STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015015	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLANTATION MANOR NURSING HOME	6450 OLD TUSCALOOSA HIGHWAY P O BOX 97 MC CALLA, AL 35111

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 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 a review of facility policies titled, Work Attire Guidelines, Hand Washing, and Cleaning Dishes/Dish Machine, the facility failed to ensure: 1. staff braids were completely enclosed inside of her hair net while at the tray line; 2. staff changed an apron (personal protective equipment) and washed her hands when going from a dirty task to another task and; 3. resident plates were not placed on wet trays and covered with wet domes. This had the potential to affect 95 of 95 residents who received meals from the kitchen. Findings Include: 1) A review of a facility guideline titled, Work Attire Guidelines revealed: Hair Restraints Wear a . hair restraint when in a food-prep area. This can keep hair from falling into food and onto food-contact services . On 3/4/2020 at 11:30 a.m., a worker was at the tray line asking staff to put her hair net on the back of her braids. The worker's braids were hanging down her back and not in a hair net at the tray line. On 3/04/2020 at 1:32 p.m., an interview was conducted with (Employee Identifier) EI #5, dietary aide. EI #5 was asked why was she at the tray line with her braids hanging down her back. EI #5 replied, she was waiting for someone to put her hair up for her. EI #5 was asked why did she ask staff to help her put her hair in a net at the tray line. EI #5 replied, she did not know. EI #5 was asked why did she come back to the tray line with her braids hanging out of her hair net. EI #5 replied, she did not know they had fallen. EI #5 was asked why should she not ask staff to help her put her braids up in a hair net at the tray line. EI #5 replied because she was around food. EI #5 was asked who should have hair nets on in the kitchen. EI #5 replied, everyone. EI #5 was asked should a hair net enclose all of her hair. EI #5 replied, yes ma'am. 2) A review of a facility guideline titled, Work Attire Guidelines revealed: . Remove aprons when leaving prep area. . A review of a facility policy titled, Hand Washing revealed . Policy: Staff will wash hands as frequently as needed throughout the day following proper hand washing . When to wash hands . After engaging in other activities that contaminate the hands. . On 3/04/2020 at 11:02 a.m., an observation was made of EI #6, the Cook. EI #6 was on the dirty side of the dish room. EI #6 was putting and pushing dirty dishes into the dishwasher. EI #6 was rinsing dirty dishes off, wearing an apron, and the water was splashing on her apron. After leaving the dish room, EI #6 changed gloves and washed her hands. EI #6 cleaned a table with a dish cloth and left the kitchen. At 11:05 a.m., EI #6 came back into the kitchen and did not wash her hands, nor change her apron. EI #6 put on a clean pair of gloves and took the temperature of the baked chicken. EI #6 then put rolls in a pan. During this observation EI #6 did not pull off the apron that was worn while she was washing dirty dishes. On 3/04/2020 at 1:56 p.m., an interview was conducted with EI #6. EI #6 was asked what did she do when she went to the dirty side of the dish room. EI #6 replied, she washed her pureed bowl. EI #6 was asked what PPE did she have on. EI #6 replied, an apron. EI #6 was asked did she change her apron. EI #6 replied, after she was informed about her mistake. EI #6 was asked did she put rolls in a pan before taking off her apron. EI #6 replied, yes. EI #6 was asked why did she not change her dirty apron. EI #6 replied, she was in a hurry. EI #6 was asked when washing down the table with a dish cloth, what did she do next. EI #6 replied, she put on gloves without washing her hands. EI #6 was asked when should she wash her hands in the kitchen. EI #6 replied, after every task. EI #6 was asked why should she wash her hands in the kitchen. EI #6 replied, to stop the spread of food borne illness. 3) A review of a facility policy titled, Cleaning Dishes/Dish Machine with a year date of 2013 revealed: . Procedure: . 9. Allow the dishes to air dry on the dish rack. . 3/04/2020 at 11:30 a.m., trays were brought to the tray line wet. EI #6 put plates on five wet trays and then covered them with three wet domes. On 3/04/2020 at 1:57 p.m., an interview was conducted with EI #6. EI #6 was asked what was wet at the tray line. EI #6 replied, the trays and the domes. EI #6 was asked why were the trays and domes wet. EI #6 replied, they did not have time to dry. EI #6 was asked who was responsible for making sure they were dry. EI #6 replied, dietary aide and everybody. EI #6 was asked why should dishes be dry at the tray line. EI #6 replied, to stop food borne bacteria growth. EI #6 was asked how should dishes be allowed to dry. EI #6 replied, air dry. On 3/04/2020 at 2:03 p.m., an interview was conducted with EI #7, dining services. EI #7 was asked what did she observe at the tray line wet. EI #7 replied, a couple of trays and a couple of domes. EI #7 was asked who was responsible for making sure dishes were dry at the tray line today. EI #7 replied, that would have been herself. EI #7 was asked why were dishes wet. EI #7 replied, there was no excuse and she was sorry. EI #7 was asked why was it important that dishes were dry at the tray line. EI #7 replied, because of cross contamination and bacteria can build up. EI #7 continued to say the resident's immune system was very weak, and their job was to make sure the temperatures were good and everything was sanitized. EI #7 was asked how should dishes be allowed to dry. EI #7 replied, air dry.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews and review of the facility policy titled, MEDICATION ADMINISTRATION, the facility failed to ensure that the Licensed Nurse signed off medication given on June 14, 15, 16 and 17, 2019 on the MAR (Medication Administration Record), for (Resident Identifier) RI #200. This affected one (1) of five (5) resident who's MAR was reviewed for medication administration. Findings include: A review of the facility's policy titled, MEDICATION ADMINISTRATION, with no date revealed, . Policy Explanation and Compliance Guidelines: . 17 . Sign MAR after administered . RI #200 was admitted to the facility on [DATE] for Encounter for other specified aftercare, Unspecified [MEDICAL CONDITION] of the liver, and Chronic [MEDICAL CONDITION] with [MEDICAL CONDITION]. A review of RI #200's Physicians orders, dated 5/24/2019 revealed . [MEDICATION NAME] 10 mg (tab) tablet give 1 tab by mouth twice a day . [MEDICATION NAME] 10(g) gram/15(ml) milliliter GIVE 45 ml by mouth . three times a day . [MEDICATION NAME] 20(mg) milligram give 1 tablet by mouth daily/prn (as needed) . [MEDICATION NAME] 550 MG TAB . give 1 tab by mouth twice daily . On 03/05/2020 at 9:37 a.m., an interview was conducted with EI #1 (Employee Identifier) Registered Nurse (RN). EI #1was the RN assigned to RI # 200's on the 3-11 evening shift on June 16, 2019. EI #1 was asked, was she familiar with RI #200. EI #1 replied, she remembered that name. EI #1 was asked, why was RI #200 taking the [MEDICATION NAME]. EI #1 replied, RI #200 was taking it for a beta blocker. EI #1 was asked why RI #200's [MEDICATION NAME] was not given on June 16, 2019, 4 PM dosage. EI #1 replied, she always gave her medication. EI #1 further stated she may have forgot to sign it out. EI #1 was asked why would a nurse not give a resident their medication. EI #1 replied, if the doctor wanted to hold it for any reason. EI #1 was asked why was the resident taking the [MEDICATION NAME]. EI #1 replied, she could not remember. EI #1 was asked why was the [MEDICATION NAME] not given on June 16, 2019, 4 PM dosage. EI #1 replied, she forgot to sign it out. EI #1 further stated she always gave the resident's medications. On 03/05/2020 at 9:52 a.m., an interview was conducted with EI #2 (a Licensed Practical

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Nurse) LPN. EI #2 was the LPN assigned to RI #200 on the 3-11evening shift June 17, 2019. EI #2 was asked why was RI #200 taking the [MEDICATION NAME]. EI #2 replied, she could not remember. EI #2 was asked why was the [MEDICATION NAME] not given on June 17, 2019, 4 PM dosage. EI #2 replied, she did not remember. EI #2 stated, she always tried to sign her medications out as she gave them. EI #2 was asked what would be the concern if RI # 200 did not take the [MEDICATION NAME]. EI #2 replied, it could effect the resident's health. EI #2 was asked why was RI #200 taking the [MEDICATION NAME]. EI #2 replied, she was not sure. EI#2 was asked why was the [MEDICATION NAME] not given on June 17, 2019, 4 PM dosage. EI# 2 replied, she always gave her medications, and she just forgot to sign out the medication. EI #2 was asked what reason would a resident not receive their medication. EI #2 replied, if the medication was not there or the resident not available. On 03/05/2020 at 10:09 a.m., an interview was conducted with EI #3, RN. EI #3 was asked did she remember RI #200. EI #3 was the RN assigned to RI #200 on the 7-3 morning shift June 14, 2019. EI#3 replied, yes. EI #3 was asked why was RI #200 taking the [MEDICATION NAME]. EI #3 replied, blood pressure. EI#3 was asked why was the [MEDICATION NAME] not given on June 14, 2019, 8 AM dosage. EI # 3 replied, if RI #200 was in the facility she would have gave the medication. EI #3 was asked why was the medications not signed off. EI #3 replied, she over looked it. EI #3 was asked why was RI #200 taking the [MEDICATION NAME]. EI #3 replied, she could not remember. EI #3 was asked why was the [MEDICATION NAME] not given on June 14, 2019, 8 AM dosage. EI #3 replied, if it was ordered, she gave it. EI #3 was asked what reason would a resident not receive their medication. EI #3 replied, only if they refused the medication. On 03/05/2020 at 10:47 a.m., an interview was conducted with EI #4 RN (Director of Nursing) DON. EI #4 was asked how important was it for a nurse to give the medication to a resident. EI #4 replied, very important. EI #4 was asked should the nurse sign out a medication after he/she give it to the resident. EI#4 replied, yes they should. EI #4 was asked why should the nurse sign out medications after she/he gave it to a resident. EI #4 replied, to show that they gave it. EI #4 was asked why would a nurse not sign out a medication on the MAR. EI #4 replied. various reasons, EI #4 further stated it could be a human error, or she forgot. EI #4 was asked why would a nurse not give a resident their medication. EI #4 replied, if the doctor has written an order to not give the medication. EI #4 was asked what was the facility policy on documentation of medication. EI #4 that the nurse should sign the MAR after she gave a medication.