STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015414	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAFAYETTE NURSING HOME	**555 B STREET SW LAFAYETTE, AL 36862**

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 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on interviews conducted during the initial tour, comments from Resident Council attendees, tray line observation, a review of the facility policy titled Monitoring Food Temperatures for Meal Service, and interviews with staff, the facility failed to consistently serve food at palatable temperatures to residents. This affected 5 of 22 interviewable residents residing in the facility, including RI #25. Findings Include: A review of the facility policy titled, Monitoring Food Temperatures for Meal Service (2016) specified: . Procedure . 3. . g. Meals that are served on room trays may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 degrees F (Fahrenheit) or greater to promote palatability for the resident. Any complaint regarding food temperatures by residents will be documented on the Food Temperature Log. Complaints will be investigated by conducting a test tray for that meal to determine if foods are remaining above 120 degrees F. . During the initial facility tour on 3/10/20 at 10:41 AM, RI #25 stated the food was always cold. On 3/11/20 at 10:00 AM, a Resident Council Meeting was conducted by survey staff. Of the 12 attendees, four residents affirmed food temperatures were not warm enough. On 3/11/20 at 10:35 AM, the surveyor observed the lunch tray line. All food temperatures were taken prior to the arrival of the surveyor, and documented as 144 degrees F or greater. Employee Identifier (EI) #5, the morning Cook, plated food directly from the pans resting on hot burners of the stove top, or from pans of food resting on top of two open oven doors, with no direct source of heat. Food items included Philly cheese steak, French fries, and pulled BBQ pork chop. Plastic (Melmac) plates were used (unheated) for each tray, and covered by plastic plate covers (with no thermal insulation) and no heated base. All trays of food were then transported to the halls and Dining Room on open-sided transfer (speed) racks. There was no visible means of maintaining food temperatures for the food once the item left the burners of the range top. On 3/11/20 at 11:12 AM, the last food cart was completed, at which time the surveyor requested EI #5 to check the temperature of the items stored on top of the open oven doors. The pulled (mechanical) BBQ Pork Chop (documented as 180 degrees F at the start of the tray line) was found to be 118 degrees F. The alternate Philly Cheesesteak (documented as 189 degrees F) registered 120 degrees F when checked by EI #5. On 3/11/20 at 11:30 AM the Dietary Manager (EI #6) and the surveyor checked the food temperatures of test trays, sent on the 100 Hall food cart. All trays had already been delivered by this time. The temperatures were as follows: REGULAR PORK CHOP: 100 degrees F (taste acceptable). CREAMED CORN: 90 degrees F (tasted slightly warm). LIMA BEANS: 100 degrees F (tasted warm). PUREED CREAMED CORN: 80 degrees F (tasted like room temp; not warm enough). EI #6 agreed the temperature was not hot enough. PUREED LIMA BEANS: 85 degrees F. Burned taste; cool temperature. Not acceptable. EI #6 agreed it was only room temperature. PUREED BBQ PORK CHOP: 95 degrees F. Barely warm taste; room temperature. PHILLY CHEESE STEAK: 80 degrees F. Room temperature. EI #6 agreed. BBQ SHREDDED PORK CHOP: 94 degrees F. Warm. On 3/11/20 at 2:44 PM, the surveyor asked the Dietary Manager (EI #6) if she had completed any Food Satisfaction Surveys of the the residents over the past six months. EI #6 stated she had, but not very many residents complained. She affirmed RI #25 had complained the food was cold, but would not eat it when it arrived and refused to have it reheated. EI #6 stated that RI #6 had also complained about cool food temperatures. When asked if the cook had the ovens turned on, EI #6 stated the temperatures were usually on low, like a warming temperature. The surveyor asked how often she conducted a test tray and what their goal temperature would be (for the residents). EI #6 responded she had never done a test tray, but would like to make sure the temperatures were staying warm. EI #6 stated the goal temperature was 120 degrees F.
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 observations, interviews and review of facility policies Handwashing/Hand Hygiene and Food Safety Requirements, the facility failed to ensure: 1. facility staff did not transport foods to residents on the halls during an activity, uncovered and using the same glovesbetween resident food distribution, and 2. during incontinent care for Resident Identifier (RI) #10, a Certified Nursing Assistant (CNA) washed her hands between glove changes, two CNAs did not touch clean linens and briefs with soiled gloves, and a CNA did not leave a resident room without washing her hands, enter a linen closet to get a clean brief then return to the resident room. This was observed on 3/10/20 and affected seven of seven residents receiving ice cream and cake during the afternoon activity, and one of one residents observed for incontinent care. Findings Include: 1. A review of a facility policy titled Food Safety Requirements date 2019, revealed, . Policy Explanation and Compliance Guidelines: . 5. Foods and beverages shall be delivered to residents in a manner to prevent contamination. . a. Covering all foods with lids or plate covers. . c. Washing hands properly before distributing . d. Washing hands between contact with residents . On 3/10/20 at 1:42 PM, the surveyor observed a staff person pushing a gray cart with 10 bowls of ice cream and cake on it down the 100 hall. The bowls of ice cream and cake were uncovered. The staff person had on blue gloves, she entered a resident room and placed a bowl on the overbed table. She returned to the gray cart with 9 bowls of ice cream and cake uncovered. Wearing the same gloves, she rolled the cart to another room and placed a bowl of ice cream and cake on the overbed table then left the room. She returned to the cart with eight bowls of ice cream and cake, wearing the same gloves she rolled the cart and entered another room, took a bowl of ice cream and cake inside the room and placed it on the overbed table. She left the room, returned to the gray cart with seven bowls of ice cream and cake remaining on the cart uncovered and wearing the same gloves, rolled the cart to the back hall (200 hall) and went in and out of four more rooms delivering uncovered ice cream and cake in bowls while wearing the same gloves. The surveyor observed three bowls remaining on the cart and asked her who received the ice cream and cake. She replied, some that did not attend the monthly birthday party in the activity room so she took it to their rooms. On 3/10/20 at 2:00 PM, an interview was conducted with Employee Identifier (EI) #4, medical records clerk. She was the staff person helping with the activity; she delivered the ice cream and cake to the residents that did not attend the group activity. EI #4 was asked, how many ice cream and cakes did she deliver. EI #4 replied, she had 10 but only gave out seven bowls. EI #4 was asked, how were the bowls covered. EI #4 replied, they were not. EI #4 was asked, where did she deliver the bowls of cake and ice cream to. EI #4 replied, residents on the front (100 hall) and back (200) halls. EI #4 was asked, what should be done to food being delivered on the halls. EI #4 replied, it should have a cover over it. EI #4 was asked, when should she change gloves when delivering food or care to a resident. EI #4 replied, every time she came out of a room she should have washed her hands and put on clean gloves. EI #4 was asked, how many times did she change gloves when exiting the resident rooms that she took ice cream and cake into. EI #4 replied, she did not, she had on the same gloves. EI #4 was asked, what was the potential harm in delivering the ice cream and cake to the residents on the hall uncovered. EI #4 replied, something in the air could get on the food and contaminate it. EI #4 was asked, what was the potential harm in using the same gloves to go in and out of seven residents rooms. EI #4 replied, she touched the cart and it may not have been clean, and she may have touched something in those residents rooms to which she could have contaminated the food. 2. A review of a facility policy titled Handwashing/Hand Hygiene, revised date August 2019, revealed, Policy Statement This facility

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 -** Few	(continued... from page 1) considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. .7. . b. Before and after direct contact with residents; . j. After contact with blood or bodily fluids; . m. After removing gloves. . 9. The use of gloves does not replace handwashing/hand hygiene. . RI #10 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. On 3/10/20 at 4:11 PM, the surveyor observed RI #10 yelling help me. Staff entered the room to comfort the resident. RI #10 was found incontinent of urine and bowels. On 3/10/20 at 4:20 PM, the surveyor observed incontinent care performed by EI #3, CNA and EI #2, CNA. EI #3 brought wipes into the room and placed a bag on the foot of the bed. EI #2 brought clean linens and a brief into the room and placed two bags open in the chair beside the bed. EI #3 turned RI #10 to the left side. EI #2 removed the linens from one side of the bed rolling towards the middle of the bed and placed the clean bottom sheet. EI #2 assisted in removing RI #10's pants and wet soiled brief. EI #2 wiped the bowel movement (bm) from the buttock area, changed gloves and with out washing her hands put on clean gloves, then wiped the front area and the buttock again until clean from the bm. EI #2 prepared the draw sheet, cloth pad and clean brief and placed them on top of the bottom sheet then under RI #10. Both CNAs turned RI #10 to the right side. EI #3 removed the soiled linens from the bed. EI #3 placed the clean linens to the other side of the bed and under RI #10 with the same gloves she handled the soiled linens. Upon turning RI #10 to the back position they noted RI #10 to have soiled the clean brief. EI #2 removed her gloves and left the room without washing her hands. The surveyor followed EI #2 to the clean linen closet. EI #2 got a clean brief from the shelf, and returned to RI #10's room. EI #2 opened the clean brief and placed it on the bed beside RI #10. EI #2 put on gloves, cleaned the bm from RI #10 again, then with the same gloves placed the clean brief under RI #10. EI #2 did not wash her hands between gloves changes, after touching soiled linens and a soiled brief, before touching clean linens and a clean brief, and EI #2 did not wash her hands before leaving the room and going to the linen closet. When EI #2 returned to the room she put on gloves and cleaned the resident again and placed the second clean brief without washing her hands or changing gloves. EI #3 removed the soiled linens from the bed then with the same gloves placed the clean linens over the bed. On 3/10/20 at 4:50 PM, an interview was conducted with EI #2, CNA. EI #2 was asked, when should they wash hands during incontinent care. EI #2 replied, every time they changed gloves. EI #2 was asked if she washed her hands every time she changed gloves. EI #2 replied, no. EI #2 was asked, why did she not wash hands after changing gloves. EI #2 replied, she put on clean gloves. EI #2 was asked, when should she touch clean linens and a clean brief with soiled gloves. EI #2 replied, they should not, they should wash hands after cleaning and changing gloves before putting on clean gloves. EI #2 was asked, how was the resident soiled. EI #2 replied, wet and bowel movement. EI #2 was asked, when should she leave a room without washing her hands. EI #2 replied, they should not. EI #2 was asked, when should she go into a clean linen closet without washing her hands. EI #2 replied, she should not. EI #2 was asked, what was the harm in changing gloves without washing hands. EI #2 replied, could cause contamination. EI #2 was asked, what was the harm in leaving the room and going into the linen closet without washing her hands. EI #2 replied, could contaminate the linens in the closet. EI #2 was asked, what was the harm in touching the clean linens and clean brief with the same soiled gloves she had on to clean the resident. EI #2 replied, could have had something on the gloves then contaminate the clean linens and could cause infection. On 3/11/20 at 3:30 PM, an interview was conducted with EI #3, CNA. EI #3 was asked, when should she wash her hands while helping with incontinent care. EI #3 replied, if she touched dirty. EI #3 was asked, when should she remove dirty linens and a soiled brief from the bed then with the same gloves place the clean linen on the bed. EI #3 replied, she should have taken the wet linen off then removed her gloves, washed her hands, put on clean gloves, then pulled the clean sheet over the bed. EI #3 was asked, what was the harm in removing the soiled linen, then with the same gloves placing the clean sheet over the bed. EI #3 replied, she could contaminate the clean linens. On 3/12/20 at 9:32 AM, an interview was conducted with EI #1, Licensed Practical Nurse, Infection Control. EI #1 was asked, when should staff go in and out of several resident rooms wearing the same gloves. EI #1 replied, never. EI #1 was asked, when should staff transport and deliver activity food on halls uncovered. EI #1 replied, never. EI #1 was asked, what was the harm in staff going in and out of several resident rooms while wearing same gloves. EI #1 replied, possible contamination. EI #1 was asked, what was the harm in activity staff transporting and delivering food to residents on the halls uncovered. EI #1 replied, contamination. EI #1 was asked, when should staff change gloves during incontinent care. EI #1 replied, they should wash hands before starting then put on gloves, after removing soiled brief and cleaning the resident, remove gloves and wash hands put on clean gloves before placing clean linens and the brief. EI #1 was asked, when should staff wash hands during incontinent care. EI #1 replied, anytime gloves are removed, after cleaning the resident, after handling soiled items, before placing clean linens and the brief, and when the procedure was completed they should wash their hands before leaving the resident room. EI #1 was asked, what should staff do after handling dirty linen and soiled briefs. EI #1 replied, remove their gloves, wash their hands, and put on new gloves, then place the clean linen and brief. EI #1 was asked, what should staff do before handling clean linen and clean a brief. EI #1 replied, wash their hands, and put new gloves on. EI #1 was asked, when should staff touch clean linens and a clean brief with the same gloves used to clean the resident. EI #1 replied, never. EI #1 was asked, what should staff do if they have to leave a resident room for more supplies. EI #1 replied, remove the gloves, wash their hands then leave the room. EI #1 was asked, when should staff leave a resident room and enter the linen closet without hand washing. EI #1 replied, never. EI #1 was asked, what would the potential for harm be in staff touching clean linen and briefs with soiled gloves. EI #1 replied, contamination. EI #1 was asked, what would the potential for harm be in staff leaving a resident room without washing their hands, then entering the linen closet for more supplies. EI #1 replied, contamination.