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F 000	INITIAL COMMENTS	F 000		
F 309 SS=D	Annual Licensure and Certification Survey. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide effective pain management for a resident currently receiving hospice services. This applies to 1(R2) of 9 residents reviewed for pain in the sample of 22. The Findings Include: Face Sheet documents R2 was admitted on April 4, 2011. Physician Order Sheet (POS) dated November 1, 2016 through November 30, 2016 documents R2 is on hospice and is being treated for several right and left hip pressure ulcers. The POS also documents the following pertinent diagnosis: osteoporosis, cerebral palsy, chronic pulmonary fibrosis, spinal stenosis and skin cancer. On November 1, 2016 at 2:54PM, R2 was sitting up in high back wheelchair , alert and requesting	F 309		

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

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to be alone in the room. On November 2, 2016 at 10:27AM, R2 was again sitting in a high back wheelchair in the room alone, R2 verbalized neck pain and began to touch the neck area and groan. E14(Nurse) was informed about R2's pain at the nursing station by the surveyor. On November 2, 2016 at 10:31AM, E19(Certified Nursing Assistant) entered the room and said she knew about R2's neck pain but had a hard time understanding what R2 was saying. E19 said she made a neck roll for R2 but R2 did not want it, E19 said she did not communicate the neck pain to E14(Nurse). On November 2, 2016 at 10:34AM, E14(Nurse) entered the room and gave R2 medication. On November 2, 2016 at 10:34AM, E19(CNA) pushed R2 out of the room and into the activity area. R2 continued to complain "neck hurts, help me", R2 touched the neck area repeatedly. E16(Activity Aide) asked R2 what was wrong, R2 responded "neck hurt and touched the neck area and groaned, E16 went to get E14(Nurse). E14(Nurse) entered the activity area said she just gave R2 medicine and R2 did not want the neck roll, R2 has to wait for the medicine to work. Throughout the activity R2 complained of neck pain and touched his neck repeatedly and moaned. On November 2, 2016 at 10:48AM, R2 was placed in the dining room for lunch, R2 continued to verbalize neck pain and groan. E17(CNA) walked by the table as R2 complained "help me, neck hurts." E17(CNA) did not provide any comfort measures.

On November 2,2016 at 11:50AM, R2 was sitting in the dining room. E14(Nurse) was at the nursing cart in the dining room. E14 said R2 had just responded to the morphine she gave earlier and she was not familiar with pain management for R2 because he was on hospice and this was

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the first time she administered morphine for pain for R2.

Care Plan for Hospice related to pain dated August 22, 2016 states, R2 has a goal to be free of pain. Interventions include provide pain management as prescribed by physician, Assess and document the frequency of the pain symptoms. Use the residents verbal and staff clinical judgement for this assessment. Give medication as ordered and keep the physician informed of the residents's progress and use non-pharmacological interventions for pain regimen.

Physician Order dated November 2, 2016 states, " Give Morphine Sulfate solution 5 milligrams by mouth every hour as needed for pain.

Record Of Narcotic Dispensed Record dated November 2, 2016 documents R2 received Morphine 4 times at 8:45 AM, at 10:30 AM, 2 PM and 10 PM. There was no documentation of continuous monitoring for pain or effectiveness of pain medication.

Resident Pain Assessment, Prevention And Management Policy updated March 23, 20111, states: " Licensed nurse will assess and manage pain routinely by asking the resident about pain and monitoring them for changes in behavior or condition. Signs and symptoms of pain may include grimacing, increased confusion, restlessness or other distressed behaviors. If pain is noted nursing staff will attempt non-pharmacological interventions such as altering the environment for comfort, physical modalities such as ice packs, cold compresses,

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F 309	Continued From page 3 mild heat, neutral body alignment, massage, rehabilitation therapy, exercises to address stiffness and prevent contractures and cognitive/behavioral interventions. Licensed nurse will notify medical doctor of change in pain, change in condition that could potentially cause pain for pharmacological interventions based on the individuals pain factors. Licensed nurse will monitor residents pain or potential for pain on an ongoing routine basis." After inquiry into pain management for R2 on November 3, 2016 at 11:30 AM, Z4(Hospice Nurse) said R2 received an additional order for a Fentanyl Patch for effective pain management. On November 4, 2016 at 10:05AM, E1(Administrator) said the facility provided in-service training to all staff regarding assessing, monitoring, managing pain and notification of the physician.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315		

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Based on observations, interviews, and record reviews, the facility failed to provide indwelling urinary catheters care and services in a manner to facilitate the free flow of urine, prevent contact with bacteria and possible urinary tract infections. This applies to 2 of 5 residents (R4 and R10), who were reviewed for urinary catheter care, in the sample of 22 residents.
The findings include:
-On November 1, 2016 at 9:53 AM, R4 was observed in bed and her indwelling urinary catheter drainage bag was touching the floor and was not in a blue holder. Later on November 1, 2016 at 1:46 PM, R4 ' s urinary catheter collection bag was again observed touching the floor.
On November 2, 2016 starting at 9:39AM, during the observation of the treatment nurse (E13) and certified nurse ' s aide (E15) providing incontinent care to R4, E13 placed R4 ' s urinary catheter ' s drainage bag on the bed for 5 minutes at the same level as R4 ' s bladder. R4 ' s indwelling urinary catheter ' s tubing and drainage bag had a lot of sediment, and the positioning on the bed did not facilitate the free flow of R4 ' s urine.
At 9:53 AM on November 2, 2016, E13 was interviewed. E13 said she should not have placed R4 ' s urinary catheter collection bag at the same level as R4 ' s bladder, nor should R4 ' s collection bag be allowed to touch the floor.
Review of R4 ' s Physician Order Sheet (POS), dated November 1, 2016 through November 30, 2016, showed R4 was admitted to the facility on March 18, 206 and had the following diagnosis: kidney Stone, Congestive Heart Failure and Pressure Sore. R4 ' s primary physician ordered: " ... (Indwelling urinary catheter care every shift. "
The POS failed to identify the specific or individual care interventions for R4 ' s indwelling urinary catheter such as: catheter size or

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F 315	Continued From page 5 direction for changing the drainage bag. Review of R4 ' s current care plan, dated July 7, 2016, did not identify indwelling catheter as a focus of concern in her care with specific nursing interventions/service and care goal. -During the initial tour on November 01, 2016, R10 was observed lying in bed. R10 had an indwelling urinary catheter drainage bag that was lying flat on the floor and housekeeping staff was mopping the floor in the room. A certified nurse ' s aide (E6) who was walking by was informed that E10 ' s urinary catheter drainage bag was touching the floor. E6 came into the room and raised E10 ' s drainage bag off the floor. E6 stated E10 ' s indwelling urinary catheter ' s drainage bag should not be on the floor. E6 said we should have it in a blue bag so it will not be touching the floor. R10 was admitted to the facility on 10/02/2001 with a history of Multiple Sclerosis and Urinary Retention. Review of the facility ' s policy and procedure for ...Catheter, dated November 3, 2016, showed the following instructions for staff: " Position the drainage bag to facilitate free flow of urine from the resident to the drainage bag. Drainage bags should be place in a drainage bag holder. Neither the drainage bag nor holder should drag on the floor ... Ensure you follow standard infection Control guidelines. The above policy and procedures were not observed being followed in the care for R4 and R10 ' s indwelling urinary catheters.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to develop and implement individualized supervision interventions to prevent falls for 2 residents (R1 and R5).

This failure resulted in one resident falling and sustaining multiple fracture injuries (R1).

This applies to 2 of 5 residents (R1 and R5) reviewed for fall incidents in the sample of 22.

The findings include;

1) R1 admitted to facility February 29, 2016 with diagnosis to include right hip fracture and history of pelvic fractures from a fall, dementia and Alzheimer disease.

R1's March 7, 2016 minimum data set assessment (MDS) include severe cognitive deficits with a BIMS (brief interview of mental status), score of only 3 out of possible 15. R1 is also described as requiring extensive assistance with transfers, ambulation and toileting activities, have loss of range of motion (ROM), to one lower extremity and have frequent urinary incontinence. R1 is also assessed to be unable to communicate needs.

R1's medical records included a physician

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statement dated July 31, 2015 stating R1 is unable to make informed decisions due to underlying dementia.

R1's March 7, 2016 fall care plan states at risk due to poor safety awareness and impulsive at times. The care plan also includes R1 is incontinent of bowel and bladder, can ambulate with hands on assistance, is receiving psychotropic medications, has hallucinations and is resistive to care. The care plan interventions included "monitor closely". The intervention did not specify R1's individualized supervision needs.

R1's physician orders, physician progress notes, urine culture results and hospital records document recurrent urinary tract infections (UTI's), due to urinary retention.
R1 was hospitalized March 12 through 21, 2016 with urosepsis infection.

During November 3, 2016, 2:20 PM interview, E20 (nurse aide), stated R1 is very confused and frequently attempts to stand and walk unassisted. R1 is very impulsive and is a fall risk.

E20 stated on April 8, 2016 there were 3 nurse aides working on the D-wing (where cognitively impaired residents reside). Just prior to R1's fall incident all 3 of the nurse aides (including E20), were bringing residents into the dining room from their rooms to get ready for dinner. R1 was placed in the dining room with other residents and the nurse aides left the dining room to get other residents when E20 heard a chair alarm sounding. E20 went out of a residents room to assess the alarm and observed R1 falling from a standing position and strike her face against one of the tables. R1's pants leg was observed

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tangled up on another residents recliner chair. E20 stated there was no staff in the dining room when R1 stood up from her wheel chair. E20 also stated R1 was always impulsive and had a history of frequently attempting to self stand and ambulate. E20 said R1 "was always very restless, felt like she always had to get up and had to keep moving."

During November 3, 2016, 3:15 PM interview, Z1 (R1's attending physician), stated R1 was a fall risk due to dementia and requires supervision.

R1's April 8, 2016 incident report and nursing progress notes include at 4:30 PM, an alarm sounded in the D-wing dining room. E20 went to evaluate the sounding alarm and observed R1 walking unassisted in dining room and then to trip on another residents wheel chair. E20 was unable to prevent R1's fall. R1's face hit against a table and fell onto the floor. R1 observed with facial discoloration, swelling and bleeding. R1 sent to the hospital for evaluation and diagnosed with right maxillary (jaw), fracture, right elbow supracondylar fracture, right orbital floor fracture and a laceration to the chin.
R1's April 8, 2016 hospital records document presence of a current UTI.

R1's April 8, 2016 fall investigation include a care plan update as a result of this fall. The new approaches only included evaluate for alternative alarm, offer busy work and discontinue previous intervention for a therapy screening.
2). R5 ' s Face Sheet documents that he is 84 years old and was admitted to the facility on June 9, 2016. R5 ' s Past Medical History from the local hospital documents that he has a history of fall on May 10, 2016 and was found to have left

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intracerebellar bleed. The patient reported to have left cerebellar intraparenchymal hemorrhage with intraventricular extension and hydrocephalus status post right frontal ventriculostomy and subsequent suboccipital craniotomy for evacuation intraparenchymal hematoma and decompression of the foramen magnum on May 10, 2016. Subsequently, the patient had impaired cognition, expressive aphasia, impaired mobility and impaired activities of daily living.
R5 ' s POS (Physician ' s Order Sheet) documents the following diagnoses: TBI (Traumatic Brain Injury), intracranial hemorrhage, status post craniotomy, and left shoulder pain.
On November 1, 2016 during tour of the facility, R5 was sitting in the doorway of his room in his wheel chair alone. R5 had multiple steri strips and reddened purplish areas on his arms.
The facility ' s fall reports documents the following falls for R5 since being admitted:
July 9, 2016 fell in room alone, trying to get into bed at 6:00pm.
August 20, 2016 fell in room while visiting spouse.
August 28, 2016 got out of bed, unable to stand.
September 1, 2016, found on floor next to bed in his room, trying to go to bathroom, no witnesses
October 15, 2016, slid out of chair in dining room, scrape to left rib cage.
October 31, 2016, in his room alone, observed on floor. Injury-skin tears and bump to left forehead, skin tears to left elbow, left forearm, right wrist, and right forearm.
R5 ' s MDS (Minimum Data Set) dated September 22, 2016 documents that he requires staff assistance for toileting, and transfers. The Brief Interview for Mental Status (BIMs) documents a score of 6/15 indicating cognitive impairment. R5 ' s MDS also documents that he

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had a fall within 2-6 months prior to admission to the facility.
R5 ' s initial Care Plan presented on November 2, 2016 by the facility for high risk for falls did not document interventions for the falls R5 sustained on October 15, 2016 or October 31, 2016. The Care Plan was dated July 12, 2016 with a goal date of October 12, 2016. The care plan did not include revisions for the falls R5 sustained in October 2016.
On November 2, 2016, E2 (Director of Nursing) stated that R5 had falls prior to being admitted to facility and was a high fall risk when he arrived to the facility. E2 stated that the facility had given R5 chair alarm but it was removed because R5 fidgeted with it. R5 ' s care plan did not document him having had an alarm or interventions for him fidgeting with it. E2 also stated that R5 requires supervision but is allowed to sit in his room alone. E2 stated that on October 31, 2016, R5 was in the dining room. E2 stated there was no staff in the dining room and R5 propelled himself to his room where he fell. E2 stated that E7 (Nurse) had passed by and saw R5 in his room by himself. R5 sustained injuries to his forehead and skin tears to his arms when he fell.
On November 2, 2016 at 2:00pm, E7 stated that R5 requires supervision. E7 stated she is aware of all the falls R5 has had. E7 stated that on October 31, 2016 she passed by R5 ' s room and saw him in his chair looking out the window alone. E7 stated she did not enter the room, attempt to bring R5 out with supervision or ask staff to go supervise him. E7 stated that when she came back past R5 ' s room she noticed the wheel chair but R5 wasn ' t in the chair. E7 stated she then noticed R5 on the floor.
On November 3, 2016 from 10:00am-11:40am, R5 was sitting in his room alone. There was no

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F 323	Continued From page 11 staff in R5 ' s room or in the lounge area outside of R5 ' s room. R5 propelled himself outside of his room and sat in the doorway. No staff stopped to check on R5. There was no one supervising R5. The facilitys Fall Prevention and Management Policy documents: Upon completion and review of the fall risk assessment, a fall safety care plan will be initiated with fall safety intervention(s) based on the resident's risk factors and individual needs. All residents will be supervised a minimum of every 2 hours and PRN (as needed) depending on their potential fall risk- if specific supervision intervals are needed this will be reflected on the fall risk care plan. The care plan will be updated with the new individualized fall safety prevention interventions(s).	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain a medication error rate of less than 5%. There were a total of 25 opportunities with 4 errors resulting in a 16% medication error rate. This applies to 2 residents (R23, R24) in the supplemental sample. Findings include: 1). On November 1, 2016 at 3:22pm, E4	F 332		

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(Registered Nurse) administered medications to R23. R23 ' s POS (Physician ' s Order Sheet) and MAR (Medication Administration Record) documents the following orders:
Nystatin suspension 100000 swish and spit 5ml by mouth three times daily;
Ferrous Sulfate elixir 220mg/5ml, give 6.8ml (300mg) via g-tube (feeding tube) twice daily.
The label on the bottle of Nystatin documented Shake well. E4 poured the Nystatin in a medicine cup and did not shake the bottle prior. E4 also instructed R23 to swallow the Nystatin.
The Ferrous Sulfate was omitted by E4.
2). On November 1, 2016 at 4:17pm, E5 (Licensed Practical Nurse) administered medications to R24. R24 ' s POS and MAR documented the following medications:
Artificial tears solution 1.4% (Glycerin 0.2%, Hypromellous 0.2%, Polyethylene Glycol 400 1%) instill 1 drop in both eyes four times daily;
Tobramycin 2 drops 4 times a day for 5 days to right eye (October 28, 2016).
E5 administered the Artificial Tears eye drop to R24. E5 stated that R24 gets one drop to both eyes. E5 pulled R24 ' s top lid up on her left eye and placed the drop on her top lid. The eye drop did not go into R24 ' s eye. E5 then held R24 ' s eye shut with tissue. E5 also administered the eye drop to R24 ' s right lid which rolled down R24 ' s face.
E5 administered the Tobramycin to R24 ' s right eye. The first drop did not come out of the bottle. E5 then stated to R24 that she has another drop. E5 lightly squeezed a tiny drop from the bottle onto R24 ' s top lid. E5 touched R24 ' s eye lid with the tip of the dropper. R24 blinked and the drop of Tobramycin rolled down her face. The eye drop did not go into R24 ' s eye. E5 did not wait between administering the Tobramycin

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F 332	Continued From page 13 drops. The facility ' s policy for Eye drops documents: Place index finger of non-dominant hand above eyebrow. Apply slight pressure and push up. Place ring finger of the same hand under the eye. Slightly push down. With the other hand, hold dropper so that a drop of medication falls into conjunctiva sac. If ointment is used, squeeze very small amount. Allow to fall into sax longitudinally. Do not let tip of dropper or tube touch eye or other surface. Allow one (1) to two (2) minutes between each drop of same medication.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to administer Ferrous Sulfate on multiple occasions for a resident with low hemoglobin as ordered by the physician. This applies to 1 resident (R23) in the supplemental sample. Findings include: R23's Face Sheet documents that she was admitted to the facility on October 28, 2016. Her POS (Physician's Order Sheet) documents the following diagnoses: Atrial fibrillation, coronary artery disease, peripheral vascular disease, prolonged QT interval, left occipital left parietal stroke and right side hemiplegia. R23's Laboratory report dated October 17, 2016	F 333		

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from the local hospital documents that she had hemoglobin of 10.0 Low (11.7-15.7). Her POS documents the following order: October 28, 2016 Ferrous Sulfate Elixir 220mg/5mg, give 6.8ml (300mg) via g-tube (feeding tube) twice daily (8:00am, 4:00pm).
On November 1, 2016 at 3:22pm, during medication observation, E4 (Registered Nurse) administered medications to R23. R23 was in her wheel chair and had a g-tube (gastronomy/feeding tube) E4 did not administer the Ferrous Sulfate. E4 circled the medication on the MAR (Medication Administration Record) indicating not given.
On November 2, 2016, E12 (Licensed Practical Nurse) also circled the Ferrous Sulfate on R23's MAR. E12 stated that the medication was not given because it is not available. Review of R23's MAR for the month of November 2016 showed that 3 doses were documented as not given (November 1, 2016 8:00am and 4:00pm and November 2, 2016 -8:00am). Along with E12, the medication cart was inventoried. Located in a drawer was a bottle of liquid Ferrous Sulfate prescribed for R23. The bottle was dated November 1, 2016. The bottle still had the protective seal and was unopened. There was no other liquid Ferrous Sulfate on the medication cart.
On November 2, 2016 at 9:53am, Z2 (Pharmacist) stated that the medication was delivered to the facility on November 1, 2016. R23's MAR was reviewed for Ferrous Sulfate for October 2016. Although there were no opened bottles of Ferrous Sulfate on the medication cart, the MAR was initialed by the nurses as if the medication had been administered twice daily from October 28-31, 2016. On November 2, 2016, The Nursing Schedule provided by, and

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according to E2 (Director of Nursing) for the wing in which R23 resides show that the following nurses worked on the following days:
E4 (Registered Nurse/RN) evening shift on October 29, 2016 - October 31, 2016.
E6 (RN) day shift October 29, 2016- October 31, 2016.
E8 (RN) October 28, 2016 Evening Shift
E4, E6 and E8 all initialed the MAR indicating that they had given the Liquid Ferrous Sulfate as ordered.
When interviewed about the medication, On November 2, 2016 at 2:25pm, E6 stated that she don't remember giving R23 liquid Ferrous Sulfate (October 29-31, 2016). E6 stated if would've given it; I would've crushed an iron (Ferrous Sulfate) tablet and given it to her. Inventory of the facility's house stock Ferrous Sulfate tablets showed Enteric Coated tablets 324mg, which could not be crushed and is not the prescribed dose.
On November 2, 2016 at 2:35pm, E4 stated that she did not administer Ferrous Sulfate to R23 (October 29-31, 2016). E4 admitted that she initialed the MAR as given, but that she should've circled the MAR because the medication was not given. E4 stated " I don't know why I didn't, it should've been circled. "
On November 2, 2016, E8 stated that she too had initialed the MAR on October 28, 2016 as giving the medication. E8 stated " I didn't give R23 any Ferrous Sulfate because it was a liquid. "
On November 3, 2016 at 9:45am, E1 (Administrator) and E2 (Director of Nursing) stated to the survey team that E4, E5 and E8 have been educated because they should ' ve gotten liquid Ferrous Sulfate from the medication room until R23's medication arrived. Located in the Medication room on the first floor, on the back

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F 333	Continued From page 16 of a shelf was an unopened bottle of liquid Ferrous Sulfate. The facility failed to administer R23's Ferrous Sulfate twice daily for 6 days from October 28, 2016-November 2, 2016 as prescribed. The facility ' s policy titled " Oral Medication Administration " documents: Check the label on the medication when obtaining the medication from the appropriate storage container. Compare the label on the medication with the MAR. Remove the correct amount of medication for the individual dose to be given at this time, being careful not to touch the medication. If for any reason the medication was not administered, circle your initials on the MAR and go to the back of the MAR sheet and document the reason the medication was not administered; the medication, time, date, and initials must also be recorded.	F 333		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		

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F 441	Continued From page 17 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to store clean linen in a manner which would prevent contamination. The facility also failed to store and maintain nebulizer masks and wash basins in a protective cover when not in use. These failures affected 1 resident in the sample of 22 (R15) reviewed for infection control and 4 residents (R25, R26, R27 and R29) in the supplemental sample. Findings include: On November 1, 2016 during the initial tour starting at 9:40 AM, the following observations	F 441		

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were made:
R25's bedside table contained a nebulizer mask that was uncovered. R15 and R27's nebulizer masks were also kept at the bedside uncovered. At 9:46 AM R29's nebulizer was also observed at the bedside uncovered, not with any protective covering. R26's nebulizer mask was observed also uncovered, at the bedside. In addition, E11 (Licensed Dietician) was observed to enter R26's room. R26 was identified as being on contact isolation precautions. Once in the room, while wearing gloves, E11 was observed to touch the remote control to R26's television. E11 then removed the gloves and left R26's room without washing her hands.

On November 2, 2016 at 10:00 AM, during the environmental tour conducted with E9 (Maintenance
Supervisor) the laundry room was toured. During the tour of the clean section of the laundry with E9 and E10(Laundry Aid), a long metal table was present against one wall. This table contained stacks of clean linen waiting for distribution according to E10. There was a table-top fan on one end of the metal table which was oscillating. The fan grille contained a heavy accumulation of dust and also contained numerous clumps of dust attached to the grille. When the fan oscillated in one direction, it blew directly on to the clean linen.

On November 3, 2016 at 11:10 AM, E9 stated that he oversees the laundry. E9 stated that this fan was not provided by the facility; it had been brought in by the employee. E9 also stated that it has since been removed. E9 stated that moving forward, they will not allow fans in the clean section of the laundry.

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F 441	Continued From page 19 Policy on Laundry and Bedding, Soiled Policy, does not address the use of a fan in the clean section of the laundry.	F 441		