STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015436	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLVIEW TERRACE	100 PERRY HILL RD MONTGOMERY, AL 36109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, medical record review and review of Potter and Perry, Fundamentals of Nursing, Ninth Edition, the facility failed to ensure Employee Identifier (EI) #6, Registered Nurse (RN), followed a physician's orders [REDACTED].#18. This affected RI #18, one of eight residents observed during medication administration observation, and one of five nurses observed. Findings Include: A review of Potter and Perry, Fundamentals of Nursing, Ninth Edition, Chapter 23, Legal Implications in Nursing Practice, page 311, revealed: .Health Care Providers' Orders .Nurses follow health care providers' orders unless they believe that the orders are in error . RI #18 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of RI #18's physician's orders [REDACTED].ADMINISTER 30ML OF WATER PRIOR TO MEDICATION ADMINISTRATION . On 03/04/20 at 3:33 p.m., during medication pass observation, the surveyor observed EI #6, RN, administer RI #18's medication via (by way of) gastrostomy tube without flushing with 30 ML of water prior to administration of medication. On 03/05/20 at 12:42 p.m., a telephone interview was conducted with EI #6, RN. EI #6 was asked when and how much water should be used to flush RI #18's gastrostomy tube during medication administration. EI #6 said 30 cc's (cubic centimeter) before and after and 10 cc's in between medications. EI #6 was asked why it was important to flush feeding tubes as ordered by the physician during medication administration. EI #6 stated to keep them patent. EI #6 was asked if he flushed RI #18's tube before he administered RI #18's medications on 03/04/20. EI #6 replied no. EI #6 was asked why he did not do this during medication pass. EI #6 answered he was just nervous.
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.** Based on observations, interviews, and review of policies: Personal Cleanliness and Standards and Beard Restraints, as well as current (2017) Food Code regulations, the facility failed to ensure staff: 1) covered all hair during the preparation and distribution of food on the 03/04/20 lunch tray line; and 2) washed hands after handling soiled equipment and before putting on another pair of gloves to resume food handling tasks. This had the potential to affect all 124 residents for whom meals were prepared and served at the time of this survey. Findings include: 1) The (undated) facility policy titled Personal Cleanliness and Standards stated the following: .Hair restraints should be worn at all times . The facility policy, Beard Restraints (undated) specified: Dietary employees must either be clean shaven or wear a beard restraint if facial hair is present to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens. The 2017 Food and Drug Administration Food Code mandates under regulation 2-401.11 (A) .FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS . During lunch tray line observations on 03/04/20 beginning at 11:00 AM, Dietary Aide, Employee Identifier (EI) #2, retrieved each plate of food from the cooks. EI #2 then covered each completed plate with an insulated dome lid and added supplements, such as margarine and other condiments to complete each tray before loading them into the transport cart. EI #2 wore a beard restraint, but had no restraint over his moustache. On 03/04/20 at 11:07 AM, tray line staff requested a Cook, EI #1, to prepare two sandwiches. EI #1 prepared two peanut butter and jelly sandwiches, without covering all of her hair. About six braids extended four to six inches down from the right side of her hair bonnet. On 03/04/20 at 11:30 AM, the surveyor observed EI #1 laying out frozen dinner rolls onto clean sheet pans. The braids remained outside of her hair restraint. On 03/04/20 at 11:50 AM, the surveyor asked EI #1 to explain why her hair was hanging outside of her cap. EI #1 stated the braids must have bounced out. When asked what the facility policy stated regarding hair coverage, EI #1 explained their policy was to cover all hair. 2) The (undated) facility policy titled Personal Cleanliness and Standards states the following: .Hand washing is also extremely important. .After wiping tables, busing dishes . .Before handling or preparing foods . The 2017 Food and Drug Administration Food Code regulation 2-301.14 When to Wash specifies: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms . immediately before engaging in FOOD preparation, including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (E) After handling soiled EQUIPMENT or UTENSILS; . (H) Before donning gloves to initiate a task that involves working with FOOD; . During lunch tray line observations on 03/04/20 beginning at 11:00 AM, Dietary Aide, EI #2, retrieved each plate of food from the cooks. EI #2 then covered each completed plate with an insulated dome lid and added supplements, such as margarine and other condiments to complete each tray before loading them into the transport cart. At 11:07 AM, EI #2 picked up several used sheet pans which fell to the floor from a nearby open-sided storage rack. EI #2 then removed his gloves and without washing hands, re-gloved before resuming his tray line duty. On 03/04/20 at 11:52 AM, the surveyor asked about hand washing between glove changes, the Dietary Manager (EI #3) responded, Wash between every glove change . On 03/05/20 at 9:00 AM, the surveyor asked the Registered Dietitian/RD (EI #4) what hazard might result from not washing hands between tasks in which contamination occurred. EI #4 stated, There's a potential for cross-contamination. On 03/05/20 at 9:07 AM the Dietary Manager (EI #3) commented that her staff .know to wash hands between tasks . The surveyor asked what potential outcome could occur if a staff member did not wash hands. EI #3 responded, Cross-contamination.
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** Based on observations, interviews, medical record reviews, a review of the facility policies titled, Hand Hygiene and Administration of Medication, and review of Potter and Perry's, FUNDAMENTALS OF NURSING, the facility failed to ensure: 1) Employee Identifier (EI) #6, Registered Nurse (RN), did not take a stethoscope from a bowl on the nurse's station into Resident Identifier (RI) #18's room to auscultate placement of RI #18's gastrostomy tube without cleaning the stethoscope before or after use. Further, the nurse failed to wash hands prior to medication administration, and prior to rinsing the plunger and syringe before storage; 2) EI #7, Licensed Practical Nurse (LPN), did not turn off an oxygen concentrator with her bare hand and then apply gloves to administer RI #91's nebulizer treatment without washing her hands. Further, EI #7 did not wash hands and change gloves to rinse and dry RI #91's nebulizer mask and reservoir for storage; 3) EI #8, LPN, did not place a medication cup containing medications inside of another medication cup of medications while preparing medications during med pass for RI #78 and RI #64; and 4) EI #9 and EI #10, both Certified Nursing Assistants (CNAs), washed their hands after removing gloves and prior to touching clean items during the provision of incontinence care for RI #77. Further, the CNAs did not clean the wash basin prior to placing it in the bedside table for storage. These deficient practices affected RI #18, RI #91, RI #78 and RI #64, four of eight residents observed during medication pass observations and three of five nurses observed and further affected RI #77, one of one resident observed during incontinence care observation. Findings include: A review of the facility's policy titled, Hand Hygiene, dated November

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

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 28th, 2017 revealed: Policy Statement Hand Hygiene shall be regarded by this organization the single most important means of preventing the spread of infection. Appropriate hand hygiene must be performed under the following conditions: . 3. whenever hands are obviously soiled. 14. After contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident's room. 18. After contact with blood, body fluids, excretions, secretions, mucous membranes, or broken skin. 21. After removing gloves. A review of a facility policy titled, Administration of Medication, revised (NAME)1st, 2019, documented: .9. Proper infection control technique will be used during medication preparation and administration. A review of Potter and Perry's, FUNDAMENTALS OF NURSING, Ninth Edition, Chapter 29, page 443 revealed: . Reservoir. A reservoir is a place where microorganisms survive, multiply, and await transfer to a susceptible host. Common reservoirs are humans and animals (hosts), insects, food, water, and organic material on inanimate surfaces . Humans can transmit microorganisms . Animals, food water, insects, and inanimate objects can also be reservoirs for infectious organisms. 1) RI #18 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 03/04/20 at 3:33 p.m., during medication pass observation, the surveyor observed EI #6, RN, pick up a stethoscope from a bowl on the nurses's station and place it around his neck. He then entered RI #18's room and placed the stethoscope in his ears, without cleaning it first, to auscultate placement of RI #18's gastrostomy tube. After recapping the gastrostomy tube, EI #6 was then observed picking up a water pitcher from RI #18's over-bed table and taking it into the bathroom to fill it up with water from the faucet. EI #6 continued wearing the same gloves while filling the pitcher, and also to administer RI #18's medications via gastrostomy tube. On 03/05/20 at 12:42 p.m., a telephone interview was conducted with EI #6, RN. EI #6 was asked when he should wash his hands during medication pass. EI #6 said before he starts, after he finished and between medications if they were different. EI #6 was asked when should he change his gloves during medication pass. EI #6 stated after he gave medications he should wash his hands and put on more, and after he took them off he should wash his hands again. EI #6 was asked should he turn on and off the faucet while wearing gloves and then wear those same gloves to administer medications per gastrostomy tube. EI #6 said no. EI #6 was asked did he fill RI #18's water pitcher while wearing gloves and then administer RI #18's medications while still wearing those same gloves. EI #6 replied yes. EI #6 was asked should he get a stethoscope from a bowl on top of the nurse's station and use it without cleaning it first. EI #6 stated no. EI #6 was asked did he clean the stethoscope he got from the bowl on the nurse's station before he used it for RI #18. EI #6 said no. EI #6 was asked what was the concern with these things. EI #6 answered cross contamination and infection control. On 03/05/20 at 1:59 p.m., an interview was conducted with EI #11, LPN/Infection Control Coordinator (ICC). EI #11 was asked when should a nurse wash their hands during medication pass. EI #11 said before and after and if they were contaminated in between. EI #11 was asked when should a nurse change gloves and wash their hands during medication pass. EI #11 stated in between different tasks and if they became contaminated. EI #11 was asked should a nurse change their gloves and wash their hands if they touched a potentially contaminated surface. EI #11 replied yes. EI #11 was asked if a nurse was wearing gloves and picked up a water pitcher to fill it with water and was observed turning on and off the faucet should he have changed gloves and washed his hands prior to administering medications. EI #11 said yes. EI #11 was asked should a nurse get a stethoscope from a bowl on the nurse's station and then use it to auscultate a resident's gastrostomy tube for medication administration without cleaning it first. EI #11 replied no. EI #11 was asked why should nurses not do those things during medication pass. EI #11 said cross contamination. EI #11 was asked what was the concern with those things discussed. EI #11 answered the potential to spread infection. 2) RI #91 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On 03/04/20 at 4:21 p.m., during medication pass observation, the surveyor observed EI #7, LPN, turn off RI #91's oxygen concentrator with her bare hand and then apply gloves to administer RI #91's nebulizer treatment without washing her hands. EI #7 then put a glove on her right hand and used the faucet to rinse RI #91's nebulizer reservoir and mask. EI #7 then used the same glove to dry the reservoir and mask and placed them in a plastic bag for storage. On 03/05/20 at 12:19 p.m., a telephone interview was conducted with EI #7, LPN. EI #7 was asked should she turn on a faucet with her gloved hand to rinse out the reservoir and mask while wearing that same glove after touching the contaminated surface. EI #7 said no. EI #7 was asked should she touch potentially contaminated surfaces with her bare hands and then apply gloves to administer medications without washing her hands. EI #7 replied no. EI #7 was asked when should she wash her hands when wearing gloves. EI #7 stated before she put them on and when she took them off to prevent contamination and infection control concerns. 3) RI #78 was readmitted to the facility on [DATE]. On 03/04/20 at 5:01 p.m., during medication pass observation, EI #8, LPN, was observed placing a paper medication cup containing medications for RI #78 inside another paper medication cup containing additional medications for RI #78. RI #64 was readmitted to the facility on [DATE]. On 03/04/20 at 5:16 p.m., during medication pass observation, EI #8, LPN, was observed placing a paper medication cup containing a medication for RI #64 inside another paper medication cup containing an additional medication for RI #64. On 03/04/20 at 5:20 p.m., an interview was conducted with EI #8, LPN. EI #8 was asked should a medication cup containing medication be placed inside another medication cup containing medications. EI #8 said no. EI #8 was asked why. EI #8 replied contamination and infection control. EI #8 was asked did she place a medication cup containing medication for RI #78 inside another medication cup containing additional medication. EI #8 said yes. EI #8 was asked did she place a medication cup containing a medication for RI #64 inside another medication cup containing an additional medication. EI #8 replied yes. EI #8 was asked why. EI #8 stated she was not thinking. 4) RI #77 was readmitted to the facility on [DATE] with a [DIAGNOSES REDACTED].#9 and EI #10, both CNAs, perform incontinence care on RI #77. Both CNAs were observed removing their gloves and applying clean gloves without washing their hands and touching clean linen without washing hands. EI #9 and EI #10 also placed the wash/bath basin into the resident's bedside table for storage without cleaning it first. An interview was conducted with EI #9 and EI #10 on 03/05/20 at 10:51 a.m EI #9 and EI #10 were asked, what should be done after removing gloves. EI #9 and EI #10 stated, Wash hands. EI #9 and EI #10 were asked if they had washed their hands after removing their gloves. EI #9 stated, I don't think so. EI #10 stated, No, I put new gloves on but didn't wash hands every time. EI #10 replied, gloves need to be changed, wash hands, and put new gloves on. EI #9 and #10 were asked if they had done that. EI #9 stated, No, not every time. EI #10 replied, no she did not wash hands after wiping the perineal area and before applying clean gloves. EI #9 and EI #10 were asked, what should be done after cleaning the perineum and before touching clean items such as the brief, the linens, etc. EI #9 and EI #10 stated, Wash hands and put on clean gloves. EI #9 and EI #10 were asked, what should be done to the wash basins. EI #9 and EI #10 stated, Wash the entire basin. EI #9 and EI #10 were asked, what was the potential for harm in not washing hands after cleaning the perineum, removing gloves, before touching clean linen, rolling a resident on soiled linen and not washing the basin. EI #9 and EI #10 answered, Cross Contamination. An interview was conducted on 03/05/20 at 2:11 p.m., with EI #11, LPN/ICC. EI #11 was asked, what should be done during incontinence care after gloves are removed. EI #11 replied, Wash hands. EI #11 was asked, what should be done after cleaning stool from the perineum. EI #11 stated, Remove gloves and wash hands. EI #11 was asked, what should be done after cleaning the perineum and before touching clean items such as the brief, linens, etc. EI #11 stated, Change gloves and wash hands and apply clean gloves. EI #11 was asked, what should be done with the bath basin after use. EI #11 stated, Clean the inside and outside of the basin or throw it away. EI #11 was asked, what is the harm in not washing hands after removing gloves, in not washing hands after wiping stool from the buttocks prior to touching clean items, and storing a dirty basin in the resident's bedside table. EI #11 stated, Potential to spread infection.