STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 10/08/2015

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) for the rejection of care and weight loss for 1 (Resident #165) of 2 residents reviewed for nutrition. Findings included:	F 278	F278 483.20(g)- (j) Assessment Accuracy/Coordination/Certified The facility does provide accurate assessments which best reflect the	10/30/15

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

Electronically Signed | 10/30/2015

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F 278	Continued From page 1 Resident #165 was admitted on 3/4/15 with cumulative diagnoses of cerebral vascular accident (CVA) and aphasia with a weight of 129.5 pounds. A review of the most recent quarterly MDS dated 9/9/15 indicated Resident #165 had severe cognitive impairment, psychosis and no coded behaviors. There was no coded rejection of care on this MDS, his weight was 101 pounds with no coded weight loss. A review of Resident #165 ' s care plan initiated 4/1/15 and updated 6/10/15 indicated he was a weight loss and nutritional risk. The goal was for his weight to remain stable thru the next review and for Resident #165 to consume 50-75 % of his meals thru next review. There was no care plan for refusal of tube feedings or meals. A review of Resident #165 ' s medical record revealed consistent refusals of meals and tube feedings and episodes of agitation and combative behaviors toward staff. These behaviors and refusals were supported on staff interviews throughout the course of the recertification/complaint survey. In an interview on 10/7/15 at 10:25 AM, the registered dietitian (RD) stated the dietary manager (DM) completed the nutritional portion of the MDS and that she should have captured any weight loss on the MDS dated 9/9/15. In an interview on 10/8/15 at 9:50 AM, the DM stated she did not capture his refusal of his meals or tube feeding on the quarterly MDS dated 9/9/15 because she assumed the social worker coded it since they were behaviors. The DM could not explain why Resident #165 was coded with no weight loss on the quarterly MDS dated	F 278	resident¿s status which are coordinated, signed and certified as complete by a Registered Nurse, after receiving signatures upon completion by each individual, who completed a portion of the assessment, also who signs and certifies the accuracy of that portion of the assessment. 483.20(g)-(j) of this part. Corrective Action for those residents found to have been affected. Resident #165 has been reassessed by the Minimum Data Set (MDS) Care Plan Nurse on 10-30-15, coded for behavior, and care planned for noncompliance due to refusing of medical treatment. The Social Worker has addressed behavior in their notes on 10/30/15 and care planning resident for refusal of medical treatment on 10/9/15. The Dietary Manager on 10-30-15 has addressed weight loss on the MDS as well. Corrective Action for those having the potential to be affected. All residents have the potential to be affected by the same alleged deficient practice. An audit of all residents with weight loss was completed by the Director of Nursing (DON) and the Unit Managers at the time of the survey. The MDS was reviewed for coding accuracy and the care plans were reviewed to ensure that any resident that refuses care contained a care plan for refusal. No other resident was found to be affected by this alleged	

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F 278	Continued From page 2 9/9/15. In an interview on 10/8/15 at 10:47 AM, the social worker (SW) stated she completed the behavior section of the MDS but she did not care plan his meal refusals or his tube feeding because dietary or the MDS nurse should have caught the refusals on the last MDS assessment. In an interview on 10/8/18 at 11:07 AM, the MDS nurse stated she was under the impression that Resident #165 was getting his tube feeding and the RD was following his nutritional status. The MDS nurse acknowledged she coordinated the care but it was the DM coded no weight loss and the SW who coded no rejection of care on the quarterly MDS dated 9/9/15. In an interview on 10/8/15 at 3:10 PM, the administrator stated his expectations would be the MDS reflect the current status of Resident #165 and that the quarterly MDS dated 9/9/15 did not reflect his ongoing rejections of care and noted weight loss.	F 278	deficient practice. Measures put into place or systemic changes made An In-service was completed by the DON on 10/7/15 with all licensed staff, Dietary Manager and Social Worker regarding identifying deficits that need to be addressed in the disciplines notes, MDS section, and care planned if necessary. A weekly nutrition at risk meeting as well as a behavior at risk meeting has been established and chaired by the Dietary Manager and Social Worker, respectfully. All residents with weight loss and those with behaviors will be reviewed, notes written, and ensured that there is a care plan in place to address the issue. Monitor The DON and or Assistant Director of Nursing (ADON) will review at least ten percent of the weight loss charts and ten percent of the residents charts that have behavior, to make sure notes are in place, MDS is appropriately coded, and care plans are in place. This audit will be done weekly for 4 weeks, then monthly for 2 months. Results will be reported to the monthly Quality Assurance and Performance Improvement (QAPI) committee by the Director of Nurses, who will have the responsibility of follow through with any recommendations from committee.	
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		10/30/15

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F 329 SS=D	Continued From page 3 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation,record review, staff, Physician and pharmacist interview the facility failed to justify the use of an antipsychotic(Risperdal 0.5mg) medication and failed to monitor behaviors for 1 of 6 sampled residents reviewed for unnecessary drugs. (Resident # 15). The facility also failed to monitor a medication blood level as ordered by the physician for 1 of 6 residents (Resident #72)	F 329	F329 Drug Regimen is free from Unnecessary Drugs Each resident¿s drug regimen is free from unnecessary drugs, is reviewed for possible reductions, and is adequately monitored.	

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F 329	Continued From page 4 reviewed for unnecessary medications. Findings included: 1. Resident #15 was admitted to the facility on 3/11/2014 with cumulative diagnoses of Hyperlipidemia, Dementia, Depression, Chronic Obstruction Pulmonary disease (COPD). Review of the quarterly Minimum Data Set (MDS) dated 6/18/2015 indicated the resident's cognition was intact. The MDS did not indicate the resident as having any behavioral problems. Lexi-Comp's Geriatric Handbook defines Risperdal as an antipsychotic used for schizophrenia and bipolar disease. The monograph also stated that this medication carries a U.S. Boxed warning from the Food and Drug Association "Elderly patients with dementia-related psychosis treated with antipsychotic are at an increased risk of death compared to placebo". Review of the care plan dated 3/31/2015 reviewed on 6/25/2015 and 9/25/2015 failed to identify any behaviors for the use of an antipsychotic medication (Risperdal 0.5 mg) Review of the physician's order sheet for September 2015 revealed the resident had a physician ' s order for Zoloft 50 mg(milligram) every day (antidepressant), Klonopin 0.5mg twice a day (antianxiety), Risperdal 0.5 mg daily at bedtime(antipsychotic), Depakote ER(Extended release) 500 mg daily at bedtime (Mood stabilizer).	F 329	Corrective Action for those residents found to have been affected. Resident #15¿s antipsychotic medication was reviewed by the Pharmacist and Geriatric Psych Nurse Practitioner on 10/7/2015 and determined to be necessary. A diagnosis was entered into the medical record. Resident #72¿s Valproic level was not able to be obtained as the patient has been discharged from the facility. Corrective Action for those having the potential to be affected. Any resident who is currently receiving psychoactive medications can be subject to this alleged deficient practice. All residents on Psychoactive medications were reviewed by the Pharmacist on 10/15/15 for appropriate diagnosis. In addition, all residents that require monitoring of a therapeutic blood level for prescribed medications have been reviewed by the Pharmacist. No other resident was found to be affected by this alleged deficient practice. Measures put into place or systemic changes made A behavior at risk meeting has been established by the Administrator, and chaired by the Social worker. Each week, a portion of the residents that are on a antipsychotic medication, will be reviewed in that meeting, that consists of the care plan team. Resident¿s records will	

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F 329	Continued From page 5 On observation of the resident on 10/7/13 at 1:30 PM, he was sitting in his recliner chair watching TV in his room. He was pleasant and alert in conversation and dressed neatly in street clothes. Interview with the Nurse Assistant (NA) # 1 on 10/7/2015 at 11:00 AM failed to identify any behaviors for the use of an antipsychotic medication (Risperdal 0.5 mg). Interview with the Nurse # 1 on 10/7/2015 at 2:00 PM failed to identify any behaviors for the use of an antipsychotic medication. Interview with the Unit manager # 1 on 10/7/2015 at 3:00 PM failed to identify any behaviors for the use of an antipsychotic medication. Review of the nurses' notes for the months of August 2015, September 2015 and October 2015 failed to establish any psychotic behaviors for Resident # 15. In an interview with the consultant pharmacist on 10/7/13 at 11 AM, she was not aware of any psychotic behaviors and had not asked the doctor for a suitable diagnosis for the continued use of an antipsychotic medication. During the Interview with Director of Nursing (DON) on 10/8/2015 at 3:00 PM, she reported the facility did not document the resident's behaviors in the nurse's notes or behavioral sheets. She added there was no way to justify the use of the antipsychotic medication without monitoring the	F 329	be reviewed to ensure there is a diagnosis in place, laboratory monitoring is being completed as necessary, and that psych services is involved to manage the medication for possible gradual dose reductions. A lab monitoring log has been initiated to place ordered labs into, so they are drawn and reviewed as scheduled. The licensed nursing staff has been in-serviced by the ADON on 10/7/15 on the procedure that whoever transcribes and notes the order, is responsible to enter the lab into the log book. Monitor Two charts of residents on psychoactive medications from each nursing unit will be reviewed weekly for 4 weeks by the Behavior Management Team to identify, review, and refer any residents on psychoactive medications to the geriatric psychiatrist for proper interventions, to ensure a diagnosis is in place, appropriate follow-up is completed as necessary, laboratory monitoring is completed as necessary, and potential gradual dose reductions occur as appropriate. Then all residents on psychoactive medications will be reviewed monthly ongoing, by the Behavior Management Team to identify, review, and refer any residents on psychoactive medications to the geriatric psychiatrist for proper interventions, to ensure a diagnosis is in place, there is a behavior monitoring tool is in place and being used, appropriate follow-up is completed as necessary, laboratory	

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F 329	Continued From page 6 residents' behavior. She added she spoke to the pharmacist and they could not justify the use of the antipsychotic medication. The DON also added the facility was going to make changes by making sure they document residents ' behaviors at the facility to justify the use of any antipsychotic medications. 2.) Resident #72 was admitted on 1/2/15 with cumulative diagnoses including Alzheimer ' s dementia, anxiety and depression. Review of the admission physician orders included Depakote (Valproic acid) 250 milligrams (mg) sprinkles four times a day by mouth. Depakote is a drug used to treat seizures and mood disorders. Review of the medical record revealed a Valproic Acid blood level on 1/7/15 was 40.1 (reference range 50-100 Microgram per milliliter. (ug/ml). A recheck was performed on 1/14/15 with the result of 32.2. A review of the July 2015 physician orders included a laboratory (lab) test to be done every 6 months to determine Valproic acid blood level. The test was scheduled for January and July. There were no lab values for Valproic acid in July 2015. Review of the Quarterly Minimum Data Set (MDS) assessment dated 09/1/15 revealed that resident #72 was severely cognitively impaired. Resident #72 also displayed behavioral symptoms of psychosis, verbal behavior symptoms towards others, rejection of care, and wandering. Resident #72 had a care plan (last updated on 09/14/15) for psychotropic medication. The goal included that the resident will have no signs or symptoms of adverse reaction from medication through the next review. Relevant interventions	F 329	monitoring is completed as necessary, and potential gradual dose reductions occur as appropriate. Results will be reported to the monthly Quality Assurance and Performance Improvement (QAPI) committee by the Social Worker monthly for six months, who will be responsible for any recommendations from committee. A monitoring tool titled Laboratory Monitoring Tool has been instituted on 10/8/15 by Unit Managers and will be reviewed/ monitored in our morning clinical ops meeting by the nurse management team to ensure ordered labs are completed per physician orders. The Monitoring Tool will be reviewed daily x two weeks, weekly x four weeks, and monthly x two months. Results will be reported to the monthly Quality Assurance and Performance Improvement (QAPI) committee by the Nurse Managers with the DON to be responsible for any further recommendations from committee.	

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included for pharmacy and physician to monitor for continued need for medication per facility protocol, and to observe resident for any adverse side effect of medications use and document and report as indicated.
Review of the Pharmacist Medication Regimen Review form dated from 05/7/15 through 09/13/15 revealed no recommendations were made for the medication Depakote for resident ' s #72. The Pharmacist review did not address that Valproic acid blood level was not done in July 2015.
Review of the physician orders dated 9/1/15 revealed a Valproic acid blood level was ordered to be done on the " next routine lab day. "
The lab order sheet dated 09/3/15 revealed that the order had been placed for a Valproic Acid blood level to be done. There were no results of the lab and no record that indicated that the resident refused.
Review of the nurse ' s notes from 09/1/15 through 09/10/15 revealed no documentation related to the Valproic Acid lab being obtained, of the resident ' s refusal or that a redraw of the blood sample had been attempted.
Physician ' s orders revealed that on 09/17/15, Depakote Sprinkles dosage was increased to 375mg three times a day for dementia.
Physician note dated 9/17/15 revealed that Resident #72 punched another resident on 9/13/15 and became combative with another resident on 09/14/15.
Physician ' s note dated 9/29/15 revealed that Depakote Sprinkles was increased again to 500mg three times a day on 9/29/15 for aggressive behavior towards other residents and staff and an antipsychotic was to be considered if there was no change in behaviors.
Review of resident ' s medical records revealed

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that as of 10/08/15, the Valproic acid level had not been obtained since 1/14/15, approximately 9 months.
Nurse #2 (day shift nurse worked on 09/1/15) was interviewed on 10/8/15 at 3:25pm. She stated that the order (to obtain Valproic acid blood level) was placed into the facility ' s lab system (no date given). However, the blood sample was never obtained. She stated that she called the lab on 10/8/15 and the lab stated there was no record of the blood sample being collected. Nurse #2 could not provide an explanation of why the lab was not obtained.
The resident ' s Geriatric Neuropsychiatry Provider was interviewed on 10/8/15 at 1:30 PM. She stated that she ordered for the Valproic acid blood level to be obtained on 09/1/15. She stated on 09/17/15, the resident was displaying very aggressive behavior and had punched another resident. In order to maintain the safety of the staff and other residents, she increased the Depakote dose to 375mg three times a day. She stated that before she increased the dose of Depakote, she looked for the resident's Valproic acid blood level. However, she noticed that the lab was unavailable. She asked staff why the level was not obtained and staff stated that the resident refused the blood sample to be drawn. She was not notified that the Valproic acid blood level was not obtained when ordered on 9/1/15.
The Director of Nursing was interviewed on 10/8/15 at 3:39 PM about her expectations for obtaining lab tests. She stated that her expectation was if the physician ordered a lab then it must be done. If the resident was alert and oriented then the resident can refuse. If the resident was cognitively impaired and he refused or became combative when attempting to draw a blood sample then the physician should be

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F 329	Continued From page 9 notified, it should be documented in a nursing note, passed along in report and the resident ' s family should be notified.	F 329		
F 441 SS=D	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 (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	F 441		10/30/15

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F 441	Continued From page 10 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to display proper isolation signage for 1 of 2 residents (Resident # 46) reviewed for contact isolation. Findings included: Resident #46 was admitted on 12/02/15 with a diagnosis of dementia. The annual Minimum Data Set dated 7/23/15 indicated she had severe cognitive impairment and required extensive assistance with all of her activities of daily living. The facility policy dated 2001 and revised 2012 titled Isolation-Categories of Transmission-Based Precautions indicated proper signs would be implemented for contact precautions. Upon entry to the facility on 10/5/15 at 6:00 AM, nursing assistant (NA) #1 was observed donning an isolation gown and entering room 211. There was no isolation sign observed on the door and an opened pack of yellow isolations gowns was observed lying over the handrail outside the door. In an interview on 10/5/15 at 6:20 AM, the Nurse #1 stated Resident #46 had shingles (a contagious rash caused by the chickenpox virus). Nurse #1 stated Resident #46 was put on contact precautions but she wasn ' t sure when the rash started. In an interview on 10/5/15 at 6:30 AM, NA #1	F 441	F441 Infection Control Program The facility does have an established infection control program that is designed to provide a safe and sanitary environment and help prevent the development and transmission of disease and infection. Corrective Action for those residents found to have been affected A Contact Precaution sign was added to the door of Resident #46 door on 10/5/15 when it was noted to not be posted. Corrective Action for those having the potential to be affected. Any residents that are identified to have a need for isolation precautions are at risk for this alleged deficient practice. At the time of survey, all residents that had isolation precautions ordered by the physician were reviewed by the DON. No other resident was found to be affected by this alleged deficient practice Measures put into place or systemic changes made	

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F 441	Continued From page 11 stated she only worked nights and Resident #46 must have be diagnosed with shingles a few days ago and she was told to wear gloves and gown when working with her. In another observation on 10/5/15 at 8:10 AM, there still was no observed signage alerting staff or visitors of the need for contact isolation precautions but an isolation kit was observed hanging on the door containing gowns and gloves. In another observation at 9:00 AM, the contact isolation sign was observed on Resident #46 door alerting staff and visitors. A review of Resident #46's nursing noted indicated on 10/3/15 at 12:32 PM, a cluster of fluid filled blisters were noted to her left lower back flank area and extended midway up her back. Resident #46 grimaced her face when area were touched. At 2:05 PM, Resident #46 was started on an antiviral and moved to a private room. In an interview on 10/7/15 at 10:00 AM NA #2 stated she worked with Resident #46 on 10/4/15 from 7:00 AM till 3:00 PM. She stated she was not told why Resident #46 was on contact isolation. NA #2 recalled someone had put a pack of yellow isolation gowns on the handrail outside her door and she was told to use them. NA #2 stated there was no isolation kit outside the room or sign on door to alert staff or visitors that Resident #46 was on contact precautions. NA #2 stated the weekend supervisor should have made sure the needed signs and supplies were available because the supervisor had a key to the extra supply room and a building outside where	F 441	The nurse responsible for not placing the precaution sign has been re-educated by the DON on 10/7/15. An In-service was provided by the DON/ ADON/Unit Managers to all nursing staff on 10/7/15, regarding the necessity of posting the precaution signs at the time when isolation is initiated. Newly hired licensed nursing staff will be educated by the Staff Development Coordinator during the orientation period, regarding the Infection Control Program and posting of precaution signage at the time of initiating isolation, Monitor The ADON and/or Unit Managers will review all isolation rooms on a daily basis for 4 weeks, then weekly for two months, and then monthly for two months to ensure proper signage is in place for all isolation rooms. Results will be reported to the monthly Quality Assurance and Performance Improvement (QAPI) committee by the ADON, who will have the responsibility of follow through with any changes or follow-up recommendations from the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 12	F 441		

additional supplies were kept.

In an interview on 10/7/15 at 10:10 AM, Nurse #2 stated she worked 7:00 AM till 7:00 PM both Saturday and Sunday on the 200 hall where Resident #46 was moved into a private room on 10/3/15. Nurse #2 stated on Saturday 10/3/15 a blistered rash was noted on Resident #46's back. Nurse #2 contacted the physician who assessed the rash and diagnosed Resident #46 with shingles. The physician ordered Resident #46 to be moved into a private room immediately and she got an isolation kit from the supply room but it did not have a hook to hang it on door so she left it at the nursing station. Nurse #2 stated the isolation signs were kept inside the isolation kits but she neglected to put an isolation sign up on door and called it an oversight.

In a telephone interview on 10/7/15 at 10:20 AM the weekend supervisor stated Resident #46 was moved to private room due to shingles. She stated all staff were notified and told to wear gown and gloves when working with Resident #46. The weekend supervisor recalled she asked Nurse #2 to put out the isolation kit and signage but she neglected to follow up on her rounds Saturday and again on Sunday to verify was done. She stated it was an oversight.

In an interview on 10/7/15 at 10:30 AM, Nurse #3 stated she took report Monday morning from Nurse #1 and was told Resident #46 was on contact isolation but she did not recall if an isolation kit or sign at beginning of the shift but she did see a kit hanging from door later Monday morning. Nurse #3 stated she recently started working at facility in July and could not recall any infection control training and was unsure if

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F 441	Continued From page 13	F 441		

shingles was contagious. Nurse #3 further stated she did not know where isolation supplies or signs were kept.

In a telephone interview on 10/7/15 at 10:40 AM Nurse #4 stated she was assigned Resident #46 first shift on Saturday on the 300 hall before she was moved to a private room. Nurse #4 stated Nurse #2 contacted the physician who diagnosed Resident #46 with shingles, placed her on contact precautions and started Resident #46 on an antiviral medication. Nurse #4 stated Nurse #2 got the isolation kit but it was broken so Nurse #2 left it at the nursing station. Nurse #4 stated she did not go back to 200 hall to see if isolation kit or sign was up on Resident #46's door.

In an interview on 10/7/15 at 12:44 PM, the staff development coordinator (SDC) stated all new staff were trained on isolation control and proper precautions depending on the type of isolation. The SDC provided evidence that Nurse #3 received proper training on 7/15/15 and verified a contact isolation sign should have been placed on Resident #46's door.

In a telephone interview on 10/8/15 at 2:12 PM NA #3 stated she worked first shift with Resident #46 Monday 10/5/15 and stated when she came in there was no isolation kit or contact isolation sign on Resident #46's door. It was later that morning when the kit and sign was put on her door.

In an interview on 10/8/15 at 2:18 PM the unit manager stated she put up an isolation sign on Resident #46's door around 9:00 AM on Monday morning and it should have been placed on the door Saturday when Resident #46 was diagnosed

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F 441	Continued From page 14 to prevent possible spread of the shingles virus. In an interview on 10/8/15 at 3:10 PM, the director or nursing stated her expectation that any isolation precautions be utilized immediately.	F 441		