STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALSTON BROOK	4748 OLD SALISBURY ROAD LEXINGTON, NC 27292

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F 000	INITIAL COMMENTS Management decision to delete F 315 after CMS 2567 was posted.	F 000		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.	F 285		8/12/16

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

Electronically Signed

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F 285	Continued From page 1 For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. 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 #24) reviewed for Level II PASRR. Findings included: Review of Resident #24's Annual Minimum Data Set (MDS) dated 11/05/15 revealed that Resident #24 had been admitted to the facility on 12/30/11 with intellectual disabilities. According to the MDS Resident #24 had been evaluated by Level II PASRR and determined to have a serious mental illness or mental retardation. Resident #24 had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making. Review of Resident #24's Medical Record did not reveal documentation of a Level II PASRR and the facility was unable to produce documentation that a Level II PASRR number had been received. In an interview on 07/21/16 at 9:35 AM the Admissions/Marketing Director stated a request for a Level II PASRR had been submitted in 2013 but there had been no follow through and the assessment had not been completed. She produced a PASRR Level II Referral Notification	F 285	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 7-19-16, the Admission Director contacted NC MUST to request a Level II PASRR for Resident #24. A representative for NC MUST, Stephanie L. RN, came on 7-21-16 and evaluated resident. A PASRR number was obtained for Resident #24 on 08/08/2016. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO	

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F 285	Continued From page 2 letter dated 07/21/16 and indicated a consultant would be coming out to the facility to perform the assessment in 1-2 days. In an interview on 07/21/16 at 11:07 AM the Administrator stated Resident #24 should have a permanent Level II PASRR number as the diagnosis of intellectual disabilities was not going to change. He stated the previous Admissions Director must not have followed through with the assessment and he was not aware Resident #24 had not received a Level II PASRR number.	F 285	BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The Admission Director reviewed all residents as of 7-22-16 to determine if any other residents were affected and in need of a PASRR number. No other residents were found to be affected. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The Admissions Director will be responsible to ensure all residents upon admission have a current PASSR number. If a resident is identified to not have a number the Admissions Director will be responsible to acquire a number for the resident identified. The Admission Director will review and maintain records for all residents for current PASSR numbers. All residents will be listed on a log with the following information: 1. Resident Name; 2. PASSR Number; 3. Expiration Date; and 4. Date updated number is received. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE	

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F 285	Continued From page 3	F 285	ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Admissions Director will present the PASSR LOG to the Administrator for review on a monthly basis. The Administrator will sign the log to indicate that he/she has reviewed the log. The Administrator will monitor the logs that are maintained by the Admission Director each month for a period of six months. If after six (6) months of review there are no issues noted then the Administrator will review the logs on a periodic basis. The Administrator will present the PASSR Log to the Quality Assurance Committee on a quarterly basis. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM 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	F 329		8/12/16

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F 329	Continued From page 4 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 staff interview and record review the facility failed to reduce an excessive dose (a dose which exceeded the geriatric maximum dosage recommendation documented in the state operations manual) of anxiolytic medication for 1 of 5 sampled residents (Resident #138) reviewed for unnecessary medications. Findings included: Resident #138 was admitted to the facility on 01/11/16 and was readmitted on 04/07/16 and 06/20/16. His documented diagnoses included depression, history of pneumonia and Escherichia coli (type of bacteria) sepsis, and transient ischemic attacks (TIAs). A 04/07/16 hospital discharge summary documented Resident #138 was hospitalized between 04/05/16 and 04/07/16 with a primary diagnosis of TIA (mini-stroke). The resident was discharged from the hospital on 04/07/16 and admitted to the facility on 04/07/16	F 329	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The consultant pharmacist prepared and sent a recommendation on 7-22-16 to resident #138's attending practitioner requesting a benefit risk assessment for the use of Alprazolam (Xanax) 0.5mg tid. The medication dosage was decreased to 0.25 mg.TID on 07/28/2016.	

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F 329	Continued From page 5 with a physician order for Xanax (a psychotropic medication prescribed to manage anxiety) 0.5 milligrams (mg) three times daily (TID). (The geriatric maximum dose of Xanax documented in the state operations manual was 0.75 mg daily. Review of the resident's July 2016 medication administration record documented he was still receiving Xanax 0.5 mg TID). Resident #138's 04/14/16 admission minimum data set (MDS) documented he had no cognitive impairment, exhibited no signs and symptoms (s/s) of delirium, was depressed, had sleep problems, was tired, had trouble concentrating, experienced thoughts that he would be better off dead, exhibited no s/s of psychosis, presented with no behavior symptoms, did not wander, did not reject care, required extensive assist with activities of daily living (ADLs) except eating (staff supervision only) and bathing (dependent on staff), and received antianxiety and antidepressant medications during all seven days of the assessment look-back period. 04/19/16 and 05/17/16 monthly pharmacy medication reviews for Resident #138 did not address the Xanax which he was receiving. A 06/3/16 physician progress note documented, "They (Resident #138's family) are also concerned that he (the resident) is pressuring them to take him home, though he has made no progress with increasing his mobility. He is asking his ___ (family member designation), who is disabled, to help him get home so he can start driving again. His ____ (family member designations) are here and do not feel he is safe to go home...."	F 329	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The consultant pharmacist will complete an audit of all residents receiving psychotropic medications to identify any potential irregularity of dosing based on the recommended geriatric dosages in the state operations manual. If any irregularity is found, a recommendation will be written and sent to the resident's attending practitioner at the time of the audit. This audit will be completed by August 12, 2016 On a monthly basis during the regular monthly medication regimen review the consultant pharmacist will review all residents receiving psychotropic medications to identify any potential irregularity of dosing based on the recommended geriatric dosages in the state operations manual. If any irregularity is found, a recommendation will be written and sent to the resident's attending practitioner at the time of the review. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: On a monthly basis at the QA Meeting the	

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F 329	Continued From page 6 A 06/20/16 hospital discharge summary documented Resident #138 was hospitalized between 06/16/16 and 06/20/16 with the primary diagnoses of aspiration pneumonia and Escherichia coli sepsis. (The resident was readmitted to the facility still receiving Xanax 0.5 mg TID). A 06/21/16 monthly pharmacy medication review for Resident #138 did not address the Xanax which he was receiving. The resident's 07/4/16 quarterly MDS documented he was depressed, tired, had appetite problems, had trouble concentrating, exhibited no s/s of psychosis, had no behaviors, did not wander or resist care, required extensive assistance with ADLs except eating (set up help only) and bathing (dependent on staff), and received antianxiety and antidepressant medications during all seven days of the assessment look-back period. Resident #138's care plan, last updated on 07/4/16, documented psychotropic medications as a problem with the resident receiving Zoloft for depression and Xanax for anxiety. Interventions for this problem included the pharmacist and physician review of medications for possible gradual dose reductions (GDRs). Resident #138 also had a care plan for behaviors which documented, "____ (name of resident) has dx (diagnosis) of depression with anxiety and insomnia, receives meds as ordered. He verbalized during this assessment that he feels down & depressed d/t (due to) missing home, feels tired d/t health and working with therapies, and he finds it hard to concentrate at times d/t mind wandering. Recently completed	F 329	DON will present a list of residents who receive psychotropic medications for review by the attending physician/ practitioner to ensure that all medications are necessary and do not exceed the geriatric maximum dosage documented in the state operations manual unless a risk versus benefits form is completed to justify continuing the medication at the dosage ordered or a gradual dosage reduction is attempted. On a monthly basis during the regular monthly medication regimen review the consultant pharmacist will review all residents receiving psychotropic medications to identify any potential irregularity of dosing based on the recommended geriatric dosages in the state operations manual. If any irregularity is found, a recommendation will be written and sent to the resident's attending practitioner at the time of the review. This is documented on the Note to Attending Physician/Prescriber Form. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:	

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F 329	Continued From page 7 ABT/pna/UTI (antibiotic for pneumonia and urinary tract infection). Verbal behaviors noted." At 10:40 AM on 07/21/16 the director of nursing (DON) stated if residents had to be placed on psychotropic medications it was the facility's responsibility to keep the residents on the lowest effective dose. She explained the lowest effective dose was determined by attempting GDRs until the dosage was as low as possible but still effective in controlling target behaviors. According to the DON, when residents exceeded maximum geriatric doses recommended in the state operations manual the facility should address lowering the dosage as soon as possible. She reported the facility could refer residents for psychiatric consults or have the consultant pharmacist approach physicians for risk versus benefit statements or GDRs. The DON commented Resident #138 had not been seen by psychiatric services, and the pharmacist had not requested a risk versus benefit statement for the resident's current dose of Xanax or asked the resident's physician for a GDR of the Xanax. She stated a lot of Resident #138's anxiety was caused by family not being able to continue to care for him at home. She reported the resident frequently commented he did not want to stay in a nursing home. At 11:56 AM on 07/21/16 Nurse #3 stated Resident #138 could be rude, agitated, irritable, and impatient. She explained this was mainly caused by his frustration over not being able to remain at home with his family. She commented these were the resident's only behavior issues, and he was not verbally or physically abusive. At 12:30 PM on 07/21/16 nursing assistant (NA)	F 329	The DON/Designee is responsible to review the pharmacy recommendations on a monthly basis to ensure the physician/practitioner has reviewed and addressed the recommendation(s) if the consulting pharmacist recommends a need for a dosage reduction or a risk versus benefits statement. The DON/Designee will document their review of the recommendations by the consulting pharmacist to the physician/practitioner on the Note to Attending Physician/Prescriber Form to ensure the recommendations have been addressed. The DON will be responsible to report to the Quality Assurance Committee on a quarterly basis the results of the QA check of pharmacy recommendations for psychotropic medications. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	

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F 329	Continued From page 8 #2 stated Resident #138 had "bad days" once or twice a week when he was irritable and resisted care. She reported otherwise the resident did not exhibit other behaviors.	F 329		
F 371 SS=F	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 observation and staff interview the facility failed to clean a fan that was blowing on sanitized kitchenware in the dish machine room, failed to maintain sanitizing solutions at an acceptable strength, failed to keep the back panel of the ice machine free of a pink slime build-up, failed to discard kitchenware with abraded interior surfaces, and failed to monitor storage areas for labeling, dating, and compliance with use-by dates. Findings included: 1. During initial tour of the kitchen on 07/18/16, beginning at 10:45 AM, there was a build-up of dirt and dust on the wall fan which was blowing in the dish machine room. There were strands of dust and clumps of dirt and dust on the face and back of the fan.	F 371	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No specific resident was determined to have been affected by this practice. The	8/12/16

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F 371	Continued From page 9 During observation of the dish machine process on 07/20/16 between 9:28 AM and 10:08 AM a fan mounted on the wall was blowing on sanitized kitchenware. The face and back of this fan had strands and clumps of dust and dirt on them. At 2:56 PM on 07/20/16 the dietary manager (DM) stated dietary employees were supposed to clean the fan in the dish machine room weekly. She reported she did not think the dietary employees were removing the fan off its wall mount, but were using a rag and a commercial cleaner on the face of the fan. The DM also commented she thought the maintenance department wiped down this kitchen fan a couple of days ago. According to the DM, keeping the wall fan clean was important because when it was running the fan could potentially blow dirt and dust onto kitchenware which the dish machine had just sanitized. At 3:15 PM on 07/20/16 a dietary aide stated dietary employees cleaned the wall fan in the dish machine monthly. He reported the staff wiped down the face of the fan using a cloth, commercial cleaners, and a quaternary sanitizing solution. He commented it was important to keep the fan in the dish room clean because it could contaminate kitchenware that exited the dish machine if it was dirty and dusty. 2. At 9:40 AM on 07/20/16 the cook was observed wiping down the food preparation table with a rag from a red bucket stored below the table. At 10:07 AM on 07/20/16 a dietary employee wiped off the lids of three cans of pudding. She used a rag from a red bucket stored below the	F 371	following are the corrective actions taken by the facility: A. The fan near the dishwashing area was immediately cleaned after Maintenance removed both the energy source and the fan from the wall on the evening of 7-20-16. B. Solution immediately removed on 7-20-16 and replaced with solution metered and premixed at dish washing sink. C. Pink residue on ice machine interior was immediately cleaned on 7-20-16. D. The affected bowls and coffee cups were removed on 7-20-16 and replaced on 7-21-16. E. All food determined to be out of date and unlabeled were removed from the refrigerators and freezers on 7-21-16. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: A. The fan near the dishwashing area was immediately cleaned after Maintenance removed both the energy source and the fan from the wall on the evening of 7-20-16. B. Solution immediately removed on 7-20-16 and replaced with solution metered and premixed at dish washing sink. C. Pink residue on ice machine interior was immediately cleaned on 7-20-16. D. The affected bowls and coffee cups were removed on 7-20-16 and replaced	

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F 371	Continued From page 10 food preparation table. At 10:12 AM on 07/20/16 strips were placed in two red buckets stored below the food preparation table. One strip did not register the presence of any quaternary sanitizer, and the dietary employee reported this bucket only contained washing detergent. The strip placed in the other red bucket only registered 50 parts per million (PPM) of quaternary sanitizer. At 2:56 PM on 07/20/16 the dietary manager (DM) stated the facility used quaternary solutions for sanitizing kitchen surfaces. She explained strips used to measure the strength of these solutions were supposed to register 150 - 200 PPM of the sanitizing agent. The DM reported if this strength was not sustained there was a danger the solutions would not kill bacteria. According to the DM, the cook made up the bucket in question at about 5:30 AM on 07/20/16. She stated staff were supposed to change out the sanitizer buckets each shift, and each time a bucket of sanitizing solution was prepared, its strength was to be checked with a strip. At 3:15 PM on 07/20/16 a dietary aide stated the cooks usually made up the sanitizer buckets, and they checked the strength of the buckets using strips. He reported if the sanitizing solutions were not strong enough then germs that could make residents sick might not be killed. 3. During initial tour of the kitchen on 07/18/16, beginning at 10:45 AM, a moist pink film was observed on the back panel of the ice machine. The ice was very close to the panel, but did not make contact with it.	F 371	on 7-21-16. E. All food determined to be out of date and unlabeled were removed from the refrigerators and freezers on 7-21-16. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: A. The fan near the dishwashing area will be cleaned and wiped down on the outside on a weekly basis by a designated Dietary employee assigned by the Dietary Manager and documented on a QA Check Form. On a monthly basis the fan will be cleaned inside and outside once the Maintenance staff removes both the energy source and the fan from the wall. The Maintenance Supervisor or designee will be responsible to perform this function. The Maintenance Supervisor will complete a Log reflecting the dates that the fan was removed and cleaned. B. Dietary staff will be in-serviced by the Registered Dietician on August 8, 2016 on the proper protocol for using sanitizing solutions using the pre-mixed solutions from the dish washing sink and the correct procedure to verify the strength of the solution. The Dietary Manager/Assistant will be responsible to test the cleaning solution on a daily basis for one (1) month at different intervals during the day, then every two (2) weeks for one (1) month and then monthly for six (6) months. This will be documented on a	

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F 371	Continued From page 11 At 8:47 AM on 07/20/16 the back panel of the ice machine had a moist pink film on it. A paper towel wiped across the panel collected a slimy, gel-like pink substance. At 2:56 PM on 07/20/16 the dietary manager (DM) stated the back panel of the ice machine was cleaned monthly when the ice was removed from the machine by the maintenance department. She reported allowing moist pink/gray build-up inside the ice machine could cause the ice to be contaminated by mold. At 3:15 PM on 07/20/16 a dietary aide stated the back panel of the ice machine was wiped down once or twice a week by dietary staff who worked the night shift. He reported this practice was supposed to prevent the build-up of mold which could drip down into the ice and make residents sick. 4. At 9:43 AM on 07/20/16 22 of 22 plastic cereal/soup bowls in storage were observed to be abraded inside. 2 of 22 plastic dessert/side dish bowls in storage and 9 of 30 plastic coffee mugs in storage were abraded inside. 33 of 74 pieces of kitchenware or 45% of the kitchenware examined was compromised by interior abrasions. At 2:56 PM on 07/20/16 the dietary manager (DM) stated staff were supposed to place kitchenware compromised by chips, cracks, and abraded surfaces in her office so she count it and reorder. She reported damaged kitchenware was not to be used in serving residents because it increased the chance bacteria might be residing on the surfaces.	F 371	log reflecting the time, the results of the test and any follow-up that is needed, i.e. staff instructions or in-services required. C. The ice machine interior will be checked and wiped clean as needed weekly by the dietary staff as designated by the Dietary Manager. This will be documented on a log to reflect the date and the staff member completing the process. The ice machine will be emptied, disassembled, and fully cleaned every two weeks by the dietary staff as designated by the Dietary Manager. D. All bowls, cups, and plates will be inspected by the Dietary staff as designated by the Dietary Manager after being washed and placed for storage to be reused. All Dietary employees will be in-serviced by the Registered Dietician on 8-08-16 concerning the protocol of taking equipment out of service and who to report to when equipment is noted to have signs of wear. Bowls, cups, and plates will be inspected the Dietary Manager/Designee on a monthly basis and documented on a QA Sheet to reflect the date, equipment checked and if replaced when signs of wear are obvious. E. All refrigerator and freezers will be inspected daily by both the First Shift and Second Shift Cooks upon the start of their shifts. The Cooks will be responsible to place both an "opened on date" and a "discard date" on all opened food items. The Cooks will also be responsible for checking dates of unopened items to ensure the "used by dates" are current. This will be documented on a log that reflects the date and time of the check	

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F 371	Continued From page 12 At 3:15 PM on 07/20/16 a dietary aide stated kitchenware with abraded surfaces was to be disposed of because flakes of the plastic could choke or make residents sick. 5. During initial tour of the kitchen on 07/18/16, beginning at 10:45 AM, an opened bag of diced green peppers found in the reach-in freezer was without a label and a date. In addition, there was a package of opened oven-roasted turkey breast and a partial bag of lettuce in the reach-in refrigerator without labels and dates. There was also a storage container of sausage gravy in the reach-in refrigerator dated 07/08/16. In the walk-in refrigerator a 5-pound container of low-fat blueberry yogurt had a use-by date of 07/04/16, an opened 48-ounce container of egg salad had a use-by date of 07/04/16, an unopened 48-ounce container of egg salad with a bulging lid had a use-by date of 06/30/16, and the use-by-date on a 5-pound container of chicken salad was not readable. A plastic storage bag containing flour tortillas was without a label and date. In the walk-in freezer two opened bags of French fries and an opened bag of tater tots were without labels and dates. At 10:20 AM on 07/20/16 in the walk-in refrigerator a 5-pound container of low-fat blueberry yogurt had a use-by date of 07/04/16, an opened 48-ounce container of egg salad had a use-by date of 07/04/16, an unopened 48-ounce container of egg salad with a bulging lid had a use-by date of 06/30/16, and the use-by-date on a 5-pound container of chicken salad was not readable. At 2:56 PM on 07/20/16 the dietary manager (DM) stated storage areas were monitored by	F 371	and who checked the refrigerator and freezer. The designated stocking employee will uncrate and inspect for inspect "used by" dates of all products. If found out of date, these will be sent back to the distributor. The Dietary Manager/Assistant will be responsible to conduct a QA check on a weekly basis varying the dates and times to ensure that both shifts are correctly labeling the opened or un-opened food items. They will document this on a QA form and indicate if there are areas of concern and instructions given. The Registered Dietician will in-service all Dietary staff on dating and usage of open foods on 8-08-2016. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: A. The fan near the dishwashing area will be cleaned and wiped down on the outside on a weekly basis by a designated Dietary employee assigned by the Dietary Manager and documented on a QA Check Form. The Dietary Manager will inspect	

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F 371	Continued From page 13 herself, her assistant, and the dietary staff member putting up stock on Tuesdays and Thursdays. She reported the storage areas were monitored for labeling and disposal of items past their use-by or discard dates. According to the DM, all opened food items, food items removed from their original packaging, and leftovers were supposed to have labels and dates on them. She commented the facility did not use items past their use-by dates, and leftover cooked items were to be disposed of after three days in storage. At 3:15 PM on 07/20/16 a dietary aide stated storage areas were monitored daily as staff entered them. He reported any staff member who opened a food item and resealed or repackaged it was responsible for placing a label and date on it. He commented if leftovers were not used after one day of storage they were to be disposed of, and the facility disposed of food items past their use-by dates. He stated continuing to keep leftovers too long and serving items past their use-by dates could result in residents receiving spoiled foods.	F 371	the fan every two weeks for a period of eight (8) weeks then every month for a period of four (4) months to make sure the procedures are being followed. On a monthly basis the fan will be cleaned inside and outside once the Maintenance staff removes both the energy source and the fan from the wall. The Maintenance Supervisor or designee will be responsible to perform this function. The Maintenance Supervisor will complete a Log reflecting the dates that the fan was removed and cleaned. B. Dietary staff will be in-serviced by the Registered Dietician on August 8, 2016 on the proper protocol for using sanitizing solutions using the pre-mixed solutions from the dish washing sink and the correct procedure to verify the strength of the solution. New staff will be in-serviced by the Dietary Manager/Assistant on the proper protocol to use pre-mixed solution from dish washing sink, use test strips to verify the strength, and never hand mix cleaning solution. The Dietary Manager/Assistant will be responsible to test the cleaning solution on a daily basis for one (1) month at different intervals during the day, then every two (2) weeks for one (1) month and then monthly for six (6) months. This will be documented on a log reflecting the time, the results of the test and any follow-up that is needed, i.e. staff instructions or in-services required. C. The ice machine interior will be checked and wiped clean as needed weekly by the dietary staff as designated by the Dietary Manager. This will be documented on a log to reflect the date	

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F 371	Continued From page 14	F 371	and the staff member completing the process. The ice machine will be emptied, disassembled, and fully cleaned every two weeks by the dietary staff as designated by the Dietary Manager. D. All bowls, cups, and plates will be inspected by the Dietary staff as designated by the Dietary Manager after being washed and placed for storage to be reused. All Dietary employees will be in-serviced by the Registered Dietician on 8-08-16 concerning the protocol of taking equipment out of service and who to report to when equipment is noted to have signs of wear. Bowls, cups, and plates will be inspected the Dietary Manager/Designee on a monthly basis and documented on a QA Sheet to reflect the date, equipment checked and if replaced when signs of wear are obvious. E. All refrigerator and freezers will be inspected daily by both the First Shift and Second Shift Cooks upon the start of their shifts. The Cooks will be responsible to place both an "opened on date" and a "discard date" on all opened food items. The Cooks will also be responsible for checking dates of unopened items to ensure the "used by dates" are current. This will be documented on a log that reflects the date and time of the check and who checked the refrigerator and freezer. The designated stocking employee will uncrate and inspect for inspect "used by" dates of all products. If found out of date, these will be sent back to the distributor. The Dietary Manager/Assistant will be responsible to conduct a QA check to inspect all	

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F 371	Continued From page 15	F 371	refrigerator and freezers weekly for two (2) months then every two (2) weeks for more two (2) months varying the dates and times to ensure that both shifts are correctly labeling the opened or un-opened food items. They will document this on a QA form and indicate if there are areas of concern and instructions given. The Registered Dietician will in-service all Dietary staff on dating and usage of open foods on 8-08-2016. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on pharmacist interview, staff interview, record review the facility's consulting pharmacy failed to notify the facility and the primary physician that the excessive dosage (a dose	F 428	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR	8/12/16

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F 428	Continued From page 16 which exceeded the geriatric maximum dosage recommendation documented in the state operations manual) of anxiolytic medication for 1 of 5 sample residents (Resident #138) reviewed for unnecessary medications needed to be addressed. Findings included: Resident #138 was admitted to the facility on 01/11/16 and was readmitted on 04/07/16 and 06/20/16. His documented diagnoses included depression. A 04/07/16 hospital discharge summary documented Resident #138 was hospitalized between 04/05/16 and 04/07/16 with a primary diagnosis of TIA (mini-stroke). The resident was discharged from the hospital on 04/07/16 and admitted to the facility on 04/07/16 with a physician order for Xanax (a psychotropic medication prescribed to manage anxiety) 0.5 milligrams (mg) three times daily (TID). (The geriatric maximum dose of Xanax documented in the state operations manual was 0.75 mg daily. Review of the resident's July 2016 medication administration record documented he was still receiving Xanax 0.5 mg TID). 04/19/16, 05/17/16, and 06/21/16 monthly pharmacy medication reviews for Resident #138 did not address the Xanax which he was receiving. The resident's 07/4/16 quarterly MDS documented he was depressed, tired, had appetite problems, had trouble concentrating, exhibited no s/s of psychosis, had no behaviors, did not wander or resist care, required extensive assistance with ADLs except eating (set up help	F 428	DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The consultant pharmacist prepared and sent a recommendation on 7-22-16 to resident #138's attending practitioner requesting a benefit risk assessment for the use of Alprazolam (Xanax) 0.5mg tid. The medication dosage was decreased to 0.25 mg.TID on 07/28/2016. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The consultant pharmacist will complete an audit of all residents receiving psychotropic medications to identify any potential irregularity of dosing based on the recommended geriatric dosages in the state operations manual. If any irregularity is found, a recommendation will be written and sent to the resident's attending practitioner at the time of the audit. This audit will be completed by August 12, 2016. On a monthly basis during the regular monthly medication regimen review the consultant pharmacist will review all	

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F 428	Continued From page 17 only) and bathing (dependent on staff), and received antianxiety and antidepressant medications during all seven days of the assessment look-back period. Resident #138's care plan, last updated on 07/4/16, documented psychotropic medications as a problem with the resident receiving Zoloft for depression and Xanax for anxiety. Interventions for this problem included the pharmacist and physician review of medications for possible gradual dose reductions (GDRs). At 10:40 AM on 07/21/16 the director of nursing (DON) stated if residents had to be placed on psychotropic medications it was the facility's responsibility to keep the residents on the lowest effective dose. She explained the lowest effective dose was determined by attempting GDRs until the dosage was as low as possible but still effective in controlling target behaviors. According to the DON, when residents exceeded maximum geriatric psychotropic dosages recommended in the state operations manual it was the responsibility of the consultant pharmacist to inform the facility and the primary physician as soon as possible. She reported this notification allowed the facility and the doctor to select from several actions such as resident referral for psychiatric consults, development of a risk versus benefit statement, and GDR consideration. The DON commented Resident #138 had not been seen by psychiatric services, and the pharmacist had not requested a risk versus benefit statement for the resident's current dose of Xanax or asked the resident's physician for a GDR of the Xanax. She stated a lot of Resident #138's anxiety was caused by family not being able to continue to care for him at home. She reported the resident	F 428	residents receiving psychotropic medications to identify any potential irregularity of dosing based on the recommended geriatric dosages in the state operations manual. If any irregularity is found, a recommendation will be written and sent to the resident's attending practitioner at the time of the review. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: On a monthly basis at the QA Meeting the DON will present a list of residents who receive psychotropic medications for review by the attending physician/ practitioner to ensure that all medications are necessary and do not exceed the geriatric maximum dosage documented in the state operations manual unless a risk versus benefits form is completed to justify continuing the medication at the dosage ordered or a gradual dosage reduction is attempted. On a monthly basis during the regular monthly medication regimen review the consultant pharmacist will review all residents receiving psychotropic medications to identify any potential irregularity of dosing based on the recommended geriatric dosages in the state operations manual. If any irregularity is found, a recommendation will be written and sent to the resident's attending practitioner at the time of the	

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F 428	Continued From page 18 frequently commented he did not want to stay in a nursing home. At 11:12 AM on 07/21/16 the consultant pharmacist stated her co-worker had reviewed Resident #138's medication regimen on 04/19/16, 05/17/16, and 06/21/16 without making any recommendations concerning the resident's dosage of Xanax. She reported when residents began receiving dosages of psychotropic medications which exceeded the maximum geriatric dose recommendations in the state operations manual these medications needed to be addressed quickly. She commented, if she had done the monthly regimen reviews for Resident #138 she would have already recommended a GDR of the Xanax or would have asked the physician for a risk versus benefit statement.	F 428	review. This is documented on the Note to Attending Physician/Prescriber Form. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The DON/Designee is responsible to review the pharmacy recommendations on a monthly basis to ensure the physician/practitioner has reviewed and addressed the recommendation(s) if the consulting pharmacist recommends a need for a potential dosage reduction or a risk versus benefits statement. The DON/Designee will document their review of the recommendations by the consulting pharmacist to the physician/practitioner on the Note to Attending Physician/Prescriber Form to ensure the recommendations have been addressed. The DON will be responsible to report to the Quality Assurance Committee on a quarterly basis the results of the QA check of pharmacy recommendations for psychotropic medications. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions	

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F 428	Continued From page 19	F 428	are achieved and sustained.	
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 transport linens so as to prevent the spread of infection.	F 441		8/12/16

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F 441	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to post an isolation sign outside a resident's door for 1 of 2 sampled residents observed for isolation precautions (Resident #173). Based on observation, staff interviews, and policy review the nursing staff failed to follow infection control policy and wash hands after wound care and before exiting a resident's room for 1 of 2 sampled residents (Resident #174). Findings included: 1. A review of the Issues in Infection Control for Nursing Homes provided by the Statewide Program for Infection Control and Epidemiology (SPICE) revealed that isolation signs must be posted on the door to the resident's room. The SPICE program has been considered a standard by the Centers for Disease Control (CDC) as a tool for communicating the procedures that healthcare workers, family and visitors should follow to prevent cross transmission. Review of the Admission Orders dated 07/07/16 showed Resident #173 was on Contact Isolation Precautions and was to receive an antibiotic three times each day for one week, then twice each day for one week, then every day for one week. Review of the July 2016 Physician Orders revealed Resident #173 was to receive the antibiotic for Clostridium difficile (C diff) (an infection in the colon). An observation on 07/18/16 at 10:35 AM revealed a sign posted on Resident #173's door which read "Please see nurse before visiting resident." Another sign was also posted which read "Sequence for Putting on Personal Protective	F 441	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A. The isolation signage per CDC guidelines was placed on resident #173's door on 7-18-16. B. All nursing staff have been in-serviced by the DON/Staff Development Nurse on proper infection control procedures and protocols to include hand washing on 7-20-16. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: A. Any resident in the future that requires isolation precautions will have isolation signage that was obtained from the	

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	345066	A. BUILDING _____ B. WING _____	07/21/2016

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F 441	Continued From page 21 Equipment (PPE). 1. Gown, 2. Mask or Respirator, 3. Goggles or Face Shield, 4. Gloves. There was no PPE seen outside Resident #173's room. PPE was seen in an alcove down the hallway from Resident #173's room lying on a table. In an interview on 07/18/16 at 10:40 AM Nurse #1 verified Resident #173 was on isolation for C diff. In an interview on 07/18/16 at 10:50 AM Nurse #2, who was putting on PPE prior to entry into Resident #173's room, stated there should be a sign on an isolation room door showing what type of precautions were required and what PPE was needed. Nurse #2 stated she knew which PPE was required because she had been informed Resident #173 had C. diff. She indicated the purpose of the sign was to protect the staff and public. In an observation and interview on 07/18/16 at 12:50 PM the "Please see nurse before visiting resident" sign was posted on Resident #173's door. It was the only visible sign posted. Nurse #1 stated the Contact Precautions sign (which showed what precautions were required) was behind the other sign. Nurse #1 flipped over the sign to reveal the Contact Precautions sign. The Contact Precautions sign was left as the visible sign on the door. In an observation and interview on 07/19/16 at 9:04 AM Nursing Assistant (NA) #1 was seen picking up PPE from the table in the alcove and walking to Resident #173's room. She stated she knew what PPE was needed because the sign on the door showed her what was needed. She stated she would not know what precautions were needed if the sign was not displayed. She indicated visitors would not know what precautions were needed and they might not check with a nurse prior to entering the room.	F 441	SPICE website and all old isolation signage were discarded. B. All nursing staff have been in-serviced by the DON/Staff Development Nurse on proper infection control procedures and protocols to include hand washing on 7-20-16. Any new employees are instructed on infection control protocols in orientation. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: A. All isolation signage has been updated from the SPICE website, placed for usage at each nurses' station in a folder marked as "Isolation Signage", and all other isolation signage was discarded. The Infection Control Nurse/Designee will be responsible to ensure that the proper signage has placed on any resident's door that requires isolation precautions as well as ensuring the folders contain an adequate number of signs on each unit. An in-service will be conducted by the DON/Designee starting on 8-04-2016 through 8-09-2016 educating the Nursing staff of the proper signage. B. When a resident is on Isolation Precautions and the sign is placed on the outside door the staff will also place a "Wash Hands Before Leaving Room" sign on the wall above the light receptacle when leaving the room as a reminder to wash their hands. C. The Infection Control	

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F 441	Continued From page 22 In an interview on 07/21/16 at 8:27 AM Housekeeper #1 stated the isolation sign on the door would let her know what precautions were needed. She stated the purpose of the sign was to protect everyone. In an observation on 07/21/16 at 9:15 AM an over the door PPE holder was on Resident #173's door. The Contact Isolation sign was taped to the door frame. In an interview on 07/21/16 at 9:30 AM the Family Nurse Practitioner (FNP) stated it was important that the correct isolation precaution sign be posted. He indicated that posting the sequence on how to put on PPE was not an effective isolation sign. In an interview on 07/21/16 at 10:20 AM the Infection Control Nurse stated the purpose of an isolation sign was to alert staff and visitors and that it explained what precautions were needed. She indicated the PPE should be located at the room where it was needed. The Infection Control Nurse stated the facility had no isolation carts or over the door PPE holders prior to the survey. She indicated PPE was placed on a table in the hallway if it was needed. She indicated she felt the sign directing the public to see the nurse protected the public. In an interview on 07/21/16 at 10:59 AM the Director of Nursing (DON) stated she expected an isolation precaution sign to be posted on isolation rooms. She indicated that the isolation sign was posted on Resident #173's door, it was just behind the other sign and was not visible. She indicated that isolation precaution signs needed to be shown for community safety. The DON stated the facility did not have isolation carts or over the door PPE holders at the start of the survey and that she had borrowed over the door holders from a sister facility. She indicated it was	F 441	Nurse/Designee will be responsible to ensure that the proper signage has placed on the inside of the room as well as the outside. INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: A. The Director of Nursing/Designee will check each nursing unit weekly for two (2) months and bi-monthly for two (2) additional months to ensure proper procedures are being followed. This will be documented on a QA Log to indicate the check has been done and the results of the check. The DON will bring the results of her checks to the QA Committee on a quarterly basis. B. The Infection Control Nurse/Designee is responsible to ensure that isolation signage is being placed on any resident's door that requires infection control protocol. When a resident is on isolation the Infection Control Nurse will check the room for the proper signage and hand washing protocols being carried out. If correction is not sustained he/she will be responsible to re-educate the staff	

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F 441	Continued From page 23 not an issue that the PPE was not kept at or in isolation rooms. 2. The facility provided the infection control policy on 07/20/16, " Handwashing shall be regarded by this organization as the single most important means of preventing the spread of infections. Policy interpretation and implementation includes: 1. All personnel shall follow our established handwashing procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. 2. Appropriate ten (10) to fifteen (15) second handwashing must be performed under the following conditions: b. whenever hands are obviously soiled. e. Before handling clean or spoiled dressing, gauze pads, etc. f. After handling used dressings, contaminated equipment. g. After handling items potentially contaminated with blood, body fluids, excretions, secretions, mucous membranes, or non-intact skin. h. After handling items potentially contaminated with blood, body fluids, excretions, or secretions. j. after removing gloves. m. Upon completion of duty. 4. The use of gloves does not replace handwashing. " The facility provided the Centers for Disease Control (CDC) sequence for putting on personal protective equipment (PPE) on 07/20/16, " under use safe work practices to protect yourself and limit the spread of contamination listed; perform hand hygiene, and to perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE. " During a contact isolation room observation of Resident #174 on 07/20/16 at 9:10 AM, Nurse #3 removed her gown and gloves after wound care in Resident #174 ' s room and tossed them into a	F 441	member who was found to be practicing incorrect infection control standards and documented on an In-Service Record Sheet. This will be given to the DON for review and brought to the QA Committee on a quarterly basis. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	

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red bio-hazard bag. Then she left the room to get additional nursing supplies from another residents ' room. When Nurse # 3 returned to Resident #174 ' s room, she was asked why she did not wash her hands prior to exiting Resident #174 ' s room and she indicated she did not want to touch anything in Resident #174 ' s room, so, she did not wash her hands. Nurse #4, who was present and observed Nurse #3 exit Resident #174 ' s room without washing her hands, indicated that Nurse #3 should have washed her hands prior to exiting Resident #174 ' s room, especially an isolation room.

During an interview on 07/20/16 at 11:15 AM., with the Staff Development Coordinator indicated staff was expected to wash their hands prior to exiting any resident room, per facility policy, and was especially important for an isolation room.

During an interview on 07/20/16 at 11:30 AM., the Director of Nursing (DON) indicated staff was expected to wash their hands prior to exiting any resident room, per facility policy.