STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 06/15/2017

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LIBERTY COMMONS N&R CTR OF COLUMBUS CTY	1402 PINCKNEY STREET WHITEVILLE, NC 28472

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation, Event ID# ZFMS11.	F 000		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		7/13/17

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

Electronically Signed | 07/06/2017

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F 329	Continued From page 1 (2) Residents who use psychotropic 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 record review and staff and physician interviews the facility failed to follow-up on a urine culture which resulted in the administration of a seven day course of resistant antibiotics for 1 of 6 residents (Resident #185) whose medications were reviewed. Findings included: Review of the Admission Minimum Data Set (MDS) dated 05/24/17 revealed Resident #185 was admitted to the facility on 05/17/17 with diagnoses of diabetes, aphasia and depression. Resident #185 was moderately cognitively impaired and needed the extensive assistance of one person for hygiene. Resident #185 was always incontinent of bladder. Review of the Health Status Note dated 05/22/17 revealed Resident #185 was sent to the Emergency Department (ED) with a complaint of pain following a fall from the wheelchair to the floor. Review of the ED Report dated 05/22/17 revealed that a urine sample for a urinalysis and culture and sensitivity was sent to the laboratory for analysis. The ED report showed Resident #185 had a urinary tract infection (UTI). Review of the After Care Instructions provided by the ED on 05/22/17 revealed Resident #185 was discharged back to the facility the same day with an order for Ciprofloxacin (Cipro) 250mg	F 329	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F329 Corrective Action for Resident Affected On 7/5/17, A med error report was completed for resident # 185 by the SDC. Attachment #1 Corrective Action for Resident Potentially Affected All current residents with urine cultures performed over the last 30 days have the potential to be affected by the alleged deficient practice. On 7/6/17, a report was generated from Point Click Care (PCC) of all residents with orders for urine cultures	

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F 329	Continued From page 2 (milligrams) take one tablet by mouth two times per day for seven days. The urine culture results were not available at discharge. Review of the May 2017 Medication Administration Record (MAR) dated 05/23/17 revealed Resident #185 was started on Cipro 250mg by mouth twice each day for a UTI and cystitis (inflammation of the bladder) until 05/30/17. Resident #185 received the full seven day course of the antibiotic. Review of the hospital urine culture and sensitivity report released on 05/24/17 revealed that Resident #185's culture had grown an organism that was resistant to Ciprofloxacin (Cipro). In an interview on 06/15/17 at 10:16 AM Nurse #2, who accepted Resident #185 back into the facility after the ED visit, stated Resident #185 had been diagnosed with a UTI. She indicated she input the order for the antibiotic into the MAR but that she was not responsible for any type of follow-up in relation to the UTI. In an interview on 06/15/17 at 11:20 AM the Infection Control Nurse stated she had not done any follow-up on Resident #185's urine culture. She indicated she had asked Resident #185's physician to review the laboratory cultures that were in the hospital system. In a telephone interview on 06/15/17 at 11:50 AM Resident #185's Physician stated he had not reviewed Resident #185's urine culture. He indicated if the infectious organism was not susceptible to the antibiotic, the medication should have been changed or if the resident was asymptomatic it should have been stopped. The	F 329	in the last 30 days. Once the report was generated, the SDC audited the residents chart to ensure if the resident was placed on an antibiotic post urine culture that they were receiving the correct antibiotic according to the sensitivities if performed. This audit was completed on 7/6/17. Attachment #2 Systemic Changes On 7/5/17, Staff Development Coordinator in-serviced all full time, part time and PRN RN's and LPN's on unnecessary medications. Attachment #3 Any in-house staff member who did not receive in-service training by 7/13/17 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training for all RN's, LPN's, and HIM and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The SDC will be responsible for auditing five residents receiving antibiotics for compliance with culture and sensitivity reports. This will be completed weekly for two weeks, and monthly for three months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Support Nurse,	

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F 329	Continued From page 3 Physician stated that the Infection Control Nurse should have followed up on the culture so the medication could have been changed or stopped. In an interview on 06/15/17 at 1:08 PM the Director of Nursing (DON) stated she expected there to be follow-up on any urine cultures that were done. She indicated if the organism was resistant to the antibiotic the resident had been placed on, the physician needed to be notified so the treatment could be changed.	F 329	MDS Coordinator, and Medical Director, at minimum. Attachment #4	
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements.	F 356		7/13/17

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F 356	Continued From page 4 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to post the correct Nurse Staffing Information sheet located in the lobby of the facility. Findings included: On entry into the facility on 06/12/17 at 10:45 AM the facility Nurse Staffing Information was observed on the wall in the lobby. The posted Nurse Staffing Information was dated 06/09/17 with a census of 99 for the 7-3 shift and 98 for the 3-11 and 11-7 shifts. In an observation on 06/12/17 at 12:30 PM the Nurse Staffing Information was observed on the wall in the lobby. The posted Nurse Staffing	F 356	F 356 A corrective action for affected resident: No specific resident was mentioned. The daily staffing records for 6/12/17 was posted immediately by the DON. Nurse staffing information will be posted in the front lobby on the wall in a holder. All current residents have the potential to be affected by the alleged deficient practice. The DON or designee will complete the nurse staff posting information when the staffing matrix is completed prior to the end of day for the next day or next three days if posting is for Friday-Monday. The	

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F 356	Continued From page 5 Information was now dated 06/12/17 and showed a census of 96 for all three shifts. In an interview on 06/15/17 at 1:08 PM the Director of Nursing (DON) stated she was responsible for posting the Nurse Staffing Information during the week. She indicated she placed the weekend sheets behind the posted sheet but no one was responsible on the weekends to post the correct Nurse Staffing Information. She indicated that she expected the Nurse Staffing Information to be posted daily and she was responsible for it not being posted. She indicated that going forward someone would be assigned to post the Nurse Staffing Information on the weekend.	F 356	nurse staff posting information will be put in the display holder at the reception desk and will be updated at the beginning of each shift by the 100 hall nurse. This will begin on 7/7/17. Attachment #5 Systemic Changes On 7/5/17 the Staff Development Coordinator began in servicing the full time, part time and prn RN's and LPN's, Administrator and Director of Nursing on the following topics. Attachment #3 The daily nursing staffing data must be posted/updated daily at the beginning of each shift. The staffing data must include the following components: • Facility name • Current Date • Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: 1. Registered Nurses 2. Licensed Nurses 3. Certified Nursing Assistants • Resident Census The required staffing information is posted daily in a clear and readable format. It is located in a prominent place (front lobby on wall) readily accessible for residents and visitors. Any in-house staff member who did not receive in-service training by 7/13/17 will not be allowed to work until training has been completed. This information has been integrated into the standard	

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F 356	Continued From page 6	F 356	orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Administrator or designee will complete QA tool staff posting to ensure the daily staff posting sheet is posted daily at the beginning of each shift. This will be completed daily Monday thru Friday for two weeks and then weekly for two months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Support Nurse, MDS Coordinator, and Medical Director, at minimum. Attachment #6	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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 safe growing and food-handling practices.	F 371		7/13/17

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F 371	Continued From page 7 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove dented cans from the food storage area, failed to maintain a clean environment for food preparation, and failed to maintain vanilla pudding at or below 41 degrees Fahrenheit. Findings included: 1. During an observation of the kitchen dry storage area at 9:00 AM on 6/14/17, four dented cans were found in the food storage pantry among the cans being used for resident service. In an interview with the Dietary manager at 9:15 AM on 6/14/17, she stated that the cans should not have been in the food storage pantry with the other cans and should have been pulled and put on the dented can cart. She reported they had just been delivered and must have been missed. 2. During an observation of the kitchen on 6/14/17 at 9:05 AM, observations were made of a greenish-brown substance resembling mold in the ice machine. The walls behind the clean pan storage rack and the walls by the prep and three compartment sinks were splattered with dried on	F 371	Corrective Action for Resident Affected No specific resident is identified. Corrective Action for Resident Potentially Affected All residents residing in the facility have potential to be affected. The facility is to ensure that all dented cans are removed from storage area. Compliance will be monitored by Dietary Management. Systemic Changes The dented cans identified during inspection were removed from the storage area. An audit tool was put into place to monitor compliance on with this procedure on 7/6/17. An in-service to review the findings of the State Survey and provide instruction on Preparing, Storing and Serving Food Under Sanitary Conditions to be conducted for all Dietary staff on 7/11/17 by the Registered Dietitian. Attachment #7	

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F 371	Continued From page 8 food matter and a red dried liquid substance. The floors near the oven and fryer were covered with a slick brown substance, the bottom shelf of the prep table behind the tray line had a sticky brown substance stuck on it with clean pans laying on top of the substance, and the ceiling and walls of the microwave had dried on food substances. During an interview with the Dietary Manager at 9:15 AM on 6/14/17, she stated that walls and floors were deep cleaned every two weeks. 3. During an observation of the lunch tray line on 6/14/17 at 11:30 AM, the temperature for vanilla pudding being served was taken and registered 60 degrees Fahrenheit. The temperatures were taken three additional times between 11:30 AM and 12:15 PM and did not reach 41 degrees Fahrenheit or below. In an interview with the Dietary Manager at 12:15 PM on 6/14/17, she stated that she was not sure why the vanilla pudding was not getting cool, but that she would pull them off the resident trays and substitute pre-packaged, non-dairy pudding. In an interview with the Administrator on 6/15/17 at 9:45 AM, she reported that she was unaware of the concerns of cleanliness in the kitchen prior to them being brought to her attention, but she had gone back in the kitchen and was able to see that the floors, walls, and other areas of the kitchen needed to be cleaned. She stated that it was her expectation that the kitchen be a clean and sanitary environment for food preparation for the residents and that it would be moving forward. In an interview with the Dietary Manager at 1:30 PM on 6/15/17, she stated that it was her	F 371	Quality Assurance The Dietary Services Director will monitor this issue using the Dietary QA Audit Tool. This will be done 5 days per week for two months and then weekly for one additional month or until resolved by QOL/QA committee. Reports will be given to the weekly QOL/QA committee and Corrective Action initiated as appropriate. The QOL/QA committee is the main Quality Assurance Committee. This regularly scheduled weekly meeting is attended by The Administrator, Director of Nursing, Dietary Services Director, SSC, ADON, and SDC. The Medical Director will review during the Quarterly QA Meeting. Attachment #8 2.Corrective Action for Resident Affected No specific resident is identified. Corrective Action for Resident Potentially Affected All residents residing in the facility have potential to be affected. The facility is to ensure that staff will properly clean all areas of the kitchen and all equipment is properly cleaned and as appropriate sanitized. Compliance will be monitored by Dietary Management. Systemic Changes The ice machine, walls, floors, shelves, and microwave identified during inspection were properly cleaned and sanitized. An audit tool was put into place to monitor compliance on with this	

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F 371	Continued From page 9 expectation that dented cans be identified and pulled immediately upon delivery, walls, floors, and prep storage areas in the kitchen are kept clean, the microwave cleaned between each meal service, the ice machine be kept free of dirt and mold, and hot and cold foods be held at the appropriate temperatures during the operation of the tray line.	F 371	procedure on 7/6/17. An in-service to review the findings of the State Survey and provide instruction on Preparing, Storing and Serving Food Under Sanitary Conditions to be conducted for all Dietary staff on 7/11/17 by the Registered Dietitian. Quality Assurance The Dietary Services Director will monitor this issue using the Dietary QA Audit Tool. This will be done 5 days per week for two months and then weekly for one additional month or until resolved by QOL/QA committee. Reports will be given to the weekly QOL/QA committee and Corrective Action initiated as appropriate. The QOL/QA committee is the main Quality Assurance Committee. This regularly scheduled weekly meeting is attended by The Administrator, Director of Nursing, Dietary Services Director, SSC, ADONn and SDC. The Medical Director will review during the Quarterly QA Meeting. Attachment #8 3. Corrective Action for Resident Affected No specific resident is identified. Corrective Action for Resident Potentially Affected All residents residing in the facility have potential to be affected. The facility is to ensure that dietary staff serve all food at the appropriate temperature and maintain all equipment in the kitchen properly cleaned & sanitized, stored appropriately	

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F 371	Continued From page 10	F 371		

and in good repair. Compliance will be monitored by Dietary Management.

Systemic Changes
The Dietary Services Director instructed Dietary Staff to store cold foods such as the vanilla pudding identified during inspection at or below 41degrees and to record the temperature of cold foods on the tray line temperature log.
Temperatures of all foods (Cold and Hot) served on the Tray line are to be monitored and documented on the Tray line Temperature Log. Any foods not at appropriate temperature are either reheated or chilled to appropriate temperature prior to meal service. An audit tool was put into place to monitor compliance with this policy on 7/6/17. An in-service to review the findings of the State Survey and provide instruction on Preparing, Storing and Serving Food Under Sanitary Conditions Food to be conducted for all Dietary staff on 7/11/17 by the Registered Dietitian.

Quality Assurance
The Dietary Services Director will monitor this issue using the Dietary QA Audit – Sanitation Tool. This will be done 5 days per week for two months and then weekly for one additional month or until resolved by QOL/QA committee. Reports will be given to the weekly QOL/QA committee and Corrective Action initiated as appropriate. The QOL/QA committee is the main Quality Assurance Committee. This regularly scheduled weekly meeting is attended by The Administrator, Director

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F 371	Continued From page 11	F 371	of Nursing, Dietary Services Director, SSC, ADON and SDC. The Medical Director will review during the Quarterly QA Meeting. Attachment #8	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		7/13/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 12 instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to store medications inside a locked medication cart for 1 of 4 medication carts. Findings included: In an observation on 06/14/17 at 3:59 PM Nurse #1 was inside the nurse's station talking on the telephone. Medication cart #1 was located on the 100 hall which was to the right of the nurse's station. A bottle of ultra-strength gas relief simethicone 180mg (milligrams) was seen on top of Medication Cart #1. The bottle contained medication. In an interview at Medication cart #1 immediately following the observation, Nurse #1 indicated she should not have left the medication on top of the medication cart when she went to answer the	F 431	Corrective Action for Resident Affected On 6/14/17 the nurse removed the bottle of Simethicone from the top of 100 hall medication cart. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by the alleged deficient practice. On 7/3/17 the ADON audited all medication carts for any medications left on top of the cart. Systemic Changes On 7/5/17 the Staff Development	

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	345207	A. BUILDING _____ B. WING _____	C 06/15/2017

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F 431	Continued From page 13 telephone. She stated she should have put the bottle of medication into the medication cart drawer and locked it prior to leaving the medication cart. Nurse #1 indicated medications should never be left on top of the medication cart because a resident or visitor could take them. In an interview on 06/15/17 at 1:08 PM the Director of Nursing (DON) stated she expected medications to be stored inside the locked medication cart. Medications should never be kept on top of the cart. She indicated she expected the nurses to lock up any medications prior to answering the telephone.	F 431	Coordinator educated all FT, PT, and PRN RN's, LPN's, and Med Tech's were in-serviced on the appropriate storage of medications. Any in-house staff member who did not receive in-service training by 7/13/17 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Attachment #9 Quality Assurance The DON will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Medication Storage. The monitoring will include auditing medication carts for medications stored on top without supervision. This will be completed weekly for two weeks, and monthly for three months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Support Nurse, MDS Coordinator, and Medical Director, at minimum. Attachment #10	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		7/13/17

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F 441	Continued From page 14 (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: (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 (facility assessment implementation is Phase 2); (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	F 441		

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F 441	Continued From page 15 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 observation, record review and staff interviews the facility failed to remove personal protective equipment (PPE) prior to exiting an isolation room (Room 706) for 1 of 1 rooms posted for contact isolation precautions (Methicillin Resistant Staff Aureus in a wound). Findings included: Review of the facility policy dated 07/01/02 and titled Contact Precautions revealed under b. "Gown - wear a gown (clean) when entering room. Remove the gown before leaving the	F 441	Corrective Action for Resident Affected On 6/13/17 the involved employee was immediately educated on appropriate removal of PPE, hand hygenine, location of isolation notebook that contains why residents are on isolation by the SDC. Corrective Action for Resident Potentially Affected All residents have the potential to be	

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F 441	Continued From page 16 resident's environment." Review of the posted Contact Precautions sign on the door of room 706 revealed hand hygiene was to be done before entering and before leaving the room. Gloves were to be worn when entering the room. In an observation on 06/13/17 at 4:48 PM Nursing Assistant (NA) #1 was seen coming out of room 706 wearing a disposable isolation gown and gloves. She was carrying a tied plastic bag. NA #1 walked approximately 20 feet down the hallway to a large covered trash receptacle and lifted the lid with her gloved hand. She disposed of the tied plastic bag. NA #1 removed her gloves and the disposable isolation gown and placed them in the trash receptacle. She continued down the hallway to the nurse's station where she applied hand sanitizer to her hands. She proceeded to a resident room, knocked on the door and entered the room. In an interview on 06/13/17 immediately following the observation, NA #1 indicated she did not realize she had not followed the facility Contact Precautions Policy. She stated she did not know why Room 706 was posted for isolation but indicated she would go and wash her hands. In an interview on 06/13/17 at 4:54 PM Nurse #3 stated NA #1 should have removed the isolation gown and gloves and washed her hands prior to exiting the isolation room. She indicated NA #1 should not have used hand sanitizer to cleanse her hands after leaving an isolation room. In an interview on 06/15/17 at 1:08 PM the Director of Nursing (DON) stated she expected	F 441	affected by the alleged deficient practice. On 6/27/17 the ADON completed infection control rounds to monitor for compliance with correct removal of PPE when exiting isolation rooms. Attachment #11 Systemic Changes On 7/5/17 all the Staff Development Coordinator educated all FT, PT, and PRN RN's, LPN's, CNA's, and Med Tech's were in-serviced on appropriate removeal of PPE, isolation notebooks and hand hygenine. Any in-house staff member who did not receive in-service training by 7/13/17 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Attachment #3 Quality Assurance The SDC will monitor this issue using the "Survey Quality Assurance Tool for Monitoring PPE Removal. The monitoring will include auditing staff practices for removing PPE when exiting isolation rooms. This will be completed weekly for two weeks, and monthly for three months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA	

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F 441	Continued From page 17 staff to follow the posted isolation precaution guidelines. She indicated she expected staff to know why a resident was on isolation and what precautions were necessary.	F 441	committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Unit Support Nurse, MDS Coordinator, and Medical Director, at minimum. Attachment #12	