

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>105631</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>08/25/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>MARSHALL HEALTH AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>207 MARSHALL DR PERRY, FL 32347</b>	
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 0921  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interview the facility failed to ensure an environment that was safe, functional, and sanitary for residents and staff in 5 of 120 resident rooms. (404, 405, 506, 603, 606) The findings include: On August 25, 2020 starting at approximately 9:15 AM, a tour of the facility was conducted and the following was observed: room [ROOM NUMBER] occupied by a resident, missing plaster from ceiling room [ROOM NUMBER] occupied by a resident, large area of mold-like substance on wall room [ROOM NUMBER], occupied by a resident, significant amount of mold-like substance inside shared bathroom around door frames and on ceiling room [ROOM NUMBER], occupied by a resident, mold-like substance on ceiling room [ROOM NUMBER], occupied by a resident, several large holes noted on wall in room, bathroom toilet tank top was missing and the toilet appeared broken with a large amount of feces-like substance in bowl and on the floor, brown stains were noted on the ceiling as well. During the tour several staff members were interviewed. Staff members D and E, both housekeeping staff, stated that on occasion the sewage backs up into the building and had been a problem for a while. Staff member F, a Certified Nursing Assistant (CNA) was observed in room [ROOM NUMBER] and stated the holes in the wall had been there for a few weeks after the previous resident had left and taken the TV and the toilet had been broken for at least a week. On August 25, 2020 at approximately 12:20 PM, a tour of the facility's East Wing was conducted. During the tour, interviews were conducted with resident # 3, staff member H, a Licensed Practical Nurse (LPN) and staff member I a CNA. At 12:24 PM, resident # 3 stated the bathrooms on her hall (300 Hall) have been known to overflow, but she doesn't know specifically which rooms. At 12:30 PM, LPN H stated that the East Wing staff toilet overflows pretty regularly, which is on the 300 Hall. At 12:44 PM, CNA I stated that the 100 Hall is known to flood and some hall ceilings leak when it rains. An interview was conducted with staff member G, a Registered Nurse (RN), while observing room [ROOM NUMBER]. She confirmed the appearance of mold-like substances on the wall. Then proceeded to room [ROOM NUMBER] and shown holes in wall and broken toilet. She stated she heard some toilets were broken but was not aware of this one. An interview was conducted with the Director of Maintenance was conducted on August 25, 2020 at 10:30 AM. He stated there was an issue with the plumbing in the building that had been ongoing for about a year and the facility had in the past received information from a plumber that one of the pipes from the facility to the city sewer connection was in some way compromised and needed repair. He was shown the concerns in room [ROOM NUMBER] and stated staff needed to put concerns in my maintenance book so we know when things need repair. He was also shown the photographs of a large amount of mold-like material in room [ROOM NUMBER] in the bathroom. A few moments later he reported after checking the bathroom, the exhaust fan motor appeared to be not functional.		
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.