STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015203	A. Building B. Wing	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attalla Health and Rehab	915 Stewart Avenue Southeast Attalla, AL 35954

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26054 Based on record review, interview and a review of the facility policies titled, Notification of Change in Condition/Statusand Change of Room or Roommate, the facility failed to ensure RI (Resident Identifier) #251's sponsor was notified of the resident's room change. This affected RI #251, one sampled resident observed for notification of change. Findings include: A review of an undated facility policy titled, Notification of Change in Condition/Status revealed: .It is the policy of (Name of Facility) that the facility inform the resident/resident's representative .when there is a change requiring notification. Circumstances requiring notification include: . 5. A change of room or roommate assignment . A review of an undated facility policy titled, Change of Room or Roommate revealed: .Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as resident and their representatives, will be given notice of such change as is possible, by phone, or in writing, or in person . RI #251 was readmitted to the facility on [DATE], with diagnoses to include Type 2 Diabetes Mellitus and Muscle Weakness. A review of RI #251's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/23/18, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 0, which indicated severe cognitive impairment. A review of RI #251's FACESHEET revealed the resident's daughter was listed as the responsible party. RI #251's daughter reported to the State Agency the resident was moved to another room in the facility and she was not notified. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/02/18 at 7:42 AM, during an interview with EI (Employee Identifier) #4, LBSW (Licensed Bachelor of Social Work), the surveyor asked when did RI #251 move from the Dementia Unit. EI #4 stated, 2/1/18 . The surveyor asked EI #4 who she notified of RI #251's room change. EI #4 stated, (His/Her) guardian (name of guardian). The surveyor asked when was the guardian notified. EI #4 stated, On the day of the move. The surveyor asked if that was RI #251's sponsor. EI #4 stated, Yes ma'am. The surveyor asked where was the evidence to reflect RI #251's sponsor was notified. EI #4 stated, After review of the documentation on that day, I failed to document that I notified (name of guardian), (his/her) sponsor. The surveyor asked what was the policy and the procedure for notification regarding a change in the resident. EI #4 stated, To notify the sponsor prior to moving the resident. The surveyor asked was policy and procedure followed. EI #4 stated, I failed to document. The surveyor again asked was policy and procedure followed. EI #4 stated, No ma'am. The surveyor asked why was RI #251 moved. EI #4 stated, (He/She) was moved because (he/she) progressed in (his/her) Dementia and was not in need of the security of the Dementia Unit.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37292 Based on interviews, medical record review, review of a facility policy titled, Abuse, Neglect and Exploitation and review of a facility document titled, Resident Incident Report, the facility failed to ensure Resident Identifier (RI) #45 was free from abuse on 05/24/18, during a resident to resident altercation with RI #12. This affected RI #45 and RI #12, two of 44 sampled residents. Findings Include: A review of a facility policy titled, Abuse, Neglect and Exploitation dated 11/27/16, revealed the following: Policy: Each resident has the right to be free from abuse, .Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, .Policy Explanation and Definitions: .1. Abuse means the willful infliction of injury . intimidation .with resulting physical harm, pain or mental anguish. 3. Verbal Abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.Compliance Guidelines: .6. Identification of Abuse, Neglect, and Exploitation - The facility will consider factors indicating possible abuse .including, but not limited to, the following possible indicators: .e. Verbal abuse of a resident overheard f. Physical abuse of a resident observed g. Psychological abuse of a resident observed . RI #45 was admitted to the facility on [DATE], with diagnoses including Seizure Disorder. RI #12 was readmitted to the facility on [DATE], with diagnoses including Schizophrenia and Anxiety Disorder. A review of a facility document titled, Resident Incident Report dated 05/24/18 documented: .resident (RI #12) cornered another resident (RI #45) in the hall and was kicking (him/her) then went after staff member who tried to separate them . On 08/02/18 at 2:07 p.m., an interview was conducted with Employee Identifier (EI) #1, Administrator/Abuse Coordinator. EI #1 was asked who was the abuse coordinator in the facility. EI #1 said he was. EI #1 was asked about the resident to resident altercation that occurred on 05/24/18 and he replied they (the facility) did not consider it a resident to resident altercation. On 08/02/18 at 4:18 p.m., during an interview with EI #6, Licensed Practical Nurse (LPN), the surveyor provided a copy of the incident report regarding RI #12 and RI #45. EI #6 was asked who reported the incident to her. EI #6 stated, EI #3, Certified Nursing Assistant (CNA). EI #6 was asked when she witnessed RI #12 kicking RI #45. EI #6 stated she did not see the initial contact, but when she went down the hall, she did see RI #12 trying to get to RI #45. EI #6 said RI #12 was wheeling his/her motorized wheelchair towards RI #45 and was cussing and yelling at RI #45. The surveyor asked EI #6 what type of issue she would consider this as. EI #6 stated, It was a form of abuse between residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/02/18 at 4:26 p.m., during an interview with EI #3, the surveyor provided copies of written statements and asked who wrote the statements. EI #3 stated, I did. The surveyor asked EI #3 what she witnessed. EI #3 stated, (RI #12), I was at the copier, I saw (RI #12) run his/her wheelchair in the back of (RI #45's) wheelchair. (RI #12) said (RI #45) was trying to block him off. EI #3 further stated, .(RI #12) was kicking at (RI #45) . EI #3 said RI #12 began cursing and said, That MF is not going to pass him/her. EI #3 said when she had the control to the wheelchair to put it in reverse, RI #12 became aggressive with her and was trying to move her hand. EI #3 said what she witnessed was violent behavior from RI #12 toward RI #45. On 08/02/18 at 4:46 p.m., during an interview with EI #2, the surveyor provided a copy of the incident report, dated 5/24/18, and asked EI #2 when she was made aware of the incident. EI #2 stated, (EI #6) called me that night and said that (RI #12) was having behavior and had a verbal altercation with (RI #45) and they had unplugged RI #12's wheelchair. The surveyor asked EI #2 when she did she review the incident reports. EI #2 stated, Usually at the time, if there is an issue report, and at morning meetings. The surveyor asked, was the facility aware of this incident (report) that stated a resident was kicking another resident. EI #2 stated, That's what the incident (report) states, Yes ma'am. The surveyor asked EI #2, based on the information that they had reviewed, what type of issue would she consider that. EI #2 stated, Resident on resident altercation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37292 Based on interviews, medical record review, review of a facility policy titled, Abuse, Neglect and Exploitation, review of a facility document titled, Resident Incident Report and review of a document titled, Alabama Department of Public Health Online Incident Reporting System, the facility failed to report a resident to resident altercation between Resident Identifier (RI) #12 and RI #45 to the State Agency within a two hour time frame, when it occurred on 05/24/18. This affected RI #12 and RI #45, two of 44 sampled residents. Findings Include: A review of a facility policy titled, Abuse, Neglect and Exploitation dated 11/27/16, documented: .13. In response to allegations of abuse .the facility must: a. Ensure that all alleged violations involving abuse .are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . RI #12 was readmitted to the facility on [DATE], with diagnoses including, Schizophrenia. RI #45 was admitted to the facility on [DATE], with diagnoses including, Seizure Disorder. A review of a facility document titled, Resident Incident Report dated 05/24/18, documented: .Narrative of incident and description of injuries: resident (RI #12) cornered another resident (RI #45) in the hall and was kicking (him/her) then went after staff member who tried to separate them . A review of a document titled, Alabama Department of Public Health Online Incident Reporting System, revealed: .Date/Time Submitted: Thursday, August 02, 2018 7:58;57 PM . Incident Type .Physical Abuse . Name(s) of resident(s) involved: (RI #45 and RI #12) . Date and time of incident or alleged incident: 05/24/2018 .6:00 PM . On 08/02/18 at 2:07 p.m., an interview was conducted with Employee Identifier (EI) #1, Administrator/Abuse Coordinator. EI #1 was asked who was the Abuse Coordinator in the facility. EI #1 said he was. EI #1 was asked was the resident to resident altercation on 05/24/18 between RI #45 and RI #12 reported. EI #1 replied they (the facility) did not consider it a resident to resident altercation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/02/18 at 4:18 p.m., during an interview with EI #6, Licensed Practical Nurse (LPN), the surveyor provided a copy of the incident report regarding RI #12 and RI #45. EI #6 was asked who reported the incident to her. EI #6 stated, EI #3, Certified Nursing Assistant (CNA). EI #6 was asked when she witnessed RI #12 kicking RI #45. EI #6 stated she did not see the initial contact, but when she went down the hall, she did see RI #12 trying to get to RI #45. EI #6 said RI #12 was wheeling his/her motorized wheelchair towards RI #45 and was cussing and yelling at RI #45. The surveyor asked EI #6 what type of issue she would consider that as. EI #6 stated, It was a form of abuse between residents. The surveyor asked who did she report this to. EI #6 stated she reported it to the doctor for RI #12 to go out for a psychiatric evaluation and she reported it to EI #2, Director of Nursing (DON). The surveyor asked EI #6 when did she report this to EI #2. EI #6 stated, The same day, within minutes of the incident. On 08/02/18 at 4:46 p.m., during an interview with EI #2, the surveyor provided a copy of the incident report dated 5/24/18, and asked EI #2 when she was made aware of the incident. EI #2 stated, (EI #6) called me that night and said that (RI #12) was having behavior and had a verbal altercation with (RI #45) and they had unplugged RI #12's wheelchair. EI #6 called me and asked if we could send (RI #12) out because he/she could not be redirected. The surveyor asked, was the facility aware of this incident (report) that stated a resident was kicking another resident. EI #2 stated, That's what the incident states, Yes ma'am. The surveyor asked EI #2, based on the information that had been reviewed, what type of issue would she consider that. EI #2 stated, Resident on resident Altercation. The surveyor asked EI #2 who should have been notified of this incident. EI #2 stated, The Administrator, the DON, Medical Director, the patient's physician and the sponsor. The surveyor asked EI #2 when should the State Agency have been notified. EI #2 stated, Within two hours of the incident. The surveyor asked when was the incident reported to the State Agency. EI #2 stated, To my knowledge it has not been. The surveyor asked was that policy not to report an incident regarding resident on resident altercation, EI #2 stated, No ma'am it's not. 38276

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 01751 Based on interview and record review, the facility failed to develop a plan of care for RI (Resident Identifier) #48's hearing deficit. This affected Resident Identifier (RI) #48, one of 44 sampled residents whose care plans were reviewed. Findings include: RI #48 has was readmitted to the facility on [DATE], with diagnoses including Mood Disorder and Chronic Pain Syndrome. The 30 day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/16/18, identified RI #48 as having moderate difficulty with hearing. The Quarterly MDS with an ARD of 07/23/18, identified RI #48 as having moderate difficulty with hearing. On 07/31/18 at 3:40 PM, the surveyor attempted to converse with RI #48 in his/her room. RI #48 was very hard of hearing, and requested the surveyor to speak directly into his/her ear. A review of the resident's record revealed no care plan had been developed to reflect RI #48's communication needs due to the hearing impairment. On 08/02/18 at 4:50 PM, the Care Plan Coordinator, Employee Identifier (EI) #14, affirmed the staff had not developed a plan to address the concern of RI #48's hearing impairment, and a care plan should have been developed. EI #14 affirmed both the resident's current and initial care plans should have addressed RI #48's hearing impairment. When asked what issues the lack of this care plan could create, EI #14 stated the staff may not be aware of RI #48's hearing issue, nor how to approach him/her.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26054 Based on interview, medical record review and a review of the facility's job description titled, CERTIFIED NURSING ASSISTANT, the facility failed to ensure staff provided incontinent care for Resident Identifier (RI) #147 when he/she requested to be changed after an incontinent episode. This affected one of one resident who complained of not receiving care after having an incontinent episode. Findings Include: A review of the facility's job description titled, CERTIFIED NURSING ASSISTANT without a date, revealed the following: .GENERAL PURPOSE Perform direct resident care duties in accordance with the resident's assessment and care-plan . ESSENTIAL JOB FUNCTIONS General Skills .Ensure residents are clean and comfortable . RI #147 was readmitted to the facility on [DATE], with diagnoses to include Chest pain and Acquired Absence of Left Leg Below the Knee. A review of RI #147's current Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident required extensive assistance of one person for personal hygiene and toileting. The MDS also revealed the resident required extensive assistance of two people for transfer. A review of RI #147's care plan with a Problem Onset date of 6/15/18 for alteration in ADL (Activities of Daily Living) function revealed the following: (RI #147 has an alteration in ADL funtion (function) related to resident: limited mobility .Approaches .Keep resident clean, dry . On 8/1/18 at 9:30 AM, an interview was conducted with RI #147. RI #147 informed surveyor he/she turned the call light on around 4:00 AM on the 11 PM-7 AM shift last night and a woman entered the room and turned the light off and he/she told her he/she was wet and needed cleaning up. RI #147 said the woman told him/her she would tell his/her care assistant when she returned from her break and turned the light off. RI #147 said he/she waited until around 5:00 AM when Employee Identifier (EI) #15, Licensed Practical Nurse (LPN) came in the room. RI #147 told EI #15 he/she had been waiting to be cleaned up for about an hour. RI #147 said EI #15 called EI #16, Certified Nursing Assistant (CNA) in to clean him/her up. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/18 at 5:00 PM, a telephone interview was conducted with EI #15. EI #15 was asked when he last entered RI #147's room during his shift last night. EI #15 said close to 5:00 AM. EI #15 was asked what RI #147 told him. EI #15 said RI #147 said he/she had been waiting an hour to get changed. EI #15 was asked what he did then. EI #15 said he told EI #16 that RI #147 needed changing at that time. EI #15 was asked if anyone else was working in that area that night that may have gone in and answered RI #147's call light. EI #15 said yes, EI #17, CNA was working too. On 8/1/18 at 5:45 PM, a telephone interview was conducted with EI #17. EI #17 was asked did she provide any care to RI #147 during her shift last night. EI #17 said no. EI #17 was asked did she go into RI #147's room. EI #17 said yes, one time. EI #17 was asked what RI #147 said to her. EI #17 said she answered RI #147's call light and he/she said he/she was wet. EI #17 was asked what she did then. EI #17 said she told RI #147, the assigned CNA was on break right then and she would tell her when she got back. EI #17 was asked why she did not change RI #147. EI #17 said RI #147 had one leg and she would need help because it took two staff members to assist RI #147 and she was not the assigned CNA for RI #147. EI #17 was asked if she told the assigned CNA that RI #147 needed changing when she returned from break. EI #17 said she was sure she did when she started making rounds. EI #17 said she told the assigned CNA she was going to have to change RI #17. On 8/2/18 at 8:30 AM, a telephone interview was conducted with EI #16, CNA. EI #16 was asked if she provided care for RI #147 on the 11 PM-7 PM shift during the early morning hours of 8/1/18. EI #16 said yes. EI #16 was asked what care she provided. EI #16 said she provided care for RI #147 because he/she was incontinent. EI #16 was asked if anyone told her RI #147 needed changing after her break was over. EI #16 said the nurse, EI #15 told her. EI #16 was asked what time that was. EI #16 said she was not sure, but she immediately went in and provided care to RI #147. On 8/2/18 at 2:40 PM, an interview was conducted with EI #2, Director of Nursing (DON). EI #2 was asked who was responsible for answering call lights and providing care to the residents when a staff member who was assigned to them left the floor. EI #2 said all staff were responsible, if licensed in that area. EI #2 was asked if a CNA was covering the floor for another CNA while on break, should the covering CNA change a resident if they told them they needed changing. EI #16 said yes.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26054 Based on observation, interview, medical record review and review of the facility's policy titled, (Name of Facility-Administering Medications through an Enteral Tube, the facility failed to ensure licensed staff flushed Resident Identifier (RI) #104's Gastrostomy Tube (GT) with the recommended amount of water in between medications during medication administration. This affected one of one resident observed with a GT during medication administration. Findings Include: A review of the facility's policy titled, (Name of Facility)-Administering Medications through an Enteral Tube with a revised date of April 2018 revealed: .25. If administering more than one medication, flush with 15 ml (milliliter) .water between medications . RI #104 was admitted to the facility on [DATE], with diagnoses to include Acute Respiratory Failure and Gastrostomy Status. A review of RI #104's Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The MDS also revealed RI #104 had a feeding tube. On 08/01/18 at 12:50 PM, the following was observed during medication administration. Employee Identifier (EI) #6, (LPN)Licensed Practical Nurse, dispensed the following medications for administration via (by) GT to RI #104: Divalproex 125 mg (milligram) sprinkles four capsule TID (three times a day). EI #6 sanitized her hands and applied gloves. EI #6 dispensed the contents of the four capsules into four separate medication cups. Gloves were removed and hands were sanitized. EI #6 mixed each medication with 5 cc's (cubic centimeters) of water. EI #6 entered RI #104's room and applied gloves. EI #6 administered 15 cc's of water, then each medication was administered and flushed with 5 cc's of water in the tube after each medication. EI #6 administered 15 cc's of water after the fourth cup of medication mixture. On 8/1/18 at 1:05 PM, during an interview with EI #6, the surveyor asked how much water should be mixed with the crushed medication. EI #6 stated, Mix with 5 cc's and 5 cc's in between each medication and 15 cc's before and 15 cc's before and after the GT medication are administered. The surveyor asked was that the facility's policy and procedure. EI #6 stated, Yes.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26054 Based on observation, interviews, medical record review, and a review of the facility's policy titled, Administering Medications , the facility failed to ensure the medication error rate was less than 5%. There were a total of 25 opportunities with two errors, which yielded a medication error rate of 8%. This affected RI #100 and RI #104, two of five residents observed during medication administration. Findings Include: A review of the facility's policy titled, Administering Medications, with a revised date of April 2010, revealed the following: .9. Medications .must be administered within one (1) hour of their prescribed time . 1. RI #100 was readmitted to the facility on [DATE], with diagnoses to include Atherosclerosis and Hypothyroidism. A review of RI #100's August Physician's Orders revealed: .COLCHICINE 0.6 MG (MILLIGRAM) CAPSULE (CAP) .BY MOUTH DAILY .RISPERDAL 0.5 MG TABLET .BY MOUTH DAILY .ATENOLOL 25 MG TABLET . BY MOUTH DAILY .FINASTERIDE 5 MG TABLET .BY MOUTH DAILY .FLUOXETINE HCL 20 MG CAPSULE .BY MOUTH DAILY .TAMSULOSIN HCL 0.4 MG CAPSULE .BY MOUTH DAILY .VITAMIN D3 5, 000 UNIT TABLET .BY MOUTH DAILY .MEMANTINE HCL 10 MG TABLET .BY MOUTH DAILY . OXYBUTYNIN 5 MG TABLET BUY MOUTH 2 TIMES A DAY .MEGESTROL ACET (ACETAMINOPHEN) 40 MG/ML (MILLIGRAM/MILLILITER) SUSP (SUSPENSION) 10 CC (CUBIC CENTIMETERS) PO (BY MOUTH) BID (TWICE A DAY) .DEPAKENE 250 MG/ML SOLUTION GIVE 50 ML .BY MOUTH TWICE DAILY . On 08/01/18 at 9:20 AM, the following was observed during medication administration. Employee Identifier (EI) #10, (RN) Registered Nurse, dispensed the following medications for RI #100: 1. Atenolol HCL (Hydrochloride) 25 mg one po QD (every day) 2. Finasteride 5 mg one po QD 3. Fluoxetine 20 mg capsule one po Qd 4. Oxybutine 5 mg one po BID 5. Tamulosin HCL 0.4 mg one capsule po QD 6. Vit (Vitamin)D3 5,000 IU (International Unit) one po QD 7. Memantine HCL 10 mg one po QD 8. Colchicine 0.6 mg one capsule po BID 9. Risperdal 0.5 mg one po BID (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Megesterol Acetamenophen 40 mg/cc give 10 cc po BID 11. Depakene 250 mg/5cc give 5cc po BID All medications except Colchicine were administered. On 8/1/18 at 10:10 AM, during an interview with EI #10, RN, the surveyor asked what time should the Colchicine have been administered. EI #10 stated, 9 AM. The surveyor asked when did she administer the Colchicine. EI #10 stated, Not administered. The surveyor asked what was the time frame for medication administration. EI #10 stated, One hour before and one hour after scheduled time. 2. RI #104 was admitted to the facility on [DATE], with diagnoses to include Acute Respiratory Failure and Gastrostomy Status. A review of RI #104's Minimum Data Set (MDS), dated [DATE], revealed the resident had a feeding tube. A review of RI #104's August 2018 Physician's Orders revealed: .DIVALPROEX DR (Delayed Release) 125 MG CAP SPRINK (Sprinkles) GIVE 4 CAPSULES PER TUBE THREE TIMES DAILY . On 08/01/18 at 12:50 PM, the following was observed during medication administration. EI #6, (LPN)Licensed Practical Nurse dispensed the following medications during medication administration via GT to RI #104: Divalproex 125 mg sprinkles four capsules TID (three times a day) EI #6 sanitized her hands and applied gloves. EI #6 dispensed the contents of the four capsules into four separate medication cups. EI #6's gloves were removed and her hands were sanitized. EI #6 mixed each medication with 5 cc (cubic centimeters) of water. EI #6 entered RI #104's room and applied gloves. EI #6 administered 15 cc's of water, then each medication was administered and flushed with 5 cc's of water in the tube after each medication. EI #6 administered 15 cc's of water after the fourth cup of medication mixture. Three of the four cups were observed with a moderate amount of a white substance on the sides and in the bottom of the medication cups. On 8/1/18 at 1:05 PM, during an interview with EI #6, the surveyor how many medication cups still had medication on the sides and the bottom of the cup. EI #6 stated, Three. The surveyor asked did the resident receive all the ordered dose of the medication. EI #6 stated, Not all. The surveyor asked what was the potential for harm. EI #6 stated, Not getting all of the medication could cause seizures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 01751 Based on observation, interviews and review of facility policies titled, Use of Leftovers and Nourishments and Supplements and the 2017 FOOD CODE, the facility failed to ensure: 1) refrigerated left-over foods were consistently labeled with a use-by date (UBD) in both the Dietary Department and on the Nursing Stations or were discarded by that UBD; 2) sour cream was covered to prevent exposure to contaminants during storage; 3) the dish washer maintained adequate wash temperatures and chlorine concentrations for dish sanitization; 4) potentially hazardous food was stored at a recommended temperature of 41 degrees Fahrenheit (F) or below; and 5) the return vent over the tray line was free of an accumulation of dust tags. This had the potential to affect all 147 residents for whom meals were prepared and served at the time of this survey. Findings include: 1) Regulations from the 2017 Food and Drug Administration FOOD CODE mandate the following: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) . READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed . (B) .at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded . The facility policy titled, Use of Leftovers dated 2008, specified the following procedure: .2. Leftovers will be covered, labeled, and dated; . 5 Use leftovers within 3 days or discard . On 07/31/18 at 8:20 AM, the surveyor observed the following stored food items which had no UBD in the walk-in refrigerator: A) one foil-covered container of pimento cheese dated 07/29/18 (with no UBD); (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B) a container of cut fruit with a UBD of 07/30/18 and C) one #10 can of beef ravioli (covered with aluminum foil), opened 07/27/18 but with no UBD. When questioned, the Certified Dietary Manager (CDM), Employee Identifier (EI) #7, explained the facility policy was to store food only three days before discarding it. On 08/01/18 at 9:55 AM, the walk-in refrigerator had a container of left over Chuckwagon Corn dated 07/31/18, with no UBD, as well as a container of Creamed Corn dated 07/31/18 with no UBD. EI #7 stated the staff knew to discard the food after three days. The facility's Nourishments and Supplements policy (undated) specifies the following: .2 b. All high protein/high calorie supplements, special nourishments, and other nourishments/supplements are individually labeled and dated . On 08/02/18 at 5:32 PM, the Registered Nurse, Unit Manager (EI #8) accompanied the surveyor to the A Hall pantry refrigerator to view the contents. A four-oz (ounce) container of commercially prepared milkshake was stored in the refrigerator without a dated label/UBD. EI #8 threw the carton away. The 2017 FOOD CODE regulation, 3-202.15 Package Integrity specifies: FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants . 2) One five pound container of sour cream in the walk-in refrigerator was stored with the lid partially off the container. The interior contents were exposed to potential contaminants. When questioned, EI #7 immediately removed the sour cream from storage. 3) The facility's DISH MACHINE TEMPERATURE LOG specified for their low temperature dish machine, a wash temperature of 120 degrees F and a (chlorine) concentration of 50-100 parts per million (PPM). On 08/01/18 at 9:08 AM, staff were observed processing the breakfast dishes through the dish machine. Three of the four cycles of dishes were processed at a wash temperature of 115 degrees F. Staff proceeded to remove the clean dishes and put them away. The dish washer, EI #11, confirmed the reading on the machine's water temperature gauge as 115 degrees F. On 08/01/18 at 9:15 AM, all three staff members working in the dish room (including EI #11, and two Dietary Aides, EI #12 and #13) were asked what the wash water temperature should be. EI #11, #12 and #13 all affirmed the temperature needed to be 120 degrees F, otherwise they would re-wash the dishes or call maintenance. All three affirmed the 115 degree temperature was a problem. EI #13 explained it usually took three cycles to get the temperature up, and they had begun the dish washing at 8:30 AM. The surveyor then requested a check of the chemical concentration of the dish machine. EI #11 determined the concentration of chlorine was 25-50 PPM (less than the 50 PPM recommendation). On 08/01/18 at 9:20 AM, the surveyor asked EI #7 if there had been a previous problem with the dish machine. EI #7 explained the temperatures of the dish machine varied, and they would contact maintenance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4) During the initial tour, on 07/31/18 at 8:30 AM (just after the breakfast tray line) the reach-in refrigerator located across from the tray line, registered an interior temperature of 58 degrees F (with beverages stored inside). On 07/31/18 at 4:48 PM (prior to the supper tray line) the interior thermometer of the reach-in refrigerator above registered 68 degrees F. The refrigerator contained approximately 30 8-oz bowls of fortified pudding, as well as trays of glasses filled with water and ice tea, and wrapped slices of bread. The facility recipe for fortified/super pudding included the following: Finished product must maintain a temperature below 41 F during entire service period . On 08/01/17 at 9:20 AM, the internal temperature of the reach-in refrigerator registered 56 degrees F. Stored inside were trays of water, tea and thickened dairy drinks. The surveyor questioned EI #7 (Dietary Manager) about the function of the reach-in refrigerator. EI #7 explained they had the unit checked the previous month and the coils were cleaned. EI #7 stated they stored only tea and water inside. When questioned about the storage of fortified pudding, EI #7 responded the staff threw the unused fortified pudding away after the tray line. On 08/02/18 at 9:50 AM, the surveyor asked EI #7 who was responsible for monitoring the temperature of the reach-in refrigerator. EI #7 explained temperature monitoring was the responsibility of all staff, particularly those on the tray line. EI #7 confirmed the internal temperature should be 41 degrees F or less. The 2017 FOOD CODE mandates under 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils .(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris . 5) On 08/02/18 at 9:25 AM, the surveyor observed an accumulation of dust tags on the return air vent over the coffee makers, near the tray line. The CDM, EI #7 affirmed the vent needed cleaning.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26054 Based on observations, interviews, medical record review, and a review of the facility's policy titled, Standard Precautions Infection Control the facility failed to ensure staff washed their hands prior to applying gloves and after removing gloves during medication administration for Resident Identifier (RI) #100, RI #104 and RI #109. This affected three of five residents observed during medication pass observation. Findings Include: A review of the facility's policy titled, Standard Precautions Infection Control dated 11/27/16, revealed the following: .1. Hand Hygiene: a. During delivery of patient care services, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . e. Perform hand hygiene: i. Before having direct contact with patients . iii. After contact with a patient's intact skin . v. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. vi. After removing gloves . 1. RI # 109 was admitted to the facility on [DATE], with diagnoses to include Dementia and Depression. On 8/1/18 at 8:37 AM, Employee Identifier (EI) # 9, Licensed Practical Nurse (LPN) was observed preparing medication for RI #109. EI #9 entered RI #109's room and applied gloves. EI #9 did not use hand sanitizer or wash her hands. EI #9 administered medication to RI #109. EI #9 removed her gloves, then pulled the curtains and window blinds. EI #9 exited the room and applied hand sanitizer. EI #9 opened the medication cart and replaced an inhaler. EI #9 washed her hands and signed the MAR (Medication Administration Record). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/1/18 at 8:50 AM, during an interview with EI #9, the surveyor asked what should have been done when gloves were removed. EI #9 stated, Wash hands. The surveyor asked was that what she had done. EI #9 stated, No ma'am. The surveyor asked EI #9 what had she touched. EI #9 stated, Blinds and curtains. The surveyor asked what should have been done before gloves were applied. EI #9 stated, Hands washed or hands sanitized. The surveyor asked was that what she had done before applying gloves. EI #9 stated, No ma'am. The surveyor asked what was the potential harm when hands were not washed before gloves were applied and after gloves were removed . EI #9 stated, Possible contamination of all surfaces. The surveyor asked what type of an issue would that be. EI #9 stated, Infection Control. 2. RI #100 was readmitted to the facility on [DATE], with diagnoses to include Atherosclerosis and Hypothyroidism. On 08/01/18 at 9:20 AM, EI #10, Registered Nurse (RN), was observed preparing medications for RI# 100. EI #10 applied gloves without washing her hands. Medication was placed into medication cups. EI #10 removed her gloves, but did not wash her hands. EI #10 positioned the medication cart in front of RI #100's room. EI #10 entered RI #100's room, touched the roommate's bedside table, placed medicine on the bedside table and positioned the bedside table near the bathroom. EI #10 went back to the medication cart positioned near the doorway of RI #100's room. EI #10 applied gloves, but her hands were not washed. EI #10 put chocolate pudding into each medication cup with the crushed medications. EI #10 removed her gloves and hands were not washed. EI #10 repositioned the bedside table. EI #10 entered RI #100's bathroom and washed her hands. Medications were administered. On 8/1/18 at 10:10 AM, during an interview with EI #10, the surveyor asked what should have been done before gloves were applied and after gloves were removed. EI #10 stated, Wash hands. The surveyor asked was that done every time gloves were applied and/or removed. EI #10 stated, No Ma'am. 3. RI #104 was admitted to the facility on [DATE], with diagnoses to include Acute Respiratory Failure and Gastrostomy Status. On 08/01/18 at 12:50 PM, EI #6, LPN was observed preparing medication for RI #104. EI #6 sanitized her hands and gloves were applied. EI #6 dispensed the contents of four capsules into four separate medication cups. EI #6 removed her gloves and her hands were sanitized. EI #6 mixed each medication with 5 cc's (cubic centimeters) of water. EI #6 entered RI #104's room and applied gloves. EI #6's hands were not washed nor did she use hand sanitizer. RI #104's tube feeding was placed on hold. EI #6 administered water flushes and medication to RI #104. RI #104's tube feeding was restarted. EI #6 removed her gloves and discarded the syringe, cups and paper towel in the trash. EI #6 did not wash her hands or use hand sanitizer. On 8/1/18 at 1:05 PM, during an interview with EI #6, the surveyor asked what should have been done before gloves were applied and after gloves were removed. EI #6 stated, Wash hands. The surveyor asked was that done every time. EI #6 stated, Not every single time, The surveyor asked what was the potential for harm. EI #6 stated, Infection.