F371. The facility must store, prepare, distribute and serve food under sanitary conditions.

- The facility served poached eggs to a resident using non-pasteurized eggs. The cook on the unit was unaware that there was a difference between pasteurized and non-pasteurized eggs and did not recognize that the wrong type of eggs had been brought to the unit. The cook admitted to not having a thermometer and not taking the temperature of the eggs.

F441. 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.

- Facility failed to identify an outbreak of flu or acute respiratory illness and failing to put appropriate measures in place to prevent the spread of an infection.

- Staff did not isolate residents or implement appropriate precautions for residents who became ill will flu-like symptoms or acute respiratory distress.

- After the Infection Preventionist quit because her hours had been reduced, the facility gave these duties to the DON, who did not have training in infection control. When residents became ill with gastrointestinal symptoms, the DON did not recognize that an outbreak had occurred, did not isolate the residents who were ill, and delayed 4-5 days before implementing measures to prevent the spread of the illness. The outbreak eventually spread to all units and affected almost 20% of residents.

- The facility did not recognize when an outbreak (influenza-like illness) had occurred, did not isolate residents who became ill, did not use appropriate precautions when caring for ill residents, did not stop staff from floating, and did not require sick staff to remain home until they had been symptom free for 48 hours. Eventually, 36% of residents became ill and one was hospitalized with gastroenteritis.

F463. The nurses' station must be equipped to receive resident calls through a communication system from--(1) Resident rooms; and (2) Toilet and bathing facilities.

- Because of remodeling, the audio portion of the nurse call system was not functioning. A resident sustained a subdural hematoma when she fell from bed trying to get to the bathroom without assistance because no one responded to the call light.