STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115404	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LUMBER CITY NURSING & REHABILITATION CENTER	93 HIGHWAY 19 LUMBER CITY, GA 31549

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, and review of the facility's policy titled, Basic Life Support/CPR the facility failed to obtain two Physician signatures and a Guardian signature for a DNR (Do Not Resuscitate) Provider Orders for Life-Sustaining Treatment (POLST) order form for one of 16 residents (R#16) reviewed for Advance Directives. Findings include: Review of the facility's policy titled, Basic Life Support/CPR with no revision date revealed: The purpose is to ensure that the facility is able to and does provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care to the arrival of emergency medical personnel in accordance with related physician's orders [REDACTED]. Review of the Quarterly Minimum Data Set (MDS) for R#16 dated [DATE] in section C for cognitive patterns revealed a Brief Interview in Mental Status (BIMS) of 12 indicating the resident was moderate cognitive impairment. Review of the [DIAGNOSES REDACTED]. Review of the Statutory Form Power of Attorney revealed the R# 16 sister was is the Power of Attorney (POA) for finance and not healthcare. Review of POLST dated [DATE] for R#16 revealed a section was checked for: Do Not Resuscitate (DNR) There were not any Physician's signatures on the document. Review of the Front sheet labeled stop revealed R#16 was a DNR. Review of the MAR indicated [REDACTED]. The POLST required two Physician's signatures due to sister signing. An interview on [DATE] at 2:57 p.m. with Staff AA stated that she goes over the POLST and advanced directives with the resident or the resident's responsible party (RP) via the admission packet and if she isn't present then the nurses complete the admission packet with the resident / resident's RP. Staff AA said the POLST/advanced directives must be completed before the resident gets to the building. An interview on [DATE] at 3:01 p.m. with Staff AA (Admission/Marketing Director) and Social Service Director (SSD) BB R#16 was a FULL CODE and when the resident was hospitalized , his sister made the decision to change R#16 to DNR on [DATE]. SSD BB indicated the doctor was not in facility at the time of change and a copy is placed on the chart and the original document was taken to the doctor's office for a signature. SSD BB agreed that R# 16 would remain a FULL CODE until the DNR POLST dated [DATE] was signed. An interview on [DATE] at 3:09 p.m. with LPN CC revealed that she identifies a resident as being a FULL CODE or DNR from the Medication Administration Record [REDACTED]. LPN CC revealed via the MAR indicated [REDACTED]. An interview on [DATE] at 5:16 p.m. with SSD BB verified that R#16 was not provided on the code status list indicating a code status of DNR or FULL CODE. She said that the resident doesn't have an advanced directive which list the sister as the POA. She said the sister is the POA of finance and confirms the resident has decision making capacity. She also confirms R# 16 returned to the facility from the hospital on [DATE] and states the resident should have been on the code status list printed by the pharmacy. She confirms R# 16 doesn't have any documentation which would give his sister permission to make decisions regarding his healthcare.
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** Based on observations, record review, staff interviews and review of the facility policy titled, Condition Change of the Resident the facility failed to promptly notify the responsible party for a change in condition for one of 33 residents (R) (R# 218) reviewed for change in condition. Findings include: Review of the policy titled, Condition Change of the Resident Documentation Guidelines revealed: Notification of the resident's responsible party, including date and time of changes in the resident's medical/mental condition and/or Status. Policy Interpretation: The Licensed Nurse or other, will notify the resident's Attending Physician or on-call Physician when there has been a significant change in the resident's physical/emotional/mental condition. Record review revealed that R#218 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. The resident has a Brief Interview for Mental Status (BIMS) of12 indicating that the resident had moderate impaired cognition. A review of the nurses notes for R# 218 dated 10/11/19 revealed the resident complained of shortness of breath. Further review revealed that R# 218's Physician was notified, but there was not any documentation that the resident's representative or family member was notified of the resident's change in status. An interview on 3/6/2020 at 1:26 p.m. with the Director of Nursing (DON) revealed that the DON's expectation was that the Physician and family be notified whenever there was a change in the resident's condition.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based on observation, staff and resident interviews, record review and review of facility policy titled, Resident/ Patient Grievance Process the facility failed to make information on how to file a grievance or complaint available for five of 33 residents. Findings include: Review of an undated policy titled, Resident/ Patient Grievance Process revealed the facility will provide written Concern/ Complaint Procedure for Residents/ Patients to the resident/ patient and/per family/ responsible party on admission. This includes, but is not limited to Information and explanation of the Concern/Complaint Process How to communicate when you have a concern or complaint Staff assistance in preparing concern/complaint reports Resolving concerns and complaints During a group Resident Council meeting on 3/4/2020 at 10:25 a.m. R#23, R#24, R#25, R#50, and R#53, who were able to respond to interview questions appropriately, stated that they did not know how to file a grievance. Record review of Resident Council Minutes dated 3/5/19 through 3/4/2020 revealed only two grievances had been filed by residents since the last survey in 2019, and neither of those two grievances were filed from residents in this meeting. Review of the Resident Council meeting minutes revealed that there was not any evidence of documentation that education on how to file a grievance had been discussed with the Resident Council. In addition, review of the facility's grievance book revealed that that there was not any evidence that R#23, R#24, R#25, R#50, and R#53 had ever filed a grievance. An interview on 3/4/2020 at 5:15 p.m. with the Social Service Director (SSD) revealed the residents can go to any staff member to file a grievance if she isn't available. The SSD stated that there are also extra grievance forms in the copy room. Once the form is completed, it is taken to the appropriate department. During admissions, residents are educated on how to file a grievance. If the resident is incoherent, their family members are educated on how to file a

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

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) grievance.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policy titled, Baseline Care Plan/Summary the facility failed to ensure that the baseline care plans were completed and reviewed with residents and/or family within 48 hours for three of 20 Residents (R's) (R#14, R#37 and R#118) of 20 residents reviewed. Findings include: Review of the policy titled, Baseline Care Plan/Summary documented that a baseline care plan for each resident will be developed within 48 hours of the resident's admission to this facility. It further documented that a written summary of the baseline care plan will be provided in a language that the resident/representative can understand. Documentation in the resident's medical record will reflect that the summary or a copy of the baseline care plan was given to the resident/representative. There was no date indicated when this policy was initiated. 1. Review of medical record for R#14 revealed [DIAGNOSES REDACTED]. Review of baseline care plan revealed the resident was admitted on [DATE] however, review of the form did not indicate that form was completed. There was no completion date and there was no evidence that the baseline care plan was reviewed with the resident or family. 2. Review of medical record for R#37 revealed [DIAGNOSES REDACTED]. Review of baseline care plan for R#37 revealed an admitted [DATE] and a completion date of 7/11/19. There was no evidence that resident/representative were involved as evidenced by no signatures or documentation that the baseline was reviewed with the resident/family. 3. Review of medical record for R#118 revealed [DIAGNOSES REDACTED]. During review of the baseline care plan for R# 118 there was an admission date of [DATE], but further review did not reveal a completion date. There was also not any evidence that the baseline care plan was reviewed with the resident or representative or completed within 48 hours. During an interview on 3/5/2020 at 12:34 p.m. with the Minimum Data Set (MDS) Coordinator revealed that nursing staff was to complete the baseline care plan and she updates it until the comprehensive care plan is completed. During an interview with the Social Services Director (SSD) on 3/6/2020 at 8:55 a.m. revealed that upon admission a 72-hour meeting is set up with residents and family members but denies that the baseline care plan is reviewed at that time. During an interview on 3/6/2020 at 12:28 p.m. with Licensed Practical Nurse (LPN) KK revealed that baseline care plans are completed typically the day that residents are admitted to the facility. LPN KK reviewed care plans for R#14 and R#37 and acknowledged that a completion date and date reviewed with resident/family should be documented. An interview on 3/6/2020 at 12:40 p.m. with the Director of Nursing (DON) revealed that the baseline care plan was to be completed immediately upon admission by the charge nurse and that the baseline care plan is then discussed during the 72-hour care plan meeting. The DON acknowledged that the date of completion date should be documented on the baseline care plan as well as the date it was discussed with the resident and/or family.
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** Based on observation, record review, and staff interviews the facility failed to follow the care plan related to potential alterations in cardiac function for one of 33 (R#218) residents reviewed for care plans. Findings include: Review of the medical record for R #218 revealed a [DIAGNOSES REDACTED]. Review of the the care plan for R#218 dated 10/15/19 revealed an intervention to assess for shortness of breath. Nursed notes dated 10/12/2019 at 5:40 p.m. documented the following: Resident comes rolling up the in his wheelchair asking for his O2 (oxygen) Sat (saturation) to be checked. He (R#218) was informed he needs to return to his room and get back on his O2. Further review revealed there was not any evidence of documentation that R#218 was assessed for shortness of breath. During an interview with the Director of Nursing (DON) on 3/6/2020 at 1:26 p.m. The DON revealed that it was her expectation that the care plans are followed and that R#218 should have been assessed for shortness of breath.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** Based on observation, record review and staff interviews, the facility failed to follow Physician's order for a 1500 milliter (ml) fluid restricted diet for one of 33 residents reviewed for diet. Findings include: A closed record review of the medical record for R#218 revealed a Physician's dietary order for a 1500ml fluid restricted diet but further record review revealed R#218 received a regular diet. During an interview with the Director of Nursing (DON) on 3/6/2020 at 1:26 p.m. revealed that the nurse should have checked the orders for R#218 and the DON revealed that R#218 should have received the 1500ml fluid restricted diet.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** Based on observation and staff interview, the facility failed to ensure that infection control practices were followed during wound care for one resident (R#5) of three residents reviewed for wound care. Findings include: Observation on 3/4/2020 at 10:16 a.m. of wound care with Licensed Practical Nurse (LPN) JJ for R#5 revealed LPN JJ picked up the 4x4 gauze squares with her bare hand. Observation revealed that she scratched her lip, she then placed the trash bag in the trashcan and moved the trash can within reach. The LPN then washed her hands and turned off the faucet and closed the bathroom door with a paper towel. Further observation revealed that LPN JJ moved R#5's urinary catheter and with the same gloves on removed the resident's dirty dressing without washing her hands or sanitizing and changing her gloves prior to removing the dressing. An interview on 3/4/2020 at 10:54 a.m. with the LPN Wound Care Nurse JJ revealed that she had been to a wound care class but was not certified in wound care. She confirmed that she handled the 4 x 4 gauze squares with her bare hands when she was setting up the supplies for the wound care, and she also confirmed that she didn't sanitize her hands, remove her gloves and don clean gloves after moving the resident's urinary catheter. LPN JJ stated that she should have asked the other staff to move the urinary catheter or she should have removed the contaminated gloves, washed her hands and donned clean gloves. An interview on 3/5/2020 at 9:00 a.m. with the Director of Nursing revealed that her expectation was that the nurses would follow infection control practice and should not have touched the 4x4 gauze squares with her bare hand and that she should not have touched the urinary catheter and then removed the resident's dressing with the same gloves.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observation and staff interview, the facility failed to post the census information readily accessible to residents and visitors on three of four days of the survey. The facility census was 70 residents, Findings include: Observations on [DATE], 3/3/2020, and 3/4/2020 of the Nursing Staff Information dated [DATE], 3/3/2020, and 3/4/2020 revealed the staffing was posted on the bulletin board near the nurse's station. The staffing sheet revealed the number of staff Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNA) for each shift, date and name of facility; however, the staffing sheet did not reveal the census for each shift. During an interview on 3/4/2020 at 12:43 p.m. with the Director of Nursing (DON) verified that the staffing sheet posted in front of the nurse's station wasn't completed and verified the census was missing from each day dated [DATE], 3/3/2020 and 3/4/2020.
F 0777 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the Physician of x-ray results for one of three residents (R A) reviewed for change in condition. Findings include: A review of the Minimum Data Sets listing for R A revealed a death in facility tracking record dated 11/24/19. A review of the Admission Alert form dated 10/9/18 revealed

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F 0777 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) that R A was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of a telephone order dated 11/23/19 revealed an order for [REDACTED]. A review of the Nurse Notes revealed that the Physician was notified of the residents change of condition and that the Physician saw the resident on 11/21/19 but there was not any documentation of the Physician being notified of the results of the chest x-ray for R A that were received on 11/24/19 at 12:28 p.m. An interview on 3/3/2020 at 4:50 p.m. with the Director of Nursing (DON) revealed that she was the Registered Nurse (RN) supervisor on duty on 11/24/19. After reviewing the resident's x-ray results with the surveyor, she stated that they showed that the resident had right sided infiltrate felt secondary to pneumonia. She stated that the x-ray was received on 11/24/19 at 12:28 p.m. and the x-ray was completed by Mobilex at the facility. The DON stated that after review of the Nurse Notes and review of the x-ray result that she was unable to tell if the Physician was notified of the results. An interview on 3/4/2020 at 3:41 p.m. with RN HH the previous Director of Nursing (DON) revealed that she remembered the resident and she remembered pronouncing her. She stated that the resident had cold type symptoms and had improved from when orders were obtained. The DON stated that she didn't know if the x-ray report was sent to the doctor or not, but that information would normally be documented in the Nurse Notes or on the x-ray result page. An interview on 3/5/2020 at 11:24 a.m. with LPN KKK revealed that she called the Physician on the morning of 11/24/19 about the resident's condition. She stated that she checked the fax around 9:00 a.m. to 9:30 a.m. and then again around lunch time. A review of the current 24-hour report log revealed that it documented such things as labs that are due, behavior changes, diet changes, transfers to other facilities, hospital returns, falls and medication changes. A review of the 24-hour report log dated 11/23/19 documented that a chest x-ray with two views was ordered for R A. A follow-up interview on 3/5/2020 at 3:12 p.m. with Physician II after reading the x-ray results for R A revealed that if he had been called the results of the x-ray report for R A with the resident having a Full Code status that he would have sent her to the emergency room for evaluation. Physician II stated that he would have expected to have been notified within approximately 30 minutes of the facility receiving the faxed results.
F 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** Based on record review, staff interviews the facility failed to ensure that the staff designated as Dietary Manager was a Certified Dietary or Food Service Manager or had a similar food service management certification or degree. This had the potential to affect 68 residents receiving an oral diet. Findings include: Review of the job description for Dietary Manager (DM) (revised 4/11) revealed entry qualifications that included but not limited to graduate of dietary manager certification course as applicable and long-term care or acute care facility experience preferred. Further review revealed DM signed the job description on 10/25/19. During an interview with the DM on [DATE] at 10:30 a.m. revealed that she began working at the facility on October 2019. The DM revealed that she is Serve Safe certified but denies that she was a Certified Dietary Manager (CDM). The DM explained that she was supposed to be signed up for the classes this week. During an interview with the Administrator on 3/6/2020 at 10:40 a.m. revealed that the Dietitian is at the facility at least once per month but is not at the facility at least 30 hours or more per week. The Administrator revealed that a visiting CDM assists the current DM but was not in this facility daily. The Administrator revealed that she was not aware of the regulations related to requirements for the DM.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of the facility policy titled, Storage, Food storage and family members, Nutritional Services Manual the facility failed to ensure that items were labeled/dated and used before the expiration date in the kitchen, emergency food storage, and in one food pantry. Failed to ensure that the ice machine was maintained in a sanitary manner. The facility failed to ensure that the dry storage area and microwave in the kitchen were clean and items in the kitchen were labeled and dated. Failed to log refrigerator and freezer temperatures. This deficient practice had the potential to affect 68 residents receiving an oral diet. Findings include: Review of the policy titled Food storage and family members dated [DATE] all food is stored in the unit refrigerators. All food should be labeled, dated, and covered with a use by date. All unit refrigerators will have a thermometer on the inside and this will be recorded. Review of policy titled Storage with a revision date of [DATE] indicated all food items stored after opening or preparation will be covered, labeled, and dated. It further indicated that dry food items are placed in a clean, ventilated storeroom according to the inventory sheets. Lastly, all items are placed on shelving units, at least 6 off the floor. Review or policy titled Nutritional Services Manual dated ,[DATE] revealed the following: Procedure 4. utilize the First in, First out (FIFO) method when stocking and rotating product. 5. Ensure all food and chemical containers are labeled with name and dated received. Review of the Preventive Maintenance documented: Schedule: At some sites the water supply to the ice machine will contain significant quantities of minerals, and that will result in a water system becoming coated with these minerals, requiring more frequent maintenance than twice per year. Bin Liner Cleaning and Sanitizing: At the same time of scale removal and ice machine sanitation. Review of the maintenance system preventative maintenance the ice machine should be have filters checked, coils cleaned, and inside sanitized every three months. During the initial kitchen tour on [DATE] at 10:30 a.m. with the Dietary Manager (DM) the following was revealed: 1. In the walk-in cooler there was an open bag of sausage with seven sausage patties with no open dated noted. 2. There was a 15-pound box of bacon that did not have an open date or expiration date. 3. There were multiple boxes of juice cups (orange, cranberry, and apple) that did not have a thaw date. The instructions on the box suggested that the juices be used within 14 days of thawing. 4. There were two white containers with flour and cornmeal in each but neither had an open date or a use by date. 5. There were two bags of strawberry yogurt with a use by date of [DATE]. 6. There was a box of cucumbers with one cut cumber being in a clear storage back with no date. 7. There was food splatter in the microwave. 8.11:10 am observation of the ice machine revealed black buildup on the lip of ice machine. During a second kitchen tour on [DATE] at 3:05 p.m. with the Dietary Manager the following was revealed: 1. In the dry storage area there were four bags of vanilla wafers dated with an in date of [DATE] but no expiration dated noted. 2. There was a container with saltines that did not have an in date or an expiration date. 3. There were four 9-ounce (oz) packages of taco seasoning with no expiration date. 4. There was a rice container half full with the lid opened. 5. There was a sugar container that did not have an in date or an expiration date. 6. The containers with Frosted Flakes, Rice Krispies, and Raisin Bran had a use by date of [DATE]. 7. There was a container with Cheerios that did not have a use by date. 8. In the emergency food area there were six Tropicana Grapefruit juices with an in date of [DATE] and an expiration date of [DATE], Frosted Mini Wheats with an in date of [DATE] and an expiration date of [DATE], and eight 1.77-liter containers of cranberry juice with an expiration date of [DATE]. Observation of the Resident Pantry on [DATE] at 4:03 p.m. with the Dietary and the CDM revealed the following: 1. In the freezer there was one party pizza with a best by date of [DATE] and enchiladas with a best by date of [DATE]. It is noted that none of the items in the freezer had a name on them. 2. In the refrigerator there was a container of mayonnaise with an open date of [DATE] and a best by date of [DATE]. During an ongoing interview with the DM on [DATE] from 10:30 a.m. until 11:15 a.m. revealed that the Dietary Manager reported that the sausage was opened this morning. It was then reported that the flour and cornmeal were placed in the plastic containers a week ago. It was also reported that the items normally don't stay in the containers longer than a week. The Dietary Manager reported that the microwave is wiped down after each use and confirmed the splatter in the microwave. The Dietary Manager then reported that she cleans the filters for the ice machine weekly, but she is not aware of who is responsible for cleaning the ice machine. She reported that she had not cleaned the inside of the ice machine since she had been employed at the facility. During an interview and observation on [DATE] at 9:18 a.m. with the Maintenance Director he confirmed that there was a black buildup on the ice machine liner. During an observation on [DATE] at 11:35 a.m. with Cook LL in the prep area Cook LL was observed pouring a partially used bag of cereal into a container that was already filled with cereal. There was a total of four cereal containers on the shelf that did not have in dates or use by dates. During an ongoing interview and observation with the Dietary Manager and CDM on [DATE] from 3:05 p.m. until 3:45 p.m. In the dry storage area, the Dietary Manager confirmed the buildup on the floors in the dry storage area and revealed that housekeeping had stripped the floor before, but the storage room should be

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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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) cleaned daily. The CDM reported that she visits the facility once a month and reported that items in containers (sugar, flour, and cornmeal) should have an open date and expiration date. The CDM revealed that the sugar was placed in the container today and should have a date on it. In the prep area in the kitchen the containers with cereal were observed and both the DM and CDM reported that new cereal should never be placed in a container that already had cereal in it. It was reported that cereal containers should be emptied and cleaned prior to new cereal being placed in it. Interview on [DATE] at 4:03 p.m. with Dietary Manager who reported that the pantry refrigerator was to be checked daily and she was responsible for doing so. The Director of Nursing (DON) reported that the resident and staff share the pantry refrigerator. During an interview with the Administrator on [DATE] at 8:17 a.m. revealed that it was her expectation that the ice machine be cleaned once a problem area has been identified. She revealed that Maintenance will now put ice machine cleaning on the monthly schedule. Upon review of the picture of the ice machine with the black build up she stated that the machine will have to be cleaned now. During the emergency water tour with the Housekeeping Supervisor on [DATE] at 2:45 p.m. there were six 5-gallon containers of water observed sitting on the floor with another 25 5-gallon containers sitting on a pallet. The Housekeeping Supervisor confirmed that the water should not be sitting on the floor. During an interview with the Administrator on [DATE] at 10:40 a.m. revealed that the dietary staff are responsible for checking for expired items in the pantry refrigerator as well as for cleaning of the pantry, and dietary is responsible for logging refrigerator and freezer temperatures in the pantry area. During a review of refrigerator and freezer temperature logs for the pantry on [DATE] the logs revealed missing temperatures for [DATE] included the 14th, 15th, 22nd-26th, and 29th. Review of log for February 2020 revealed missing temperatures from the 10th thru 18th and 20th thru 29th.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility failed to ensure the use of proper handwashing and sanitizing during meal service for one of three halls. Findings include: 1. An observation on [DATE] at 12:19 p.m. of lunch trays being served to residents on the 100 (A) Hall revealed staff were observed passing out lunch trays and not sanitizing hands between residents. The staff were observed to assist resident's in their room by going into the closet and handing items to the residents then assisting with tray set up. The staff were observed to repeat this action with seven of 12 trays that were on the lunch cart. 2. Observation on 3/3/2020 at 5:38 p.m. of trays being delivered for the 100-hall with Certified Nursing Assistant (CNA) FF revealed that she spilled a cup of tea on one of the trays on the meal cart for 100-hall, she then delivered a tray to room [ROOM NUMBER] and did not sanitize hands prior to delivering the tray. After delivering trays to room [ROOM NUMBER] CNA FF then moved the cart and delivered a tray to room [ROOM NUMBER]-1 without sanitizing her hands and then she delivered a tray to room [ROOM NUMBER]-2, room [ROOM NUMBER]-1, and room [ROOM NUMBER]-2 without sanitizing her hands between delivering the trays. Further observation revealed that CNA FF then delivered a tray to room [ROOM NUMBER]-2 without sanitizing and she handled the bedside table and began to set-up the resident's meal. CNA FF was observed to don gloves prior to putting mayonnaise on the resident's bread but did not wash or sanitize her hands prior to donning the gloves. CNA FF was then removed her gloves and adjusted the trash bag in the trash can and then sanitized her hands. An interview on 03/03/20 at 6:04 p.m. with CNA FF revealed that she sanitized her hands in room [ROOM NUMBER] and sanitized again in room [ROOM NUMBER]. The resident in room [ROOM NUMBER] confirmed that she sanitized her hands as she entered his room. CNA FF confirmed that in room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER] that she delivered the tray without sanitizing but since she didn't set the tray up that she didn't sanitize. CNA FF stated that she was supposed to sanitize in every room, and she agreed that she needed to work on sanitizing prior to serving every tray. An interview on 3/6/20 at 3:33 p.m. with the Administrator revealed that she expected staff members to sanitize their hands between delivery of every tray.
F 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** Based on record review and staff interviews the facility failed to provide vaccination against influenza or pneumonia and failed to provide evidence that the resident was offered these vaccines for one of five residents (R) (R#5) reviewed for vaccines. Findings include: A review of the medical record for R#5 revealed that there was not any documentation of the influenza and pneumonia vaccines being given or offered to the resident. An interview on 3/6/2020 at 3:03 p.m. with the Administrator confirmed that there was not any documentation of the vaccines being offered or given to R#5. An interview on 3/6/2020 at 3:05 p.m. with the Administrator and the Director of Nursing revealed that the expectation was that residents be offered the flu and pneumonia vaccine on admission and as appropriate. The Administrator stated that she did not know why this resident was not offered the vaccine.