STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015089	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN NURSING HOME	100 SANDERS DRIVE EVERGREEN, AL 36401

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** - Few	**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, a facility policy titled, Assisting the Impaired Resident with In-Room Meals and a facility document titled, Inservice Dignity and Respect, the facility failed to ensure a CNA (Certified Nursing Assistant) did not stand while feeding RI (Resident Identifier) #46 the lunch meal on 03/10/20. This deficient practice affected RI #46, one of four sampled residents who required assistance with feedings. Findings Include: A review of a facility policy titled, Assisting the Impaired Resident with In-Room Meals, with no date revealed the following: Policy: The purpose of this procedure is to provide a well-balanced meal to the resident who needs assistance with eating . Procedure: . 3 . be seated during the feeding, position a chair where it will be convenient for you and the resident, providing resident dignity . A review of a facility document titled, Inservice Dignity and Respect, with no date, revealed the following: . the facility must promote care for residents in a manner . that maintains or enhances each resident's dignity . Promoting resident . dignity in dining such as avoidance of: . Staff standing over residents while assisting them to eat: . RI #46 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. RI #46's Care Plan revealed the following: Problem Onset 10/3/14 . ADL's (activities of daily living) Resident requires assist w/(with) . eating . Approaches .* Provide assistance with meals . On 03/10/20 at 12:20 p.m., the surveyor observed EI (Employee Identifier) #1 standing up while feeding RI #46, while the resident was sitting on the side of the bed. On 03/10/20 at 12:39 p.m., an interview was conducted with EI #1, a CNA. EI #1 was asked did she feed EI #46 his/her lunch meal. EI #1 said yes. EI #1 was asked what position was she feeding RI #46. EI #1 said she was standing. EI #1 was asked what was she taught about feeding residents. EI #1 said to sit down on the side of them (resident), pay attention to them and make sure they are offered everything on the tray. EI #1 was asked what position should she have been in when feeding the resident. EI #1 said she should have been sitting in front of, or on the side of RI #46. EI #1 was asked why was she standing feeding RI #46. EI #1 said there was no chair so she just stood up. EI #1 was asked what was the concern with standing up feeding a resident, would it be a dignity concern. EI #1 said yes it would be a dignity issue. On 03/12/20 at 2:25 p.m., an interview was conducted with EI #2, RN (Registered Nurse), Staff Development Coordinator. EI #2 was asked how were CNAs trained to assist the residents with feeding. EI #2 said they were trained to sit down to feed residents, for safety purposes of the residents. EI #2 was asked what position should the CNA be in when feeding residents. She said sitting down facing the resident. EI #2 was asked should staff be standing feeding a resident. She said no. EI #2 was asked what was the concern with the CNA standing while feeding a resident. EI #2 said it is a dignity concern.
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 and interviews, the facility failed to ensure Resident Identifier (RI) #6 had an isolation sign outside of the door. This affected RI #6, one of one resident observed on isolation. Findings include: RI #6 was admitted to the facility on [DATE] and readmitted on [DATE]. RI # 6 had a [DIAGNOSES REDACTED]. On 03/10/20 at 3:29 p.m., an observation was made of RI #6's room, an isolation cart containing gloves, mask, and gowns were outside of the room. No observed isolation sign on the door indicating the type of isolation such as contact, airborne, or droplett the resident was on, or what staff/visitors should do before entering the room. On 03/11/20 at 9:09 a.m., an observation was made of RI #6's room, an isolation cart (remained) outside of the room. Still no observed isolation sign on the door indicating the type of isolation the resident was on, or what staff/visitors should do before entering the room. On 03/12/20 at 8:09 a.m., an observation was made of RI #6's room, an isolation cart remained outside of the room. No observed isolation sign on the door indicating the type of isolation the resident was on, or what staff/visitors should do before entering the room. On 03/12/20 at 1:29 p.m., an interview was conducted with Employee Identifier (EI) #3, Unit Manager. EI #3 was asked, who was the unit manager on the hall where RI #6 was. EI #3 replied, she was. EI #3 was asked, what kind of precautions was RI #6 on. EI #3 replied, on contact isolation. EI #3 was asked, why was the resident on these precautions. EI #3 replied, the resident had ESBL positive urine. EI #3 was asked how staff knew what precautions the resident was on. EI #3 replied there was a sign, it was on the care plan, it was in the books. The resident had a door hanger and they changed it out, she thought that they must have taken it off when they took it because it was attached to it. EI #3 was asked, how do visitors know what to do. EI #3 replied, usually the only visitor the resident had was her/his sister and she came once or twice a week and has been told what to do. EI #3 was asked, was there a sign on the door. EI #3 replied, no. EI #3 was asked, where was the sign for the door. EI #3 replied she did not know but it had been there. EI #3 was asked, should there be a sign. EI #3 replied, yes. EI #3 was asked, why was there not a sign for the door. EI #3 replied it obviously came off the door. EI #3 was asked, who was responsible for ensuring there was a sign on the door. EI # 3 replied that would be every personnel in this building. EI #3 was asked what was the potential concern of not having a sign outside of a resident's room that was on transmission-based precautions. EI #3 replied, that someone may come in and get contaminated and expose it to someone else. On 03/12/20 at 1:46 p.m., an interview was conducted with EI #4, Infection Control Nurse. EI #4 was asked, what kind of precautions was RI #6 on. EI #4 replied, on contact isolation. EI #4 was asked, why was the resident on these precautions. EI #4 replied the resident had ESBL in the wound and urine. EI #4 was asked, how did staff know what precautions the resident was on. EI #4 replied it was posted on the door, and every time they put residents on precautions they did in-services. EI #4 was asked, how did visitors know what precautions the resident was on. EI #4 replied when they first put the resident on precautions they contacted them and let them know. EI #4 was asked, where was the sign for the door. EI #4 replied usually they put it on the door and it was under the resident's name. EI #4 was asked, should there be a sign. EI #4 replied yes. EI #4 was asked, why was there not a sign for the door. EI #4 replied, she did not know if it fell off, she really did not know, but there was a sign on the door. EI #4 was asked, who was responsible for ensuring there was a sign on the door. EI #4 replied all staff really, she was the infection control person, so she initiated it. EI #4 was asked, what was the potential concern of not having a sign outside of a resident's room that was on transmission-based precautions. EI #4 replied that someone entering into that room without the proper Personal Protective Equipment (PPE) could cause a visitor or another resident to get what that resident had.

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.