STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055011	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACACIA PARK NURSING & REHAB CENTER	1611 SCENIC DRIVE MODESTO, CA 95355

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat residents with respect and dignity when Licensed Vocational Nurse (LVN) 2 failed to address two of three sampled residents (Resident 46 and 59) by their given name and instead referred to them by the term, Honey. This practice made Resident 46 and 59 feel disrespected. Findings: During a medication administration observation on 3/11/2020, at 3:23 p.m., with LVN 2, LVN 2 addressed Resident 46 by the term, Honey and administered her medication. LVN 2 proceeded with Resident 59 and referred to Resident 59 by the term, Honey. During an interview on 3/12/2020, at 9:05 a.m., with Resident 46 in her room, she stated, . I do not want to be called Honey my husband calls me honey and I do not want the nurse or others to call me that. I like to be called by my first name or by my married name because that is respectful. During a review of Resident 46's Minimum Data Set (MDS- a resident assessment tool used to plan care) dated 1/23/2020, the MDS assessment indicated Resident 46 was cognitively impaired with a Brief Interview for Mental Status (BIMS- an evaluation of attention, orientation and memory recall) score of 9 (0-7 - severely impaired; 8-12 moderately impaired; and 13-15- cognitively intact). During an interview on 3/12/2020, at 9:13 a.m., with Resident 59, she stated, I want to be called by my first name . Resident 59 stated she did not like to be called, Honey. During a review of Resident 59's MDS dated [DATE], the MDS assessment indicated Resident 59 was cognitively intact with a BIMS score of 13. During an interview on 3/12/20, at 2:01 p.m., with LVN 2, LVN 2 stated she should have called the residents by their given names in order to remain professional and to demonstrate respect towards the residents. During an interview on 3/12/20, at 2:10 p.m., with the Director of Nursing (DON), the DON stated LVN 2 was expected to call the residents by their given names to ensure a respectful encounter with each resident. During a review of the facility's policy and procedure titled, Quality of Life-Dignity dated 8/09 indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Policy Interpretation and Implementation. 1. Resident shall be treated with dignity and respect at all times .7. Staff should speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs .
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on observation, interview, and record review, the facility failed to ensure one of 16 sampled residents (Resident 39) needs and preferences were accommodated when the facility did not replace Resident 39's missing television remote control. This failure affected Resident 39's independence and resulted in a fall when he got up unassisted from bed to turn his television on. Findings: During an interview on 3/10/2020, at 9:48 a.m., with Resident 39's family member (FM)1, FM 1 stated Resident 39 was admitted to the facility with his own TV and remote control on 11/3/2011. FM 1 stated over the years Resident 39 had experienced losing his television remote control which the facility replaced. FM 1 stated Resident 39 lost his television's remote control sometime in December 2019. FM 1 stated he made a request for the facility to replace Resident 39's remote control which had not yet been done. FM 1 stated Resident 39 sustained a fall after getting up alone and unassisted from bed to turn his television on during the night shift on 2/22/2020. FM 1 stated Resident 39 would not have fallen if his television remote control would have been accessible. During a review of Resident 39's progress notes dated 2/22/2020 at 1:20 a.m., indicated, Upon hearing calling out or help from resident's room . (Resident 39) found .kneeling on the floor and notified the (nurse) .the resident said, I was trying to get down to put my (television) TV on. During a concurrent interview and record review on 3/11/2020, at 11:49 a.m., with the Maintenance Director (MD), the Maintenance Repair Notification (MRN) log dated 12/8/2019, indicated, Location: (Resident 39's Room Number); TV remote is missing, family request one. The MD stated he did not provide the remote control to Resident 39 as requested. During an interview on 3/11/2020, at 2:40 p.m., with the Director of Nursing (DON), the DON stated she did not know Resident 39's TV remote control was missing. The DON stated she expected the MD to act on the family's request for a remote control for Resident 39's use as soon as possible. The DON stated if the remote control was not available, the MD was expected to inform the DON or the Administrator about it. During a review of the facility's policy and procedure titled, Quality of Life - Accommodation of Needs dated 8/09, indicated, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being .The resident's individual needs and preferences shall be accommodated to the extent possible .
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess one of 16 sampled residents (Resident 31) when Residents 31's Minimum Data Set (MDS) (an evaluation of a resident's cognitive, function, behavioral, and care needs) was inaccurately coded as having a fall with major injury. This failure resulted in inaccurate information being sent to the Center for Medicaid Services (CMS) and possibly not providing needed services to the resident. Findings: 1.During a concurrent observation and interview on 3/10/2020, at 1:52 a.m., with Resident 31, Resident 31 was laying in her bed in her room. Resident 31's bed was in the lowest position with two-inch-thick soft mats placed on both sides of the bed. Resident 31 stated she did not remember having any falls in the past. During a review of Resident 31's Minimum Data Set (MDS-assessment of memory and functional needs) dated 1/6/2020, indicated Resident 31 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS-assessment of memory and recall) score of 11 (0-7 severe impairment, 8-12 moderate impairment, 13-15 no impairment). Section J of the MDS assessment indicated Resident 31 had fallen once with no injury and one fall with major injury since her last assessment dated ,[DATE]. During a review of Resident 31's Nurse's Notes (NN) dated 11/25/19, indicated Resident 31 had been yelling from her room, a certified nurse assistant (CNA) found Resident 31 on the floor/mat, Resident 31 stated she slid off the bed, and an assessment was completed which showed no injury. During an interview on 3/12/2020, at 3:06 p.m., with the Administrator (ADM) and the Assistant Director of Nursing (ADON), both stated Resident 31 did not have a history of falls with major injury. During a concurrent interview and record review on 3/13/2020, at 8:39 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 31's MDS assessment dated [DATE] was reviewed. The MDSC stated Resident 31's MDS Section J, indicated Resident 31 had a fall with major injury since her last assessment in 10/19. The MDSC reviewed the NN, dated 11/25/19 and stated Resident 31 had fallen but was assessed to have no injury from the fall. The MDSC reviewed Resident 31's paper chart, assessments, and post fall assessments, and stated, she was unable to find anything in Resident 31's chart indicating she had had a major injury from a fall while in the facility. The MDSC stated Resident 31's MDS dated [DATE] was coded incorrectly.
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.**

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055011	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACACIA PARK NURSING & REHAB CENTER	1611 SCENIC DRIVE MODESTO, CA 95355

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	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to administer a metered dose inhaler (MDI-pressurized canister of medicine in a plastic holder with a mouthpiece used to administer a consistent dose of medication) in accordance with professional standards to one of three sampled residents (Resident 55) when Licensed Vocational Nurse (LVN) 3 administered two puffs of a MDI without waiting one minute between each puff. This failure potentially placed Resident 55 at risk to not receive the maximum effectiveness of the MDI. Findings: During an observation on 3/12/2020, at 8:33 a.m., in Resident 55's room, Resident 55 was lying in her bed and on continuous supplemental oxygen by way of a nasal cannula. Resident 55 requested LVN 3 provide her with an administration of her MDI. LVN 3 retrieved Resident 55's MDI from a medication cart and entered Resident 55's room. LVN 3 stated, I have your (MDI). LVN 3 gave Resident 55 one puff of medication from the MDI, waited two seconds, and gave Resident 55 another puff of the medication. During an interview on 3/12/2020, at 8:40 a.m., with LVN 3, LVN 3 stated she was supposed to wait two minutes before the second puff was administered. During a concurrent interview and record review on 3/12/2020, at 8:45 a.m., with Assistant Director of Nursing (ADON), reviewed Resident 55's physician orders [REDACTED]. The ADON reviewed Resident 55's physician order [REDACTED]. During an interview on 3/12/2020, at 8:47 a.m., with the Pharmacist (PharmD), PharmD stated research indicated the most effective administration of a MDI was to wait one to two minutes after administering the first puff and before administering the second puff. During a concurrent interview and record review on 3/12/2020, at 9:18 a.m., with LVN 3, reviewed the facility's policy and procedure (P&P) titled Administering Medications through a Metered Dose Inhaler, dated 10/2010. LVN 3 stated the P&P indicated, .11. 14. Administer medication .15. Repeat inhalation, if ordered. Allow at least one (1) minute between inhalations of the same medication and at least two (2) minutes between inhalations of different medications . LVN 3 stated she administered the second puff of medication without waiting one minute. During a review of the professional standard titled, Lippincott Manual of Nursing Practice 10th Edition dated 2014, page 16-17 indicated, Standards of practice General Principles . 1 b. These standards provide patients with a means of measuring the quality of care they receive. Common Departures from the Standards of Nursing Care . failure to monitor or observe a change in a patient's clinical status .failure to perform a nursing treatment or procedure properly . failure to implements a physician's orders [REDACTED].Failure to administer medications properly and in a timely fashion .Failure to observe a medication's action or adverse effect .Failure to adhere to facility policy or procedural guidelines .
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 16 sampled residents (Resident 35) received treatment and services to increase range of motion and or to prevent further decrease in range of motion when Resident 35's care plan interventions for the management of his right hand contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) were not followed. This failure potentially placed Resident 35 at risk for further complications to his right hand contracture. Findings: During a review of Resident 35's Face Sheet (a document containing resident profile information) indicated Resident 35 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. During a review of Resident 35's physician's orders [REDACTED]. During a review of Resident 35's care plan dated 5/15/18, indicated, Impaired mobility positioning related to generalized muscle weakness .Interventions .Resting hand splint (brace used to keep a limb in a neutral position of rest to prevent pain and muscle contracture) place splint 5 (times per week) 4-6 hours a day . During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool used to plan care) dated 1/9/2020, the MDS assessment on Functional Limitation in Range of Motion indicated Resident 35 had impairment of upper and lower extremity. During an observation of Resident 35's contracted right hand on 3/10/2020, at 10 a.m., and 4 p.m., Resident 35's contracted right hand was resting on top of the bed cover without the use of a hand splint. During an observation of Resident 35's contracted right on 3/11/2020, at 11 a.m. and 3 p.m., Resident 35's contracted right hand was resting on top of the bed cover without the use of a hand splint. During an observation on 3/13/2020, at 10:36 a.m., Resident 35 was in his room with Licensed Vocational Nurse (LVN) 3. LVN 3 requested Resident 35 remove his covers and show his right hand. Resident 35's right hands was contracted with a closed fist and without the use of a hand splint. Resident 35 nodded no when asked if a hand splint was applied to lessen the contracture of his right hand. During a concurrent interview and record review on 3/13/2020, at 11:01 a.m., with Restorative Nursing Assistant (RNA) 1, RNA 1 stated Resident 35's splint application schedule indicated a resting splint should be applied on Resident 35's right hand every Tuesday, Wednesday, Friday, Saturday and Sunday (five times a week) 4-6 hours a day. RNA 1 stated she did not apply the resting hand splint on Resident 35 on 3/11/2020 or on 3/13/2020. During a concurrent interview and record review on 3/13/2020, at 11:16 a.m. with the Occupational Therapist (OT), the OT stated Resident 35 was referred to a restorative nursing program (RNA) for the management of his right hand contracture. The OT reviewed the RNA referral dated 2/17/2020, which indicated, .RNA (Restorative Nursing Assistant: Instruction: . Hand splint Management . regular skin check 3x/week x 6 months as tolerated. Resident Goal: . Prevent contractures . The OT stated Resident 35's hand splint management should have been implemented as ordered. During a review of the facility's policy and procedure titled, Restorative Nursing Services dated 7/2017, indicated, Policy Statement. Residents will receive restorative nursing care as needed to help promote optimal safety and independence .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement an effective infection control program when: 1. One of 12 staff members who declined a flu shot did not properly wear a face mask to cover her mouth and nose. 2. Licensed Vocational Nurse (LVN) 1 failed to perform hand hygiene between provisions of care for three of three sampled residents (Resident 3, 7 and 70). 3. One of one ice machine's was dirty and visibly soiled. These failures placed residents at risk for acquiring infections by cross contamination (spread of bacteria from one place to another). Findings: 1. During a concurrent observation and interview on 3/11/2020, at 2:57 p.m., with LVN 2, LVN 2 prepared medications and interacted with residents while she wore a surgical face mask without covering her mouth and nose. LVN 2's nose was exposed above the face mask. LVN 2 stated she wore the face mask because she did not receive the annual flu shot. LVN 2 stated the face mask was only effective if it covered her mouth and nose. During a concurrent observation and interview on 3/11/2020, at 3:01 p.m., with the Infection Preventionist (IP), the IP observed LVN 2 in the hallway with her mask under her nose and stated the mask needed to be over LVN 2's nose and mouth to protect residents from possible infections. During a concurrent interview and record review on 3/12/20, at 8:55 a.m., with the IP, the IP reviewed a letter from the County Health Department titled, Mandatory Influenza Vaccination or Masking of Health Care Workers During Influenza Season dated 9/9/19, which indicated, .Mandatory masking of unvaccinated healthcare personnel remains essential to influenza prevention .all acute care hospitals and long-term facilities in (county name) HCWs are both at risk for influenza and can transmit [MEDICAL CONDITION] to their vulnerable patients . The IP reviewed the facility's P&P titled, Example of Safe Donning and Removal of Personal Protective Equipment (PPE), (undated), and stated the P&P indicated, Masks should be placed with the flexible band (top) to the nose bridge and (the bottom of the mask) below the chin. 2. During a medication administration observation on 3/11/2020, at 7:17 a.m. with LVN 1, LVN 1 applied a pair of gloves without sanitizing hands and proceeded to performed a finger stick (prick of a finger with the lancet to get a small drop of blood) on Resident 3. LVN 1 removed and discarded the used gloves, then donned a new pair of gloves without sanitizing her hands and administered the scheduled morning medication for Resident 3. LVN 1 proceeded to prepare and administer morning medications to Resident 7 and 40 without performing hand hygiene in between each resident. During an interview on 3/12/2020, at 10:56 a.m.,with LVN 1, LVN 1 stated he should have performed hand hygiene before and after the use of gloves, after performing a finger stick and after direct contact with a resident. LVN 1 stated this was necessary in order to prevent the spread of bacteria from one person to another. During a review of the facility's policy and procedure titled, Administering Medications dated 12/12, indicated, Policy Statement. Medication shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 22. Staff shall follow established facility infection control procedures (e,g, hand washing, antiseptic technique, gloves, isolation precaution, etc.), for the administration of medications, as applicable . During a review of the facility's policy and procedure titled, Handwashing/Hand- Hygiene dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055011	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACACIA PARK NURSING & REHAB CENTER	1611 SCENIC DRIVE MODESTO, CA 95355

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) 8/15 indicated,Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non- antimicrobial) and water for the following situations: b. Before and after direct contact with he patient; c. Before preparing or handling medications; i. after contact with the resident's intact skin; l. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; m. After removing glove; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9 The use of gloves does not replace hand washing/hand hygiene. Integration of gloves use along with the routine hand hygiene is recognized as the best practice for preventing health care- associated infections . During a review of the facility's policy and procedure titled, Standard Precautions dated 12/07, indicated Standard Precaution will be used in the care of all residents regardless of their diagnosis, or suspected or confirmed infection status. Policy Interpretation and Implementation. Standard Precautions include the following practices:1. Hand hygiene a. . refers to hand washing with soap . or using alcohol; based hands rub (gels, foams, rinses) that do not require access to water . d. Wash hands after removing gloves (see below) 2. Gloves: Remove gloves promptly after use, before touching non- contaminated items and environmental surfaces, and before going to another residents and wash hands immediately to avoid transfer of microorganism to another residents or environments . 3. During an observation on 03/10/2020 at 8:05 a.m., in the facility's Dietary Department, the Head Cook (HC) stated the facility had one ice machine that was located in the kitchen. A collection of water on the floor behind the ice machine was observed. The HC validated observation. During a concurrent observation and interview on 3/11/2020 at 8:08 a.m., with the Maintenance Supervisor (MS), in the kitchen, the MS opened the ice machine door and accessed the inside areas of the ice machine. Once the door was open the inner compartment of the ice machine was visible and water condensation dripped down the ice supply down below. The left and right side of the door was visibly soiled with a brown and black colored substance. The MS validated the observation and wiped the areas with a white paper towel. The MS stated the ice machine was soiled and could have fallen down into the ice being served to the residents. During a review of the facility's Policy and Procedure dated 2018, indicated, Policy: The Food and Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving and storing of food. There shall be adequate equipment for cleaning, disposal of waste and general storage. All equipment shall be maintained as necessary and kept in working order.
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep all essential equipment working safely.** Based on observation, interview and record review, the facility failed to ensure kitchen equipment was safely maintained when a thick layer of ice buildup was found inside the walk-in freezer door. This failure had the potential to impact the ability of dietary staff to store food in a safe and sanitary manner to all residents who received meals from the kitchen. Findings: During a concurrent observation and interview on 3/10/20, at 8:05 a.m., in the facility's Dietary Department, the Head Cook (HC) stated the facility had one walk in refrigerator and one walk in freezer. During a concurrent observation and interview on 3/10/20, at 8:41 a.m. the walk in freezer temperature was zero degree and the freezer door was observed with a thick layer of ice formed around the inside door. The Dietary Manager (DM) confirmed the walk-in freezer had a thick layer of ice buildup inside the freezer door. The DM stated, I will have the maintenance clean the ice. During an interview on 3/11/20, at 9:30 a.m., with the DM, the DM stated the ice built-up around the walk-in freezer door had been ongoing since she started working at the facility six years ago. The DM stated, It has gotten worse in the last two years. The DM stated the contracted repair company had recommended to have a portable freezer outside in case the freezer stopped operating. During an interview on 3/11/20 at 9:38 a.m., with the Registered Dietician (RD), the RD stated the walk-in freezer door was repaired two years ago. The RD stated she was aware and had observed the issue with the freezer door that resulted in formation of thick ice around. The RD stated she reported the ice buildup problem to administration and had discussed her concerns of the freezer not functioning properly with the MS. The RD stated the last time she checked the walk-in freezer was two weeks ago for her monthly inspection and had noticed the increased amount of ice build-up. The RD stated at that time she had reported her concern again to the facility administrator. During a concurrent observation and interview on 3/11/20, at 10:30 a.m., The DM measured the ice build up around the door of the walk-in freezer which indicated left corner had 6 1/2 feet in length, 4 1/2/ inches wide, 1 inch thick ice build-up; above the door to the freezer had ice buildup of 7 inches in length, 2 inches wide and 1 1/2 inches thick. The right side of the door had scattered ice build-ups, on top 4 inches in length, 4 inches wide and 1/2 inch thick. The bottom part had 6 1/2 inches in length, 5 1/2 inches wide and 3 1/2 inches thick. The DM stated, the MS Will get the ice scraped off tonight. During an interview on 3/11/20, at 11:55 a.m., with a Maintenance Company Staff (MCF) for the facility's walk-in freezer, he stated that he had recently conducted an inspection and checked the Freezer and did not find any issues. The MCF inspected the freezer door and stated that he was not concern about the ice buildup on the door because both the refrigerator and the freezer were keeping appropriate temperatures. He stated the ice buildup could have been caused when the freezer door was being opened many times. The MCF stated the freezer door should not have ice build-up. During an interview on 3/11/20, at 12:30 p.m., with the Administrator (ADM), the ADM submitted a copy of previous reports from the contracted refrigeration company regarding ice buildup around the walk-in freezer. The ADM stated, the MS Will be scraping off the ice buildup tonight. The ADM stated the facility did not have plans to replace the freezer unit and the food stored in the freezer would be okay because the freezer temperatures were okay. During a review of Service Order/Invoice dated 2/15/19, indicated Found the cooling coil was iced up, manually defrost all the ice (twice) . During a review of Service Order/Invoice dated 3/11/20, indicated found ice buildup around the door and corners of freezer body, because of air leak or bad insulation. recommend replacing entire freezer box. During a review of the facility's Policy and Procedures, dated 2018, the Section 8 Sanitation indicated Policy: The Food and Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving and storing of food. There shall be adequate equipment for cleaning, disposal of waste and general storage. All equipment shall be maintained as necessary and kept in working order.