the gastrointestinal illness among residents, which as a result, made for additional residents to become ill with diarrhea/vomiting. Additionally, the facility failed to maintain an Infection Control Program designed to provide a safe and sanitary environment and to help	4 203	**4 203 Infection Control** Corrective Actions Taken: 1. Second floor was placed on appropriate lockdown/isolation status as soon as nurse received the positive lab results. 2. Infection Control consultant came to the facility and reviewed the facility's Norovirus infection policy and procedure.	3/16/16 & ongoing 3/17/16

Continuation of 4 197 Pharmaceutical Services

COMPLETION DATE

Identification of other residents Affected:

All residents have to potential to be affected.

System Change to Ensure Deficient Practice will not recur:

	Item	Completion Date
1.	DON, ADON, Administrator and Consultant met with the licensed nurses on 4/6/16. Reviewed the revised policy and procedure on discontinued and expired medications and destroying medications.	4/6/16
2.	It was made clear to all licensed nurses that multi-use vials must be dated upon opening. This will be discarded after 30 days from the date it was opened.	4/6/16 & ongoing
3.	Expired medication log was revised to include the findings and be signed by the nurse.	4/1/16
4.	All nurses receiving orders to discontinue medication must update the MAR and POS, document on the progress notes and remove the discontinued medications from the med cart.	4/7/16
5.	Night shift licensed nurse will continue to check the medication room every Friday for expired medications, treatments and IV fluids.	4/1/16 & ongoing
6.	Discontinued medications will be separated and placed in a box for disposal and will be prepared for disposal according to facility policy.	4/1/16 & ongoing
7.	Expired medications will be disposed of according to facility policy.	4/1/16 & ongoing
8.	Copy of the policy on expired medications and disposal of medications is placed on the nursing communication binder for everyone to review.	4/8/16

Monitoring System Change to Ensure Deficient Practice will not recur:

	Item	Completion Date
1.	DON will conduct audit of the medication room and med-carts, report findings during our weekly meetings.	4/8/16 & ongoing
2.	Administrator will do random check of medication of the medication carts and med room. Findings will be discussed with the QAPI committee.	4/11/16 & ongoing
3.	Consultant pharmacist will also conduct monthly audits and include her findings on the monthly pharmacy report.	4/29/16 & ongoing

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4 203	Continued From page 14 prevent the development and transmission of disease and infection. Findings include: A) The facility failed to follow and implement their infection control policies and procedures, including the Norovirus Infection policy and procedure. On 3/15/16, during the morning entrance conference, the Administrator stated their facility currently had a suspected Norovirus outbreak. He presented the surveillance information and said as of 3/15/16, 12 residents were identified to be ill. The outbreak was initially identified with 4 residents who developed symptoms of diarrhea and/or vomiting on 3/8/16. He stated it was contained to the second floor nursing unit and was reported to the State epidemiology branch and the facility's Medical Director. However, during the initial tour of the second floor, it was found there was no signage on the unit to indicate that the 12 ill residents were on any form of transmission based and/or contact precautions due to the outbreak. There also was no EPA approved disinfectant wipes in or by the rooms, nor visible personal protective equipment (PPEs) for the staff and visitors to readily don/use at the entrance of the resident bedrooms. On 3/15/16 at 2:33 PM, the Director of Nursing produced an updated surveillance form which showed 4 of the 12 residents (Residents #147, #29, #63 and #16) had tested positive for the Norovirus in their stool sample. Yet, during the afternoon observations, staff and visitors were observed freely walking in and out of the rooms with no PPEs or monitoring on the unit. Please	4 203	3. Isolation signage on the door was changed with more specific instruction. 4. PPE's were placed outside the door of each room on isolation to be used by everyone entering the room. 5. Nursing staff prevented family members from visiting the residents temporarily. No new admissions were accepted on the second floor while unit is on lockdown. 6. Direct care staff worked only on the unit that they are assigned; staff working on 2 units was not allowed. 7. All staff was advised to wash hands with soap and water and avoid using alcohol based hand sanitizers.	3/17/16 3/17/16 3/17/16 3/18/16 & ongoing 3/18/16 & ongoing

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4 203	Continued From page 15	4 203		

refer to second surveyors' observed findings below in Section B.

On 3/16/16 at 7:22 AM, a morning tour of the second floor found Resident #16 had a red sign on her door which stated, "Visitors: please report to the Nurses' station before entering the room." Otherwise, there still was no signage posted although the Norovirus was confirmed by lab results on the afternoon of 3/15/16. Another resident (Res #102) had no signage but was newly identified to have symptoms of diarrhea on 3/14/16 per the Administrator. Yet, this resident was found to be out of his room although ill, without staff monitoring him. Please refer to second surveyor's observed findings below in Section B.

On 3/16/16 at 7:29 AM, a CNA walked into the room of Res #63 to deliver meal trays. This staff wore no PPEs. This resident had been identified to be positive for the Norovirus. Again, staff failed to adhere to their Norovirus policy and was not being monitored.

On 3/16/16 at 8:08 AM, the Administrator produced an updated outbreak surveillance form and said another resident (Res #100) was newly identified "just this morning. The total count now is 15 residents." He said he would report this update to the State epidemiology office.

On 3/16/16 at 12:22 PM, Res #100's lunch meal was delivered with disposable items on a yellow tray. There also was a plastic bag containing PPE gowns on an overbed table at the foot of her bed. However, no staff were observed to wear them. The disinfecting wipes being used for the resident's surrounding area were found to be bleach free wipes.

Provider's Plan of Correction	Complete Date
8. Bleach solution diluted according to recommendation and SaniBleach wipes was used for disinfecting equipment, bathroom and floors.	3/18/16 & ongoing
9. Frequent cleaning of the bathrooms and floor was done.	3/18/16
10. All residents in the unit remained in the unit. Affected residents were maintained on isolation precaution in their rooms until after 72 hours of the last symptom.	3/18/16 & ongoing
11. Facility hired Pathway Health, a group of consultants, to assist in putting us back into compliance.	4/4/16
12. DON talked to the therapists and advised them to always ask nursing staff of the current situation of the residents they are attending to.	4/5/16
13. DON talked to the attending physician and asked him to sanitize his hands and stethoscope in between resident examination	4/5/16

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4 203	Continued From page 16 On 3/16/16 at 1:18 PM, during an interview with the Assistant Director of Nursing (ADON) and unit charge nurse, they stated their signage for "No Visitors allowed 3/8/16" was only "posted yesterday afternoon (3/15/16)" by the Administrator. The ADON confirmed surveyors' observations that visitors were coming in and out of the residents' rooms, "but we tell them they're not supposed to go into the residents' rooms." The ADON said there were 5 visitors that came in and one "stopped" by the charge nurse, but only after the surveyors queried what protocols were being implemented to prevent the spread of the Norovirus. Review of the visitor's log book from 3/15/16 still showed numerous visitors coming to visit the facility with no education or monitoring being provided by the staff. Please also refer to second surveyor's observed findings below in Section B. On 3/16/16 at 1:25 PM, during a walk through on the second floor with the ADON, she confirmed that Resident #100 is on contact precautions. Yet, there was no signage on the resident's bedroom door. The ADON stated she should have signage. In addition, the staff were still using the disinfectant wipes with no bleach to wipe down the resident's overbed table and surroundings. Although by this time, the second floor unit was to have no visitors per the sign posted on 3/15/16, there were two visitors who were noted to be in other residents' rooms. Staff continued to not monitor the visitations during the outbreak. The ADON and charge nurse stated, "we just did contact precautions." The ADON said it was her responsibility to check the unit staff for handwashing and that they were following isolation contact precautions. When asked how this was being done, she said she told	4 203	Identification of Other Residents Affected: Without proper infection prevention, all residents and staff exposed could be affected. System Change to Ensure Deficient Practice does not recur: 1. Infection Control Consultant reviewed the facility's infection control policies and practices; she gave recommendations for facility to improve our infection prevention. 2. Isolation signs were revised. It shows specific instructions to follow for different kinds of isolation and infection. 3. Residents on isolation precautions will be confined in their rooms until 72 hours passed after the last symptom is observed. 4. In compliance with CDC guideline, everyone entering an isolation room must wear the recommended PPE.	3/22/16 4/1/16 4/1/16 & ongoing 3/18/16 & ongoing

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4 203	Continued From page 17 the staff verbally, and if they did not follow the protocol, she issued a warning slip to them. She did not have any documentation or line implementation/ tracking measures to show how she was monitoring and analyzing the potential for transmission due to breaks in technique/protocol. She also said they did not have a plan in place for staff cohorting on the unit during this outbreak. On 3/16/16 at 1:35 PM, an initial brief interview with the DON revealed she was not involved in monitoring this outbreak. She had been at a nursing conference on 3/8/16, and said the Administrator "was the one who started the surveillance and taking the lead." She acknowledged however, that she is the facility's designated Infection Control Coordinator (ICC). The DON also said the ADON "is the one who has been monitoring the residents and nursing staff" for hand hygiene and use of PPEs. She stated she had no documentation for it. On 3/16/16 at 1:57 PM, an interview with the Administrator was done. He verified the Norovirus Infection policy and procedure is the current one that staff were to follow. He stated, "it should be the nursing staff who has to ensure it is being implemented and (the DON), she is the infection coordinator for many years now." The Administrator stated he was the first one to identify the 4 residents on 3/8/16 with symptoms of foul-smelling, large watery stools and vomiting. He said for their initial precautions, it meant limited visitation and volunteers were not allowed to go to the suspected outbreak areas. The advice from their Medical Director at that time was "follow your protocol." The Administrator was asked about the potential	4 203	5. Facility organized isolation carts where PPE's, isolation signage, and disinfectant wipe or spray is kept. This will be placed by the room entrance if isolation of a resident is necessary. 6. Staff education on infection control specific to Outbreak Management was given on 3/30/16. This will continue until all staff has completed this training. 7. All staff was trained and gave a return demonstration on how to properly use PPE and handwashing technique. 8. Facility will purchase only EPA health care grade PPE to provide adequate protection of residents and staff.	4/7/16 & ongoing 4/15/16 4/15/16 4/1/16 & ongoing

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4 203	Continued From page 18 cross-transmission of infection by staff and how it was being monitored. He stated he was reinforcing the importance of handwashing and to clean with the bleach solution. He did not however, have an explanation for the spread and said "my initial reaction was to contain the possible infection on the unit. I was so worried. We have to bring out all the PPEs that is needed and do everything to contain it." Upon query for those residents who did not get a specimen sent for testing, the Administrator said they could not collect it for everyone who became ill. He said he needed to discuss with the State epidemiology branch as to those residents without a stool culture done, when they would be considered "cleared" of infection. However, for the 4 residents with the positive Norovirus cultures, such as Res #29, whose last loose stool was on 3/11/16, the Administrator acknowledged they should have kept her on contact precautions until the culture results came back, but did not. In fact, Res #29 was observed to be out in activities with other residents on the unit on 3/15/16. Please also refer to second surveyor's observed findings below in Section B. On 3/16/16 at 4:14 PM, another interview with the DON was done. She has been the facility's ICC for 16 years. She has no certification, but receives CDC updates and IC information via webinars and conferences to maintain her role as the ICC. The DON was asked to produce her investigation or any documentation she had of this Norovirus outbreak from 3/8/16 to present. She stated, "Actually when I received it from 8th, I got the information on the 9th, and then I was so busy during that time, I had to meet with the Chief	4 203	9. Medical Director sent a letter to all attending physicians and APRN's reminding them of infection control and antibiotic stewardship.	4/15/16
			10. Nursing staff will advise therapists and consultants what they are supposed to do if the resident they are going to see is currently on isolation.	4/1/16 & ongoing
			11. Department heads are doing an audit on infection control focusing on hand sanitation in between care of resident, sanitizing equipment, handling of soiled or potentially infected materials and cleanliness of the environment using the audit tools provided by Pathway Health consultants.	4/8/16 & ongoing
			12. Department heads and QAPI committee are meeting regularly to discuss findings and agree with a proper solution.	4/11/16 & ongoing

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4 203	Continued From page 19	4 203		
	Operating Officer for 2 days, so (Administrator) took over my place so that's why he did the reporting, gathering the data and communicating with the State and to (Medical Director) of what's going on. It's not really me--(Administrator) has been communicating with the nurses, he was the one who initiated the contact precaution right away for the residents. So the contact person on this one is (Administrator)."		Monitoring System Change to Ensure Deficient Practice will not Recur: 1. As recommended, facility will designate 1 staff to be an Infection Preventionist and In-Service Coordinator that will provide necessary training and follow up on infection prevention implementation.	By 5/30/16
	She further stated, "So today is the first time I have spoken with (individual) in the Department of Health, about the surveillance and what's happening. (Administrator) is still the one going to the nurse's station and doing the preventive measures. He talked to the CNAs, gave them instructions, posted signs."		2. Meantime, DON will continue to function as interim infection control coordinator with the assistance of all department heads and Pathway consultants.	4/18/16 & ongoing
	The DON was queried who was ensuring it is being implemented, and her response was, "Him, ADON and me too, but I took over this Monday. I make sure that they have this one, the sanitizer, gloves, the disposable gowns, masks, it were all taken out the first day." This was not observed when the survey team entered on 3/15/16.		3. Department heads will help in implementing our infection control policy and monitor employee practices in the different departments. Findings will be reported during our QAPI meetings and agree with a solution following acceptable standard of practice.	3/15/16
	The DON was asked what the facility's plan was to contain the outbreak. She said, "the plan--it's all in the binder, the infection control and this one given by (consultant) regarding Norovirus. We were set to meet with her yesterday, but it was rescheduled. I never write anything about it, this is the only document I have (the Administrator's outbreak surveillance spreadsheet). I did not document the things that we did."		4. Will seek guidance of consultants and Medical Director if any new situation is encountered.	4/15/16 & ongoing
	She was asked what kind of precautions were implemented and responded, "First, instructed all CNAs to observe handwashing use of gloves everytime they handled the patients, they have			

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4 203	Continued From page 20 PPEs. Contact precaution at first, but CNAs advised not to bring them out of the room. All the patients listed in here with symptoms with vomiting and diarrhea cannot get out of the room. Yeah, they were instructed and charge nurse to keep the patients inside the room. I base it from the last symptoms, when they had symptoms on the 8th, they were not out until the 15th. Some came out because already free of symptoms. If still awaiting a stool culture result? Then these people--when we're waiting for the culture--well, we only sent for 4. Really, he (Administrator) is the one going in and out to the nurse's station as well." For the newly identified Res #100, the DON stated she was informed, "only this morning about the loose BM." Did you check to see if she had the appropriate signage--everything as you stated? "No, I did not, I did not check on her this morning. But because the nurse should put the sign. Really, I didn't check if the sign is posted. Actually, since (Administrator) is the one in communication with our staff all the time, I thought he did-- we work together and (ADON) too. The reason why too, I didn't really go that side, but I have to go up and down (the first and second floors). I didn't wear PPEs." The DON said if there is signage, "if they are doing nursing care, they supposed to wear mask, gown, glove, but after touching the patient, they supposed to use hand sanitizer, before they touch any other residents. We just had inservice last week to use hand sanitizer after every patient after nursing care. Hand washing after 2 hand sanitizer use, they have to do handwashing as much as possible." She confirmed their staff should use the hand sanitizers alternating with hand washing (soap and water) by the third time.	4 203	KEPT INTENTIONALLY BLANK	

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4 203	Continued From page 21	4 203	KEPT INTENTIONALLY BLANK	

(Note: The final contact precaution sign posted on 3/18/16 stated, "Handwashing To Be Done With Soap and Water Only").

The DON was also asked if staff had to clean the residents' areas with the Sani-cloths and how she knew the appropriate ones were being used. She replied, "Yeah, yeah. Actually, we let them know and on the container, we have 2 mins, 5 mins--the contact time. It's five minutes." She could not state that surveillance was being done for this because she stated she did enter the second floor nursing unit where the outbreak was.

The DON confirmed she had no documentation or analysis of the Norovirus outbreak from the start. She also did not cohort staff and stated, "No, I thought (Administrator) doing this. I did not really document on this...I made sure they have all preventive supplies what they need, like containers of their dirty items. I did not go up to the part there (the second floor unit) and because I saw already on floor the ADON making rounds during this time."

Review of the facility's Norovirus Infection policy 2/08 [last reviewed 5/15], found: "In the event that Norovirus infection is suspected, precautions will be initiated immediately to prevent or minimize the transmission of infection. Policy Implementation: 1. Norovirus infection will be suspected once there is a report of diarrhea and vomiting of at least 3 times per day on at least 3 residents. 2. Soon as Norovirus infection is suspected, facility must immediately initiate Contact Isolation precautions. 3. Residents showing signs of infection will be confined in their rooms to minimize the risk of transmission to other residents. 4. Limited or restricted visitation will be imposed immediately. 5. Stool specimen of

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4 203	Continued From page 22 residents showing signs of infection will be sent to lab for Norovirus testing. 6. Once confirmed, no resident will be allowed to go to other floor and staff will work only on the unit they are assigned. 7. All surfaces and equipment will be cleansed with bleach wipes or spray...11. Admissions will be closed and group activities on the unit will be discontinued until after 4 days of the last reported case..." This policy was not consistently implemented such that by 3/9/16, 1 more resident became ill, but notably that all 5 residents at that point in time were in different rooms. Then on 3/10/16, 6 more residents came down with the gastrointestinal illness, with an additional 2 more residents by 3/11/16, 1 more resident on 3/14/16 and another resident on 3/15/16. An undated Infection Surveillance policy found: "Procedures...6. If infection is confirmed, Charge Nurse initiating treatment should complete the Infection Report, filling up all details..." The DON, with 16 years as the ICC, had no initial reports or documentation to produce regarding this outbreak within their facility. Another undated policy, "Management of Outbreak of Communicable Diseases, found: "Policy...5. Symptomatic residents and employees are considered potentially infected and are cultured and isolated as indicated...For Director of Nursing...3. Assigning nursing personnel to same residents group for the duration of the outbreak...For Nursing Staff...4. Initiating isolation barriers as directed or as necessary. 5. Confining symptomatic residents to their rooms for at least 72 hours after onset of infection...For the Medical Director...2. Overseeing the management of the outbreak." The Administrator said their Medical Director's response was if the residents had no fever and	4 203	KEPT INTENTIONALLY BLANK	

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4 203	Continued From page 23 were asymptomatic, the residents would be in the clear. However, the Administrator noted that none of these residents had fever as one of their symptoms. As of the result of the lack of following their own policies and procedures to prevent the spread of the Norovirus, on 3/17/16 at 8:18 AM, the Administrator was notified of the IJ. He verified the LHC Norovirus Infection policy is current and is what the staff had to follow. The Administrator developed an initial abatement plan on 3/17/16 at 2:50 PM, which was not accepted by the survey team as it lacked immediate corrective measures to prevent further spread of the Norovirus. On 3/18/16 at 8:30 AM, the Administrator produced an acceptable IJ abatement plan. Some of the corrective measures were observed by surveyors on the unit as applicable, and included: - The facility contracted with an infection prevention consultant to review the entire infection control program. The consultant is to provide recommendations to correct areas related to staff knowledge of infection prevention, education needs, need for isolation signage, proper placement and care of residents. - New policies and procedures will be written and implemented. - Temporary isolation signs have been placed on rooms for residents who continue to be ill with Norovirus. - Rounds were completed by the IP consultant on the second floor on 3/17/16. - Inservicing to be conducted by the Administrator for evening and night staff and EVS/laundry staff. Cleaning of the unit, especially the bathrooms and floors to be more frequent, at least 3-4x/day. - PPEs placed outside the door of each room on	4 203	KEPT INTENTIONALLY BLANK	

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4 203	Continued From page 24 isolation, to be used before entering the room. - Use of Sani cloths with bleach and Clorox solution to clean bathrooms and floors. - No admissions on the second floor while it is on lockdown; visitation is not allowed unless necessary and visitor instructed what to do and use PPE before entering the room. - Resident will be cleared of infection 72 hours after the last diarrhea and vomiting is noted. - Infection will be cleared after the last case has no symptoms for 72 hours. - Terminal cleaning of the unit done once lockdown is lifted before any further admissions occur. In addition, as verified by the DON during her interview, there was no documentation or active case finding upon her knowledge, or others, when a the Norovirus outbreak was suspected. She stated she had knowledge of it on 3/9/16, but as the Infection Control Coordinator for the facility, failed to fully ensure the facility's policies were being implemented. As a result, additional residents became symptomatically ill. The facility only took corrective action to systemically implement measures once the IJ was identified and thus, failed to safeguard the health of the residents and visitors. B) A review of the facility's policy and procedures for "Norovirus Infection" notes when norovirus is suspected, precautions will be initiated immediately. Policy implementation includes the following: "Residents showing signs of infection will be confined in their rooms to minimize the risk of transmission to other residents..." The facility failed to implement its policy for residents on contact precaution with signs of infection and for residents not on contact precaution with signs and symptoms of infection.	4 203	KEPT INTENTIONALLY BLANK	

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4 203	Continued From page 25 1. Observation during the lunch meal on 3/15/16 found Resident #102's meal tray with clear liquids. The staff member delivering the trays reported the resident has diarrhea. On the afternoon of 3/15/16 a record review was done for Resident #102. A physician's order dated 3/15/16 notes to offer Resident #102 a liquid diet until diarrhea stops and to place the resident on contact precaution. During the meal observation, Resident #102 was observed to be in the bathroom and used the toilet independently. On 3/15/16 at 2:10 P.M. an interview was done with the Licensed Nurse (LN). The LN confirmed Resident #102 was placed on contact precaution, inquired what does this mean, contact precaution. The LN responded it means strict hand washing and use of gloves. Further queried whether the resident is required to remain in his room, the LN reported that he usually "mingles" with the other residents and the staff members will keep an eye on him to ensure he doesn't mingle with the other residents. During the interview with the LN, Resident #102 was observed wheeling himself into the activity room. The resident went to the refrigerator, opened the door and wheeled himself to the front of the refrigerator. A staff member asked the resident what he wanted, the staff member was heard telling the resident to return to his room and they will bring him some juice. A staff member wheeled him back to his room. The staff member confirmed the refrigerator contained residents' food and drinks. The refrigerator was not sanitized after the resident on contact precaution went into the refrigerator. On 3/17/16 at 9:32 A.M. the DON was interviewed. Queried whether the refrigerator	4 203	KEPT INTENTIONALLY BLANK	

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4 203	Continued From page 26 needed to be sanitized after the resident went into the refrigerator, the DON responded that she had heard about it. The DON did not confirm the refrigerator required sanitizing. 2. On the morning of 3/15/16, Resident #29 was observed seated on a large table with fellow residents playing Bingo. Resident #29 was seated between two residents. During lunch, the resident was seated in the dining room with another resident. A review of the "Outbreak Surveillance Form" notes Resident #29's onset date of illness (diarrhea) was 3/10/16 with last date of illness on 3/11/16. A stool sample taken on 3/10/16 was found to be positive for norovirus on 3/15/16. Observations on 3/16/16 found Resident #29 confined to her room. 3. On 3/16/16 during the lunch meal, the following residents were observed dining the activity/dining room: Resident #86, Resident #89 and Resident #96. Resident #86's onset date of vomiting and diarrhea was 3/8/16 and date of last illness was 3/9/16. Resident #89's onset date of diarrhea was 3/11/16 with last date of illness documented as 3/12/16. Resident #96's onset date of diarrhea was 3/10/16 and last date of illness of 3/10/16. At this time, the Administrator and DON were unable to provide information related to discontinuation of limiting residents with signs and symptoms of illness with other residents. On 3/18/16, the Administrator reported residents without signs and symptoms of illness for 72 hours would be able to join residents in the dining/activity room. 4. On the afternoon of 3/15/16, Resident #147 was observed ambulating with a forward wheel walker with the assistance of a therapist. This resident was listed on the "Outbreak Surveillance	4 203	KEPT INTENTIONALLY BLANK	

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4 203	Continued From page 27 Form" with onset date of vomiting and diarrhea of 3/9/16 with last date of illness of 3/10/16. The resident was not wearing personal protective equipment (gown, gloves and face mask) This resident's stool was noted to be positive for norovirus on 3/15/16. The resident was treated with imodium. On 3/17/16 at 2:00 P.M. an interview was done with the Speech Language Therapist (SLT). The SLT was able to confirm Resident #147 participated in occupational and physical therapy on 3/16/16 at 2:42 to 3:40 P.M. The SLT reviewed the therapist's note of 3/15/16 to confirm Resident #147 received therapy services for bed mobility and had complained of stomach pain. The facility failed to confine Resident #147 with signs of infection and failed to ensure communication with the therapy department was done to practice contact precautions (confine the resident to the room and to use appropriate personal protective equipment). 5. On 3/16/16 during the lunch meal, Residents #116 and #113 were found to have non-disposable plates/bowls and utensils. Resident #116 had an onset of vomiting and diarrhea on 3/8/16 and last date of illness on 3/9/16. Resident #116 was treated with imodium. Resident #113's onset date of vomiting and diarrhea was 3/10/16 with last date of illness of 3/13/16. Other residents (Resident #63, Resident #147 and Resident #102) identified on the surveillance form were provided meals on a yellow tray with disposable plates/bowls and utensils. Interview with the Administrator found residents with infections require a special tray (yellow) with disposable plates/bowls and	4 203	KEPT INTENTIONALLY BLANK	

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4 203	Continued From page 28 utensils. 6. The facility failed to limit visitors to the unit during the outbreak of norovirus. On 3/16/16 during the lunch meal observation. There were three visitors present assisting residents with their meals. One visitor was observed to obtain a meal tray from the cart without hand sanitizing. On 3/16/16 at 12:05 P.M. a visitor was observed to enter the unit. The visitor reported she was going to visit a relative in Room 212, Resident #146. Inquired what information was provided to her while visiting her family member. The visitor reported she was asked where and who she was going to visit and how long she was going to stay. The visitor reported she was told there is a virus on the second floor. Further queried what other instructions were provided. The visitor reported she is to take precautions, wear a mask and use the hand sanitizer. A review of the surveillance log found Resident #146's roommate with onset of illness, vomiting and diarrhea on 3/11/16 with last date of illness dated 3/10/16. C) A staff member failed to ensure hand hygiene/glove change was done during care of a resident on contact precaution. The facility also failed to provide appropriate disinfecting solution for this resident with positive culture for [redacted] [redacted] and ensure equipment use is designated for only this resident. On 3/16/16 at 9:40 A.M. observed a Certified Nurse Aide (CNA #1) bringing Resident #81 out of the shower. Resident #81 was seated in a shower commode. The CNA was wearing a yellow gown, booties, gloves and face mask. The CNA was placed the resident in her wheelchair at the foot of the bed. The CNA removed the	4 203	KEPT INTENTIONALLY BLANK	

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4 203	Continued From page 29 resident's bed linen, put the resident's socks on, went to the covered shelf and brought out clean linen. The CNA then made up the resident's bed. Subsequently, another CNA provided assistance to transfer the resident to bed. CNA #1 removed a yellow gown from the plastic covering which was placed on the chair between two armoires. CNA #2 was observed to put on a yellow gown, gloves and face mask at the linen shelf. The two CNAs transferred the resident to bed. CNA #2 removed the gown, glove and face mask and tossed it in the receptacle in the resident's room. CNA #1 placed the shower commode back into the bathroom. A "disinfectant wipe" was used to wipe the top of the commode, the armrest and the plastic pipes at the base. CNA #1 did not change gloves during the observation period. At 9:50 A.M. the CNA confirmed the wipes used to clean the shower commode was from the commercial "disinfectant wipes" container and the equipment is wiped before and after the residents with a five minute wait time before using the equipment again. A record review was done on 3/17/16 at 8:39 A.M. Resident #81 was admitted to the facility on 9/27/13. A review of the physician's order for 1/23/16 notes an order for cipro due to fever/cough. Subsequent note for 2/4/16 documents the resident is positive for [redacted] and [redacted] from suctioned sputum. The resident was placed on contact isolation. The order for 3/17/16 notes to discontinue contact isolation. On 3/17/16 at 9:32 A.M. an interview was conducted with the Director of Nursing (DON). The care observation done on 3/16/16 from 9:40 A.M. to 9:50 A.M. was shared with the DON. Queried the DON whether a glove change was needed during the CNA's care of Resident #81.	4 203	KEPT INTENTIONALLY BLANK	

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4 203	Continued From page 30 The DON replied a glove change is not needed when you go from a clean area to another clean area. Further queried whether a glove change was indicated following the removal of the bed linens and going into the clean linen storage. The DON responded a glove change was indicated. The DON reported the commercial disinfectant wipes with bleach is adequate to sanitize the shower commode; however, due to the resident's sputum being positive for [redacted] and [redacted] the equipment should be designated for only Resident #81. The DON further stated the wipes that were provided to the rooms this week is adequate. The DON also confirmed the underside of the shower commode seat needed to be wiped down. A review by two surveyors found the commercial disinfectant wipes did not include bleach. Subsequent observation found the commercial disinfectant wipes were removed and replaced with a solution that includes bleach. D) On 3/15/2016 at approximately 12:30 PM, a physician was observed checking a resident's chest with a stethoscope. He then went and placed his hand on another resident's forehead to tilt her head backwards and used his other hand to touch the resident's eye area. He then went to the nurse's station and pulled a medical record out to write in. No hand washing or hand hygiene was observed to be done by this physician between his examination of the residents or thereafter.	4 203	KEPT INTENTIONALLY BLANK	