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	345315	A. BUILDING _____ B. WING _____	C 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND ACRES NURSING AND REHABILITATION CENTER	1170 LINKHAW ROAD LUMBERTON, NC 28358

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F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a resident assessment for a Level II PASRR (Preadmission Screening and Resident Review) was completed for 1 of 1 sampled residents (Resident #20) reviewed for Level II PASRR. Findings included: Review of Resident #20's Annual Minimum Data Set (MDS) dated 11/05/17 revealed that Resident #20 had been admitted to the facility on 02/11/14 and presently had diagnoses of anxiety disorder, depression and schizophrenia. Review of the PASRR Level I Determination Notification letter dated 02/10/14 revealed that "No further PASRR screening is required unless a	F 644	The process that lead to the deficiency is that facility failed to ensure a resident assessment was completed for resident # 20 for level 2 Preadmission Screening and Resident Review (PASRR). The level 2 PASSR screening was re-submitted by the Social Worker on 1/23/18 for resident # 20. The PASSR level 2 was temporarily approved on 1/25/18 for resident # 20. 100% audit of PASSR 2 was initiated on 1/30/18 by the Social Worker in regards to all residents to include resident # 20 for screening of level 2 PASSR. There was seven residents that qualified for level 2 PASRR upon re-screening.	2/26/18

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

Electronically Signed | 02/15/2018

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F 644	Continued From page 1 significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation, or if present, suggests a change in treatment needs for those conditions." Review of Resident #20's medical record revealed a new diagnosis of schizophrenia dated 01/07/15. In an interview on 01/24/18 at 4:10 PM the SW, who has worked at the facility for approximately 7 months, stated when a resident was newly diagnosed with a mental illness the resident needed to be evaluated for a Level II PASRR. He indicated Resident #20 should have been evaluated when first diagnosed as any symptoms would have been much more apparent. The SW stated that as he had not been in his current position when the evaluation should have been completed, he did not know what had happened or why the evaluation was not done. In an interview on 01/24/18 at 4:30 PM the Director of Nursing stated it was her expectation that when a resident received a new mental illness diagnosis a Level II PASRR assessment should be initiated.	F 644	Social Worker (SW), Admission Coordinator and Administrator were in-serviced on 2/13/18 by the Administrator on level 2 PASRR screening requirements. During orientation any newly hired SW or Admission Coordinator will be in-serviced by the Administrator on level 2 PASRR requirements. 10 % of all residents that are newly diagnosed with a mental illness or if diagnosis present and have a change in treatment needs for that diagnosis to include resident # 20 will be reviewed by the Admission for level 2 PASRR screening weekly X 8 weeks and monthly X 1 month utilizing a PASRR Screening Audit tool. The Social Worker will correct any identified areas of concerns during the audit. The Administrator will review and initial the PASRR for completion and that all areas of concern have been addressed. The Administrator will forward the results of the PASRR Screening Audit tool to the Executive QI Committee monthly x 3 months. The Executive QI committee will meet monthly x 3months and review the PASRR Screening Audit tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655		2/26/18

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F 655	Continued From page 2 §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details	F 655		

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F 655	Continued From page 3 of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission with measurable objectives and timetables to address the immediate needs for Resident #230 for tube feeding, a urinary catheter and oxygen therapy for 1 of 3 residents Resident (#230) reviewed for accidents and tube feeding. . Findings included: Resident #230 was admitted to the facility on 12/30/17. Diagnoses included in part, traumatic subarachnoid hemorrhage, congestive heart failure, chronic obstructive pulmonary disease and gastrostomy (feeding tube). The Minimum Data Set (MDS) 5 day assessment dated 1/6/18 revealed the resident was severely cognitively impaired and required an extensive assist to total dependence with the assistance of one staff member with all activities of daily living (ADLs). Resident #230 had no impairments and used a wheelchair. Resident #230 had a condom catheter (not indwelling) and was frequently incontinent of bowel and was coded as being on a feeding tube and having oxygen therapy. A review of the care plans on 1/1/18 revealed there was no care plans or interventions regarding the feeding tube, the condom urinary catheter or the oxygen therapy. An observation of Resident #230 on 1/24/18 at 6:00 am revealed the resident was lying in bed with his eyes closed. The oxygen was infusing	F 655	The process that lead to the deficiency is Minimum Data Set Nurse (MDS) failed to develop a baseline care plan within 48 hours of admission for resident # 230. Resident # 230 no longer at facility. 100% audit of all residents admitted in the last 30 days was initiated on 2-12-2018 by the Corporate Resident Assessment Instrument (RAI) Reimbursement Consultant nurses to ensure that base line care plans were in place to be completed by 2-26-2018. There was 2 baseline care plans that were not initiated within the 48 hour time frame. All base line care plans are up to date. The interdisciplinary care plan team members (MDS Coordinator, MDS Nurse, Social Worker (SW), Dietary Manager, Activity Director, Director of Nursing (DON) and Administrator were in-serviced on 2-14-2018 by the Corporate Resident Assessment Instrument (RAI) Reimbursement Consultant in regards to base line care plans requirements. All newly hired MDS Coordinator, MDS Nurse, Social Worker (SW), Dietary Manager and Activity Director will be in-serviced during orientation by the DON in regards to base line care plan requirements. 10 % of all new admits will be reviewed by the DON for base line care plans weekly X 8 weeks and monthly X 1 month utilizing the Base Line Care Plan Audit Tool. The DON will immediately retrain the MDS Coordinator, MDS Nurse, Social Worker	

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F 655	Continued From page 4 via nasal cannula at 2 liters with humidified oxygen. The tube feeding was infusing at the prescribed rate. The bed was noted to be in the lowest position with a winged mattress in place. An interview was conducted with the MDS/Care Plan nurse on 1/25/18 at 3:45 pm. The MDS/Care Plan nurse reported when there was a new admission to the facility her role was to initiate a base line care plan within 48 hours of the admission. The MDS/Care Plan stated she determined what would be needed for care planning by reviewing discharge notes from hospital and the diagnoses. The MDS/Care Plan nurse also indicated she would educate and inform the resident and the family regarding the resident's care. The MDS/Care Plan nurse reported based on Resident # 230's diagnoses, she should have had a care plan for a condom catheter, oxygen therapy, and the feeding tube. The MDS/Care plan nurse confirmed at this time there was no plan of care in place for these diagnoses for Resident #230. The MDS/Care plan nurse reported at this time Resident #230 no longer had the condom urinary catheter, but he was admitted with one. An interview was conducted with the Director of Nursing (DON) on 1/25/18 at 4:30 pm. The DON revealed the MDS/Care Plan nurse should have included tube feeding, oxygen and the urinary catheter care in the base line care plan that was done within the first 48 hours since he was admitted with these diagnoses. The DON reported her expectation was for the nurse to complete the base line care plan accurately based on the resident's diagnoses.	F 655	(SW), Dietary Manager or Activity Director during the audit for any identified areas of concerns. The MDS coordinator or MDS nurse will update the care plan during the audit for any identified areas of concerns. The Administrator will review and initial the Base Line Care Plan Audit Tool weekly X 8 weeks and monthly X 1 month to ensure completion and that all areas of concerns have been addressed. The Administrator will forward the results of the Base Line Care Plan Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI committee will meet monthly x 3months and review the Base Line Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 656	Develop/Implement Comprehensive Care Plan	F 656		2/26/18

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F 656 SS=D	Continued From page 5 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 6 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive Care Plan for 1 of 5 Residents (Resident #43) reviewed for unnecessary medications and failed to develop a person centered Care Plan that met the needs of the resident for 1 of 1 sampled residents (Resident #75) whose Care Plan was reviewed. Findings included: 1. Review of the Quarterly Minimum Data Set (MDS) dated 12/04/17 revealed Resident #43 was readmitted to the facility on 04/15/17 with diagnoses of non-Alzheimer's Dementia, anxiety disorder and depression. Resident #43 received 7 days of an antipsychotic medication during the 7 day look back period. Resident #43 was severely cognitively impaired. Review of the Physician's Orders dated 09/07/17 revealed an order for Seroquel (an antipsychotic medication) 25mg (milligrams) to be given every night at bedtime. Review of Resident #43's Care Plan revealed no Care Plan for antipsychotic medication use. In an interview on 01/24/18 at 3:40 PM with MDS Nurse #1 and MDS Nurse #2 it was stated that antipsychotic medications should be care planned for residents who received them. The MDS nurses indicated they attended "stand-up" meetings and wrote down any new medications, including antipsychotic medications, that	F 656	The process that lead to the deficiency was the Minimum Data Set Nurses (MDS) failed to develop a comprehensive are plan for resident # 43 antipsychotic medication use and to develop a person centered care plan for resident # 75. Resident # 43 care plan was reviewed and revised on 2-13-2018 by the Corporate Resident Assessment Instrument (RAI) Reimbursement Consultant to reflect the resident to include antipsychotic medication use. Resident # 75 care plan was reviewed and revised on 2-15-2018 by the Corporate Resident Assessment Instrument (RAI) Reimbursement Consultant to reflect a person centered care plan. A 100% audit of all care plans was initiated on 2-12-2018 by the Corporate Resident Assessment Instrument (RAI) Reimbursement Consultants, including care plans for residents # 43 and resident # 75 and residents with antipsychotic medication use and to ensure that all areas of the care plan reflect the resident's individual needs to be completed by 2-26-2018. Any deficient care plans were updated to reflect the resident by the Corporate Resident Assessment Instrument (RAI) Reimbursement Consultants. The interdisciplinary care plan team	

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F 656	Continued From page 7 residents were ordered to receive and then developed care plans for the medication use. Both MDS nurses indicated that new Care Plans were developed from this information. The MDS nurses stated that Resident #43's Care Plan had been updated during the week of 11/27/17 and that the development of an antipsychotic Care Plan had just been missed. In an interview on 01/24/18 at 4:30 PM the Director of Nursing stated it was her expectation that antipsychotic medications be care planned for residents who received them. 2. Resident #75 was admitted to the facility on 11/21/17 with pertinent diagnoses that included Alzheimer's dementia and weakness. Review of the comprehensive Minimum Data Set assessment dated 12/23/17 for Resident #75 was completed. The assessment documented that she had severely impaired cognition and had received antipsychotic and antidepressant medications all seven days during the assessment look back period. An observation of Resident #75 was made on 01/22/18 at 12:15 PM. She was laying on her right side in bed with a pillow propped behind her to offload pressure from her buttocks. She could not engage in a meaningful conversation related to her severely impaired cognition. Family was present during the observation and reported that the resident was not ambulatory and could not participate in her own activity of daily living care. The family said that she was dependent on staff	F 656	members (Dietary manager, MDS Coordinator, MDS Nurse Social Services Director, Activities Director, Director of Nursing (DON) and Administrator) have been re-educated on the requirements for completing a comprehensive care plan for each resident to include antipsychotic medication use and person centered care plans and to review and revise the care plan for each resident change as needed by the Corporate Resident Assessment Instrument (RAI) Reimbursement Consultant on 2-14-2018. 10% of all resident's care plans to include care plans for resident #43 and resident # 75 will be audited weekly x 8 weeks then monthly x 1 month by the DON to ensure that the care plans accurately reflects the resident to include antipsychotic medication use and person centered care utilizing the Care Plan Monitoring Tool. The interdisciplinary care plan team members will be retrained and the care plan will be revised immediately by for any identified areas of concern. The Administrator will review and initial the Care Plan Monitoring Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Administrator will forward the results of the Care Plan Monitoring Tool the Executive QI Committee monthly x 3 months. The Executive QI committee will meet monthly x 3months and review the Care Plan Monitoring Tools to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or	

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F 656	Continued From page 8 for all care. They also reported that the resident was not a dialysis patient. The family stated that Resident #75 had not had a change in her condition since admission to the facility. Review of the plan of care for Resident #75 dated 11/22/17 recorded that she was independent for manicures, attended dialysis three times a week, and volunteered in the facility as she desired. In an interview with MDS Nurse #2 on 01/23/17 at 2:32 PM she stated that Resident #75 had dementia and was not capable of independent activities such as manicures. She also reported that Resident #75 was not capable of being a volunteer and did not go to dialysis. She said that the care plan was wrong and needed to be corrected. In an interview with the Director of Nursing on 01/25/17 at 12:25 PM she stated that she expected resident care plans to correctly reflect the needs of each individual resident.	F 656	frequency of monitoring.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		2/26/18

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F 812	Continued From page 9 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to: a) dispose of expired products including 17 out of 17 boxes of oatmeal grits, 3 out of 3 boxes of biscuit mix and 6 out 6 boxes of instant carnation mix from the dry storage room, b) failed to label 1 out 3 22-quart containers of beans with a date when opened, and c) failed to remove the scoop in the flour bin. Findings included: During an initial tour of the kitchen on 1/22/18 at 11:45 pm an observation of the dry storage room and kitchen area revealed: a) Seventeen out of seventeen boxes of oatmeal grits which expired on May 9, 2017, 6 out 6 boxes of instant carnation mix which expired on March 3, 2017, and 3 out of 3 boxes of biscuit mix which expired on November 19, 2016. b) One out three 22-quart bins was not dated. The bin contained navy beans. An interview with the Dietary Manager (DM) on 1/22/18 at 11:45 am revealed she should have disposed of the expired items and ensured that all items that have been opened were labeled and dated. The DM reported there was a dietary aide (DA) that also assisted with stocking and	F 812	The process that lead to the deficiency was the facility failed to dispose of expired products, label items when open, and failed to remove the scoop in flour bin. The 17 boxes of oatmeal grits was discarded on 1/22/18 by the Dietary Manager. The 3 boxes of expired biscuit mix was discarded on 1/22/18 by Dietary Manager. The unlabeled 22 quart container of beans were labeled on 1/22/18 by Dietary Manager. The scoop was removed from flour bin on 1/22/18 by the Dietary Manager. 100% Audit of dry storage area was completed on 2/1/18 by the Dietary Manager to ensure expired food items were removed, repackaged food items are labeled, and no scoops left in bins. The Dietary Manager immediately removed any expired food items, labeled any repackaged food items, and removed scoops during the audit. 100% In-service was initiated on 2/13/18 with all dietary aides, cooks, and dietary manager by the Administrator regarding ensuring that all expired food items are removed from dry storage, label all repackaged food items when opened and placed in container, no scoops are to be left in bins to be completed on	

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F 812	Continued From page 10 checking products in the dry storage area. The DM reported some of the DA's responsibility was to rotate the stock weekly when new product arrived, remove any expired items, and label and date all products that have been opened. c) One out of 3 bins was noted to have the scoop located inside the bin. An interview with the DM on 1/22/18 at 11:58 am revealed that the scoop should not have been inside the bin. The DM reported the staff was aware that the scoops were to be left on the outside of the bin. An interview with the Dietary Aide on 1/25/18 at 12:30 pm revealed some of her responsibilities included to put away new product weekly as well as rotate the stock, check for expired products and remove the products from the dry storage area, and date and label any items that have been opened. The DA reported she over looked the expiration date on grits, biscuit mix and the instant carnation boxes and forgot to date the bin with the navy beans. An interview was conducted with the Administrator on 1/25/18 at 4:40 pm. The Administrator reported his expectation was that the DM and the responsible kitchen staff removed expired items from the dry storage room, dated and labeled any opened items and ensured the scoops were not left in any of the bins that required a scoop.	F 812	2/26/2018.All newly hired dietary employees to include dietary aides and cooks will be in-serviced regarding ensuring that all expired food items are removed from dry storage, label all repackaged food items when opened and placed in container, no scoops are to be left in bins during orientation by the Dietary Manager. The Activity Director will audit the dry storage to ensure no expired items noted, all repackaged items are labeled when placed in containers, no scoops noted in bins utilizing Dry Storage Audit Tool weekly X 8 weeks then monthly X 1 month. The Dietary Manager will remove any expired food items, unlabeled items, and scoops from bin during audit. The Administrator will review and initial the Dry Storage Audit Tool weekly X 8 weeks then monthly X 1 month to ensure completion and that all areas of concerns have been addressed. The Administrator will forward results of the Dry Storage Audit Tool to the Executive QI Committee monthly X 3 months. The Executive QI Committee will meet monthly X 3 months and review the Dry Storage Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		2/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345315	A. BUILDING _____ B. WING _____	C 01/25/2018

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F 880	Continued From page 11	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 12 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interview and record review the facility failed to maintain infection surveillance for 1 of 1 residents (#67). Findings included: Resident #67 was admitted to the facility on 08/28/17with diagnoses that included malignant carcinoid tumor of ascending colon, hemiplegia, aphasia, and cerebral infarction. On 11/02/17 he was diagnosed with shingles. A Minimum Data Set Assessment completed	F 880	The process that lead to the deficiency was the facility failed to maintain infection surveillance of residents to include resident # 67. The Facility Infection Control Surveillance Policy was implemented to include resident # 67, surveillance and data analysis beginning 2-12-2018 by the Corporate Nurse Consultant. The month of November, December and January infection control surveillance and data was completed and documented to track and	

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F 880	Continued From page 13	F 880		

12/25/17 documented his cognitive skills for daily decision making as independent-decision consistent/reasonable. He was independent for activities of daily living.

Record review of a physician progress note dated 11/02/17 revealed the physician completed an assessment on Resident #67. She ordered Valtrex 600mg three times daily for 10 days to treat a diagnosis of shingles and isolation precautions.

Review of the Medication Administration Record for November 2017 revealed that Resident #67 received Valtrex 600 mg three times daily from 11/03/17 through 11/13/17.

Review of the nursing progress notes dated 11/19/17 documented that the shingles on Resident #67 were crusted over and contact precautions were stopped.

In an interview with the Director of Nursing on 01/23/18 at 3:30 PM she stated that she was in charge of infection control, surveillance and reporting. She said that she did not track the shingles case for Resident #67 and did not know when the shingles crusted over. She said he went out of the building twice during the time that he had shingles that his shingles were covered with dressings. She reported that no one at the facility was SPICE (Statewide Program for Infection Control and Epidemiology) certified but that she and another nurse were scheduled to go to SPICE training in March 2018.

In an interview conducted with the Administrator on 01/24/18 at 11:30 AM she stated that she expected the facility to have a method in place to trend infections in the facility by the Corporate Nurse Consultant to be completed by 2-23-2018.

A 100% audit was initiated on 2-14-2018 for current residents by the Corporate Nurse Consultant for presence of infections with required documentation completed on the Infection log for surveillance and data analysis to be completed by 2-26-2018.

The Director of Nursing and the Staff Facilitator responsible for Infection Control, will be in-serviced by the Corporate Nurse Consultant related to the responsibility of the facility to ensure an Infection Control Program is maintained that includes surveillance and data analysis of monthly infections by 2-26-2018.

The Director of Nursing or Staff Facilitator will review all news orders for antibiotics and all residents progress notes to identify residents with infections and document on the infection control surveillance monthly infection log for all identified residents to include resident name, date, name of infection, date of onset of infection, and signs and symptoms of infection 5 x per week x 4 weeks, then weekly x 4 weeks then monthly x 1 month. Upon analysis by the Director of Nursing or Staff Facilitator, the data collected from the infection control surveillance will be entered on the monthly infection control report by the Director of Nursing or Staff Facilitator to track and trend infections in the facility

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F 880	Continued From page 14 determine the presence of infections, to track trends and to record occurrences. She said that she was not aware that the facility was not tracking infections. In an interview with Physician #1 on 01/25/17 at 2:50 PM she stated that when Resident #67 completed the course of Valtrex on 11/13/17 he was most likely no longer infectious. She said that no one from the facility had called her to tell her when the shingles crusted over. She stated that the facility was having trouble monitoring infections and that Resident #67 should have come off isolation when the Valtrex was completed on 11/13/17.	F 880	monthly x 3 months utilizing the Infection Control Audit Tools. The Administrator will review and initial the Infection Control Monitoring Audit Tools for completion and to ensure all areas of concerns were addressed per the infection control surveillance protocol, and retrain the Director of Nursing or Staff Facilitator for all identified areas of concern during the audit monthly x 3 months. The Administrator will forward the results of the Infection Control Monitoring Audit Tools the Executive QI Committee monthly x 3 months. The Executive QI committee will meet monthly x 3months and review the Infection Control Monitoring Audit Tools to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	