STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345413	A. BUILDING _____ B. WING _____	01/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLESHERS FAIRVIEW HEALTH CARE	3016 CANE CREEK RD FAIRVIEW, NC 28730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and record review the facility failed to honor food preferences for 1 of 5 sampled residents (Resident #12) reviewed for food choices. The findings included: Resident #12 was assessed on the most recent Minimum Data Set (dated 11/21/13) as cognitively intact. During an interview on 01/28/2014 8:55 AM, Resident #12 voiced a concern that food preferences were not honored. Resident #12 said that she had informed staff on many occasions that she did not like broccoli and would not eat it. The resident expressed frustration that she continued to receive broccoli two to three times per week. On 01/29/14 12:30 PM Resident #12 was observed in the dining room when her lunch was delivered by the Occupational Therapist. When she lifted the lid from one of the bowls Resident #12 scrunched her nose, shook her head and	F 242	Dietary Manager spoke with affected resident and updated likes and dislikes on tray card to correct the issue for the affected resident. Dietary Manager interviewed all residents regarding likes and dislikes and updated resident tray cards to ensure this does not happen to any other residents in the future. In-service training with dietary staff on 2/3/14 regarding the importance of accuracy in checking tray cards for likes/dislikes during tray line to make sure residents do not receive dislikes at meals. In-service training with all nursing staff on 2/20/14 regarding checking tray cards upon delivery of meals to double check that no dislikes are served. If any present or resident states they do not want what is served, an alternate will be offered and a dietary communication slip filled out and turned in to the kitchen to update the dislikes.	2/20/14

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

Electronically Signed | 02/17/2014

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F 242	Continued From page 1 said, "Ugh, broccoli. No way. No way." Review of the resident's tray card did not indicate a dislike for broccoli. When asked about the resident's food preference on 01/29/2014 at 12:34 PM, the Occupational Therapist and Nurse Aide (NA) #1 simultaneously said, "That whole table doesn't like broccoli." At 12:40 PM on 01/29/2014, the Occupational Therapist indicated she was aware of Resident #12's dislike for broccoli but had not reported it to kitchen staff. On 01/30/14 at 3:22 PM Nurse #2 stated that when staff became aware of food preferences or dislikes, the information was to be put into a "Dietary Communication" book or it was to be written on the resident's meal card and given to the kitchen staff. The Registered Dietician (RD) was interviewed on 01/30/14 at 3:24 PM. The RD reviewed the computer for Resident #12's preferences and said that broccoli was not listed on the resident's tray card. The RD indicated that the computer information for the tray cards had been erased from the program within the last three months, "so we have been trying to re-interview people and get that information." She also indicated it was her expectation that when staff were aware of a resident's dislikes, that she or the dietary manager were to be informed so the resident would not continue to receive the food she disliked. On 01/31/2014 at 10:11 AM, NA #1 was interviewed and indicated she had known Resident #12 didn't like broccoli and that information should have been given to the dietary	F 242	QA coordinator will ensure monitoring or resident meal trays for accuracy and note if staff is offering alternates, as needed, for 5 meals a week and document findings. QA coordinator will review audits in QA meetings at least monthly and address effectiveness of POC, make changes as needed to ensure correction achieved and maintained. Monitoring will continue until three months of compliance has been achieved. QA will then ensure quarterly monitoring of two meals for six more months to ensure full compliance. Resident Council will address monthly whether dislikes are served and whether alternates were offered when they do not like or want items served. All resident council minutes will be reviewed by the dietary manager who documents corrective action for any issue mentioned. Resident Council minutes will be reviewed in QA meetings monthly and ensure that all items have been corrected, or if further action needs to be taken.	

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F 242	Continued From page 2 staff.	F 242		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to provide foot support for one of three sampled residents (Resident #68) reviewed for positioning. The findings included: Resident #68 had diagnoses including advanced dementia with behaviors. The Minimum Data Set (MDS) dated 12/05/2013 indicated the resident was severely cognitively impaired, required extensive assistance of two staff for transfers and mobility and her balance was unsteady. The Care Plan dated 12/12/2013 indicated the resident was at risk for falls and one of the approaches included a cushion in her wheelchair. On 1/27/2014 at 1:12 PM, Resident#68 was observed sitting in a wheelchair near the nursing station. The resident was seated on a cushion that was approximately 4 inches thick. The resident's feet hung down without support and the tips of her toes were approximately 3 inches from	F 309	Affected resident was given a different lower wheelchair with a smaller cushion to allow good positioning with feet on the ground. All other residents in wheelchairs were assessed to check for correct positioning and to ensure no other residents were affected by this practice. In-service training by therapy on 2/20/14 regarding positioning with all nursing staff to make staff aware of proper positioning of residents during routine daily care with focus on wheelchair positioning, use of wheelchair cushions and positioning of feet and legs in wheelchairs. Therapist or CP Coordinator will assess residents for correct positioning upon any new orders for cushions in wheelchairs. QA to ensure monitoring of 10 wheelchair	2/20/14

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F 309	Continued From page 3 the floor. On 1/28/2014 at 11:53 AM, Resident#68 was observed sitting in a wheelchair near the nursing station. The resident was seated on a cushion that was approximately 4 inches thick. The resident's feet hung down without support and the tips of her toes were approximately 2 inches from the floor. On 01/29/2014 at 10:35 AM Resident#68 was observed sitting in a wheelchair by the nursing station. The resident was seated on a cushion that was approximately 4 inches thick. The resident's feet hung down without support and the tips of her toes were approximately 3 inches from the floor. On 01/29/2014 at 3:51 PM Resident#68 was observed sitting in the hallway by her room. She was seated in a wheelchair on a cushion that was approximately 4 inches thick. The resident's feet hung down without support and the tips of her toes were approximately 3 inches from the floor. On 1/30/2014 at 7:48 AM, Resident#68 was observed sitting in a wheelchair near the nursing station. The resident was seated on a cushion that was approximately 4 inches thick. The resident's feet hung down without support and the tips of her toes were approximately 2 inches from the floor. During an interview on 01/30/2014 at 10:02 AM, Nurse Aide (NA) #1 indicated the resident was extensive care and that the resident was seated on the cushion because she was inclined to stand up and could fall. NA #1 stated, "I saw her stand, but since they put the cushion in her chair it	F 309	residents 3 times weekly to check for correct positioning and document until three months of compliance achieved. QA coordinator to review audits in QA meetings at least monthly to evaluate effectiveness of correction, document areas of concern and make changes as needed to ensure correction is achieved and maintained.	

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F 309	Continued From page 4 prevents her feet from touching the ground." NA#1 added, "We do have foot pedals here but she doesn't have any." Nurse #1 was interviewed on 01/30/2014 at 10:10 AM about the fact that Resident #68's feet were not supported for proper body alignment when she was seated on the cushion in her wheelchair, Nurse # 1 said, "We were just doing the best we could to keep her safe. She has no safety awareness." On 01/30/2014 at 10:28 AM, the Occupational Therapist was interviewed about the fact that Resident #68's feet were not supported for proper body alignment when she was seated on the cushion in her wheelchair. The Occupational Therapist indicated that foot-rests had been tried but, "if her feet touch the floor in the afternoon she will push up into standing position and she has no safety awareness." The Physical Therapist was interviewed about Resident #68 positioning on 01/31/2014 at 10:50 AM. He indicated that he considered residents on a case-by-case basis but that generally a resident's feet should be supported for proper body alignment. On 01/31/2014 at 2:18 PM, the Director of Nursing said, "We will get her feet so they can touch the floor. We will discuss options. A resident should be positioned properly."	F 309		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:	F 356		2/5/14

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F 356	Continued From page 5 o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. 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: Based on observations, staff interviews, and record review the facility failed to include hours worked and the daily census in the posted staffing data for 4 of 5 days of the survey. The findings included: On 01/28/2014 at 3:30 PM, the Daily Staffing	F 356	No residents were affected by the incomplete posting of staffing information. A new completed form was put in place immediately to ensure no residents affected by incorrect posting in the future. A new form was developed that includes	

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F 356	Continued From page 6 information was posted at the front Receptionist's desk. The staffing sheet was incomplete in that it included the number of nursing staff for each shift but did not include the number of hours worked. The Daily Staffing sheet also did not include the census for the day. On 01/29/2014 at 9:30 AM, Receptionist #1 stated, "The second shift receptionist writes this (Daily Staffing sheet) out every day. Then in the morning I do the census." Observation at that time revealed the Daily Staffing information was posted at the front Receptionist's desk. The staffing sheet did not include the number of hours worked or the census for that day. On 01/30/2014 at 11:30 AM, the Daily Staffing information was posted at the front Receptionist's desk. The staffing sheet did not include the number of hours worked or the census for the day. Receptionist #1 was interviewed at that time. She explained that Receptionist #2 worked in the late afternoon and evening and was responsible for starting the Daily Staffing Sheet for the following day. Receptionist # 1 stated that the Daily Staffing sheet was displayed at the Receptionist's desk but that she would not put the census for 1/30/2014 on that day's sheet until the following morning. Receptionist #1 said, "I won't know today's census until tomorrow so tomorrow morning (on 01/31/2014), I will put the census on today's (01/30/2014) sheet and hand it in." On 01/31/2014 at 8:35 AM, the Daily Staffing information was posted at the front Receptionist's desk. The staffing sheet did not include the number of hours worked or the census for the day.	F 356	facility name, date, current census, total number of staff by shift and category and total hours worked by shift and category. Form to be completed every morning at the start of shift for current day and updated throughout the day as needed and posted at the receptionist desk. In-service training by the DON to receptionists to ensure that staff knowledgeable in correctly filing out form and posting requirements. QA coordinator will ensure monitoring of staff posting 4 times a week to check that staffing form is filled out accurately and completed, posted as required and document findings until one month of compliance achieved. QA coordinator will review audits in QA meetings at least monthly and check for effectiveness of correction, make changes, as needed, to ensure compliance is achieved and maintained.	

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F 356	Continued From page 7 On 1/31/2014 the Director of Nursing was interviewed at 2:07 PM about the Daily Staffing Sheets. The Daily Staffing sheets had blank spaces to record the number of registered nurses, licensed practical nurse and the nurse aides for each shift but did not provide a space to record the number of hours worked. After reviewing the Federal Regulation, the Director of Nursing stated it was her expectation that the facility follow the regulation to post the hours for each discipline for each shift and that the day's census should be on the sheet in the morning for the day for which it was posted.	F 356		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide health shakes and fortified juice as ordered by the physician for 1 of 3 sampled residents reviewed for nutrition. (Resident #43) . The findings included: Resident #43 was admitted to the facility from the hospital on 11/08/13 with diagnoses including pneumonia, iron deficiency anemia, hypothyroidism, depressive disorder and failure to thrive. Review of the Minimum Data Set (MDS) dated 11/22/13 revealed Resident #43 was assessed as	F 367	Dietary was notified that supplement had not come out on tray for affected resident. The items were highlighted, dietary staff spoken to, and supplements have come out on tray from then on. Dietary has now highlighted all supplements on tray cards for residents with supplements ordered to come out on tray to make sure they are given for all residents and ensure that no residents are affected by this in the future. New dietary policy of highlighting supplements on tray cards to allow for better identification.	2/20/14

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F 367	Continued From page 8 severely cognitively impaired with a BIMS score of 3. A care plan for Resident #43 revealed an entry dated 11/14/13 for a health shake with lunch and supper and a fortified juice with breakfast. Review of physician orders revealed an order dated 11/14/13 for a health shake with lunch and supper and fortified juice with breakfast signed by the registered dietician (RD) and physician. Record review revealed an RD note on 11/21/13 which assessed resident #43's weight at 95.3 pounds and noted that Resident #43 had refused to take water but accepted supplements and was on weekly weights. Review of the RD's third quarter assessment dated 12/05/13 revealed Resident #43 had good acceptance of supplements with variable oral intake, and required assistance from staff at meals. On 01/27/14 at 12:35 PM Resident #43 was observed in the main dining room eating her lunch meal. She was observed not to have a health shake on her tray. Review of the tray card revealed she was to have a health shake served at this meal. Resident #43 was observed for the entire lunch meal until 12:46 PM when she got up and left the dining room without receiving a health shake. On 01/28/14 at 12:22 PM Resident #43 was observed in the main dining room eating her lunch meal. She was observed not to have a health shake on her tray and was not provided one during the entire lunch meal.	F 367	In-service training with dietary staff on 2/3/14 on importance of tray card accuracy and new policy of highlighting supplements on tray cards to better identify who gets them. In-service training with nursing staff on 2/20/14 on importance of checking tray cards for accuracy upon delivery to residents and to note highlighted areas as supplements that come out on tray to make sure they are present. QA coordinator to ensure monitoring of trays for residents who get supplements on trays at least 5 times weekly for accuracy and document until three months of compliance maintained and then quarterly for six months to ensure compliance. QA coordinator to review audits in QA meetings at least monthly to check for effectiveness of plan, make changes as needed, and ensure compliance is achieved and maintained.	

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F 367	Continued From page 9 On 01/29/14 at 8:35 AM Resident #43 was observed in her room and she stated she had already eaten her breakfast. Resident #43's finished tray was observed on the meal cart. Review of the resident's tray card revealed no mention that she was to receive fortified juice with her breakfast meal. On 01/31/14 at 8:30 AM Resident #43 was observed in her room with no breakfast tray on her table nor any juices or beverages left from the tray. The resident's tray was observed on the meal cart and no fortified juice cup was observed on the tray. Review of the resident's tray card revealed no mention that she was to receive fortified juice with her breakfast meal. On 01/31/14 at 2:30 PM an interview was conducted with the RD. She stated resident #43 had been readmitted on 11/09/13 to the facility from the hospital due to pneumonia. The RD stated that health shakes were ordered at lunch and supper and a fortified juice for breakfast. The RD noted Resident #43 was on weekly weights because she weighed 96 pounds when she came back from the hospital. Traditionally, the RD said Resident #43 would take more by drinking than eating. The RD said she did a 30 day quarterly assessment on 12/02/13 and the resident weighed 99 pounds so she had been gaining weight. The RD revealed the tray cards need to reflect the orders for supplements that are to be served at meals. The RD stated the tray cards need to be monitored by staff to make sure everything listed on the tray cards such as health shakes and fortified juice were served with meals.	F 367		

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F 367	Continued From page 10 On 01/31/14 at 2:41 PM an interview was conducted with the Food Service Director (FSD). He revealed the kitchen has all the necessary supplements available to be placed on resident meal trays and staff had been trained to monitor resident meal trays on the tray line to make sure everything listed on the residents tray card has been placed on the residents tray. The FSD stated he was aware Resident #43 had orders for health shakes at lunch and supper and fortified juice at breakfast. He stated he had not checked the tray card before it left the kitchen at breakfast and lunch and missed the absence of the health shakes and fortified juice. The FSD reported more training was needed for kitchen staff to better monitor the tray cards.	F 367		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep dented cans out of the ready to use stock; failed to discard an expired food item; failed to label and date stored foods in a walk-in cooler and failed to keep food storage equipment clean.	F 371	No residents were directly affected. The dented cans, expired and undated items were discarded immediately and the food storage equipment cleaned to prevent any residents from being affected in the future.	2/20/14

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F 371	Continued From page 11 The findings included: 1. Observations of the canned good storage rack on 01/27/14 at 9:15 AM revealed five cans on the ready to use rack were found to be badly dented at the rims, top and bottom, and in the middle. The products observed were a can of cheese, a can of soup, 2 cans of marinara sauce, and a can of V-8 juice. In an interview with the Food Service Director (FSD) on 01/27/14 at 9:24 AM he revealed when cans are placed on the rack they are ready for use. He had not observed the dented cans on the ready to use rack and showed a bin on another rack where dented cans were to be placed for return and credit from the food procurer. In an interview with a cook on 01/29/14 at 5:14 PM he stated when cans are delivered the cooks unpack them and place them on the rack ready for use. The cook said cans are supposed to be checked for dents before placing them on the rack for use. He revealed if cans are dented they are placed in a bin located on another rack for return for credit. 2. On 01/27/14 at 9:25 AM the walk-in cooler contained a gallon mayonnaise container with two pink facility stickers with hand written dates of 08/13 and 09/13. There was no manufacturers date on the container. Another gallon mayonnaise container and a container of cottage cheese were observed to have been opened with no date when opened. There was no manufacturer's use by date on these containers.	F 371	Cleaning schedule updated to include daily and weekly cleaning of food storage equipment. In-service training with dietary staff regarding updated cleaning schedule and expectations such as if something becomes soiled in between cleaning times during food preparation that it should be wiped off then as well, proper storage of food items including dating, removing dented cans and placing them in return bin, correct procedure for washing and drying food equipment. QA coordinator to ensure monitoring cleaning of storage bins, cleaning and drying of food prep equipment, dating of opened containers, and checking for dented cans 3 times weekly and document until compliance maintained for three months and then quarterly for six months to ensure compliance. QA coordinator to review audits in QA meetings at least monthly to check for effectiveness of correction, make changes, as needed, and follow up to ensure compliance achieved and maintained.	

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In an interview with the FSD on 01/27/14 at 9:28 AM he revealed the pink sticker date of 09/13 was the expired date and the mayonnaise should have been discarded. He said the other mayonnaise and cottage cheese containers should have been dated when opened and dated when to be used. The FSD observed the mayonnaise and cottage cheese containers and did not observe a manufacturer's use by date on them.

3. Observations of the kitchen's dry storage area on 01/27/14 at 9:30 AM revealed 6 plastic bins with packaged gravy mixes, poultry and biscuit mixes located in the drawers of the bins with a build up of food crumbs and an accumulation of sticky matter on the outside of the bins. In addition, at the same time observations in the kitchen revealed plastic bins holding sugar, flour, bread crumbs and thickeners had sticky and greasy food matter on the tops of the bins as well as on the sides of the bins. On 01/30/14 at 8:05 AM the 6 plastic bins observed in the dry storage area remained with food crumbs inside the drawers and an accumulation of sticky matter on the outside of the bins.

In an interview with the FSD on 01/29/14 at 5:25 PM, when he was shown the plastic bins holding the flour, sugar, bread crumbs and thickeners, he stated they should be cleaned once a week on Monday. The FSD stated the plastic bins had been cleaned on Monday but noted the thickener bin had not been cleaned and he said it should have been cleaned on Monday.

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F 371	Continued From page 13 In an interview with the FSD on 01/30/14 at 9:00 AM, when he was shown the 6 plastic bins in the dry storage area with food crumbs inside the drawers and an accumulation of sticky matter on the outside of the bins, he stated these bins get cleaned once a month and noted they should be cleaned more than once a month. 4. Observations on 01/27/14 at 9:34 AM revealed 4 plastic food preparation containers stacked together with moisture observed in each container. In an interview on 01/30/14 at 7:15 AM with the FSD he revealed food preparation equipment should be air dried and not stacked with moisture ready for use.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		2/20/14

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F 441	Continued From page 14 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to implement isolation precautions for 1 of 1 residents with a Herpes zoster infection (Resident #119) and properly label and store a bedpan and urine hat in 1 of 1 shared resident bathrooms. Findings included: 1. Review of the Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions (IP): Preventing Transmission of Infectious Agents in Healthcare Settings, was completed. Appendix A, titled Type and Duration of Precautions Recommended for Selected Infections and Conditions, revealed a recommendation of airborne and contact isolation	F 441	Affected resident with herpes zoster is no longer in facility. Hospital was contacted about resident, they stated she was not on isolation in hospital prior to her admission to our facility and is currently in hospital and is not on isolation at this time. Unmarked bedpan and urinal hats were discarded and no longer needed or used by the affected resident. All residents on antibiotics and antivirals reviewed to check if any infection control precautions/isolation were needed. All rooms were checked to ensure that personal items were labeled, covered and stored correctly. This will ensure that no	

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F 441	Continued From page 15 precautions for Herpes zoster (shingles), if disseminated in any patient or if localized in an immunocompromised patient until disseminated infection was ruled out, for the duration of the illness. Further, if the infection was localized in a patient with an intact immune system with lesions that could be contained or covered, standard precautions were indicated for the duration of the illness. Review of the facility's policy manual, under the tab labeled QA (quality assurance) program, revealed a policy with a review date of 08/10 and titled Quality Assurance Program which stated "all conditions suspected of being contagious are isolated until proven non-contagious" by a physician. This policy further directed that appropriate isolation was used according to policy and personnel were to be instructed in isolation techniques. This policy further directed that visitors were instructed in use of appropriate isolation procedures and signs were to be posted inside and outside the door. Review of the policy manual revealed no polices or a resource to identify residents with infections requiring IP or what was required for each type of IP. Resident #119 was admitted to the facility on 01/20/14 with a diagnosis of Herpes zoster of the left eyelid. Review of admission orders revealed a prescription for the antiviral medication valacyclovir hydrochloride, 1 gram dose by mouth every 8 hours. Review of an admission nursing note dated 01/20/14 revealed Resident #119 as pleasantly confused and her left eye as "red and swollen, crusty exudate" and the sclera and conjunctiva as "red and irritated." Review of admission orders revealed no orders for IP. Review of an undated resident profile for	F 441	other residents are affected by these issues. New infection control policies and procedures put in place, updated signage obtained, Infection Control Manual for LTC facilities, and the CDC Guidelines for LTC obtained to provide guidance to the SDC and nurses on correct action to take. Nursing administration who review potential admissions will note any that would require infection control precautions/isolation and make sure that it is in place prior to resident arrival. In-service training to all nursing staff on 2/17/14 on infection control, general guidelines, new policies and procedures, including isolation procedures, and signage to be used. Review of personal items policies in in-service on 2/20/14 including labeling, cleaning and storing. QA coordinator to ensure monitoring of infection control by reviewing of all residents on antibiotic and antiviral medications 4 times a week to see if infection control precautions are necessary and if so, are they in place and document. QA coordinator will ensure that 10 rooms are checked weekly for personal items labeled and stored correctly. These will continue to be monitored until three months of compliance achieved. QA will then monitor all antibiotic/antiviral use quarterly and review in the infection control quarterly meetings to ensure compliance	

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F 441	Continued From page 16 Resident #119, retrieved and printed from the Care Tracker electronic medical record system, revealed "resident not to leave room until approved by MD. Wash hands frequently. Encourage resident not to scratch eye. Wear cotton gloves provided by family." Review of a physician's history and physical (H & P) note dated 01/21/14 revealed the Resident had been on the antiviral medication valacyclovir hydrochloride for 10 days. Under the heading Review of Systems of the H & P note, the physician documented vision in the Resident's left eye as usually better but "now she has shingles in it." Under the heading Physical Exam of the H & P note, the physician documented the left eye as "irritated on the eye and also around the eyelids." Documented diagnoses included Herpes zoster with other ophthalmic complications and delirium due to conditions classified elsewhere. The Plan in the H & P documented the presence of confusion and Resident #119 requiring another 10 days of valacyclovir hydrochloride. In the H&P there was no documentation of IP. Review of another nursing note dated 01/23/14 revealed the physician was called for increased complaints of pain, redness and drainage to the Resident's left eye. A family member was documented as inquiring if the valacyclovir hydrochloride could be discontinued but the physician was reported as stating due to the pain and the shingles he did not want the medication to be stopped, which was communicated to the family member. Another nursing note dated 01/24/14 revealed continued pain to the Resident's left eye with yellow exudate drainage, with the Resident encouraged not to rub the eye. Daily nursing notes dated 01/24/14 through	F 441	maintained. QA coordinator will review audits in QA meetings at least monthly to ensure effectiveness of plan, make changes, as needed, and follow up to ensure compliance is achieved and maintained.	

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01/29/14 revealed Resident #119 continuing to rub her left eye, with red and irritated sclera and conjunctiva and yellow exudate.

On 01/29/14 at 12:20 PM a sign titled Universal Precautions in Patient Care was observed on Resident #119's doorframe. On this sign in the upper left corner was observed the handwritten comment "see nurse before entering room." No personal protective equipment (PPE) was located in the hallway outside the Resident's room.

Review of nursing notes dated 01/29/14 revealed a family member of Resident #119 voicing concerns regarding the Resident having a mental and physical decline, not eating and wanting for the Resident intravenous nutrition. Review of orders dated 01/29/14 directed the Resident be sent to the emergency room per the family request. Review of nursing notes dated 01/29/14 revealed Resident #119 left the facility at 6:00 PM that day.

On 01/30/14 at 1:50 PM the staff development coordinator (SDC) was interviewed. The SDC stated she was the infection control (IC) representative for the facility. The SDC provided for review a policy manual which she stated contained individual IC policies throughout the manual. She stated the medical director was called and made decisions regarding IP.

On 01/30/14 at 3:28 PM the SDC was interviewed. She stated she had attended the state infection control course in 2012. She stated she did not refer to the facility policy manual for determining what was required for possible IP, but referred to a folder with information printed from the CDC and other internet sites. The SDC

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stated she had a reference called Control of Communicable Diseases, 2013 edition notes from the state infection control course and that these references and the folder were kept in her office. She stated nurses would call the physician, herself or the director of nursing (DON) for guidance. She stated isolation signs were kept in medication rooms at the nursing stations. She stated she was aware of Resident #119 who was admitted with shingles, which started as periorbital in nature with weeping. The SDC could not recall which nurse had told her but she was informed that the shingles lesions did not dry up. She stated Resident #119 could not keep her hands washed and the Resident would rub her eye. The SDC stated staff wanted the Resident to remain in her room and a weekend nurse, who had access to all the isolation precaution signs, used one with pictures of hands to throw up a little red flag. When asked to show what this sign looked like, the SDC presented a sign measuring approximately 6 inches by 8 inches with red colored hand shapes and the printed words "drainage precautions" on a black background. She stated she took down this sign on approximately Monday, 01/20/14 and replaced it with another sign. When asked to show what this sign looked like, the SDC presented a sign measuring approximately 8 ½ inches by 11 inches, titled Universal Precautions in Patient Care and in the upper left corner was observed the handwritten comment "see nurse before entering room." The SDC stated a family member of Resident #119 was wary about visitors. She stated no PPE was put outside the Resident's door but gloves were located in the room. The SDC stated Resident #119 was not put on isolation precautions during her admission to the facility.

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F 441	Continued From page 19 On 01/30/14 at 4:30 PM the medical director was interviewed. He stated the IC manual should contain policies and guidelines to assist nurses determining the need for IP for identified infections. He stated based on the signage put on the Resident's door and with the rubbing of her eye that contact precautions would have been appropriate but not droplet precautions. He stated the language of universal precautions is old language and should not be used if standard precautions have replaced it and covered precautions for all residents. The medical director stated the facility should have been using up-to-date signage as recommended by the CDC. On 01/31/14 at 2:42 PM the DON was interviewed. She stated if nurses did not know what to do with IP they could call her, the SDC or access the CDC's website as all three medication carts had internet access. She stated the facility always knew ahead of time of pending admissions. The DON stated she did not think nurses had access to an IC manual. She stated nurses could make a call to the CDC, the SDC, the DON or the DON could call the medical director. The DON stated there was no mention in Resident #119's hospital records of any IP. On 01/31/14 at 3:35 PM the administrator was interviewed. She stated the facility had IC policies and procedures in their manual and the medical director, the CDC and information from the Centers of Medicare and Medicaid Services (CMS) were other resources. She stated the facility used doctor orders and standard precautions and IP are done on an individual basis with doctor orders from the medical director.	F 441		

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2. Review of the facility's policy manual, under the tab labeled Nursing Procedures, revealed undated policies titled Bedpans and Urinals. The bedpan policy directed that each would be marked on the bottom with the resident's name in indelible ink and stored in a plastic bag on the bottom shelf of the resident's bedside table when not in use.

On 01/27/14 at 3:26 PM, in a shared bathroom between rooms 409 and 411 were observed an unlabeled gray fracture bedpan and an unlabeled urine hat, resting on a grab bar behind the toilet tank and leaning against the wall. The bedpan and urine hat were not in a bag. These items were observed with the same findings on 01/28/14 at 11:25 AM, 01/29/14 at 8:35 PM, 01/29/14 at 11:00 AM and on 01/30/14 at 7:47 AM.

On 01/30/14 at 3:21 PM, the staff development coordinator (SDC) was interviewed. The SDC stated she was the infection control (IC) representative for the facility. She stated that as long as they were labeled and clean they could be kept in the bathroom or in a bag in bottom drawer of bedside table that stored no other items.

On 01/30/14 at 4:05 PM the SDC was shown the presence of an unlabeled grey fracture bed pan and, after the SDC donned gloves, of two unlabeled urine hats with one nested in the other, resting on a grab bar behind the toilet tank and leaning against the wall. The bedpan and urine hat were not in a bag. The SDC stated they should have been labeled with resident names, bagged and kept in bedside tables.

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F 441	Continued From page 21 On 01/31/14 at 2:42 PM, the DON was interviewed. She stated bedpans and urinals were to be marked and she was aware that some were found that were not marked.	F 441		