STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105408	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TREASURE ISLE CARE CENTER	**1735 N TREASURE DRIVE NORTH BAY VILLAGE, FL 33141**

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** - Some	**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 observations, interviews and records review, the facility failed to ensure soiled dishes are handled in a sanitary manner. As evidenced by food trays with soiled dishes and utensils were left on the floor/ground in front of the kitchen door inside the facility. This facility's deficient practice has the potential to increase the risk of an insect and rodent manifestation. There were 166 residents residing in the facility at the time of the survey The findings include: On 09/22/2020 at 5:45 AM, during a tour of the facility two piles of food trays with soiled dishes and utensils were observed on the floor outside of the kitchen door inside the facility. (Photograph evidence). On 09/22/2020 at 6:20 AM, during an interview Staff A, Dietary Aide revealed that sometimes she saw one or two roaches in the kitchen. Staff A stated that the kitchen staff left food racks outside the kitchen for staff to place dirty dishes during the nighttime, but sometimes the staff left the soiled food trays on the floor near the kitchen door. Staff A stated that the dirty dishes should not be left on the floor. On 09/22/2020 at 6:30 AM, Staff B, Cook revealed that, sometimes the night shift staff left the dirty dishes on the floor in front of the kitchen door. Staff B reported that the dirty dishes should not be left on the floor. Staff B explained that the kitchen staff leaves a rack for staff to put the food trays with soiled dishes. On 09/22/2020 at 6:38 AM, the Food Manager revealed that the facility has a cleaning schedule and a pest control schedule. The kitchen is opened at 5:00 AM and closed at 8:00 PM. The food trays with dirty dishes from the night shift are left outside the kitchen. The Food Manager was asked about the dirty dishes and food trays observed on the floor by the surveyor. The Food manager stated that should not happen and stated It is not good On 09/22/2020 at 7:17 AM, Staff C, Certified Nursing Assistant (CNA) revealed that sometimes they had 2 to 3 food trays left and they put them in a plastic bag. Staff C stated that they had a meeting because they did not want staff to put the food trays on the floor, outside of the kitchen during the night. Review of in-service training record dated 9/1/2020 revealed, an in-service was presented by the Infection Control Preventionist (IP)/Assistant Director of Nursing (ADON) to all Certified Nurse Assistants (CNAs), Licensed Practical Nurses (LPN) and Registered Nurses (RN). The program content indicated : No trays should be left on top of Dietary cart after resident have completed their meals all soiled trays should be removed and returned on Dietary cart and taken back to Dietary Department. No trays should be left on floors. Review of the facility's pest control reports revealed that the pest control company came to the facility on [DATE]. Pest activity was found during service in the kitchen area interior cockroaches noted. Sanitation issues that could cause pest problem was also noted (Yes). On 9/19/2020 the pest control company was in the facility, the report indicated pest activity was found during service in residents' rooms. The report also indicated that no structural concerns that could cause pest problems.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to maintain a safe environment as evidenced by gas odor noted in the kitchen due to outage of the grill's pilot light. In addition, the facility failed to ensure a reported concern from staff regarding a gas smell was properly addressed. This facility's deficient practice has the potential to affect any of 166 residents residing in the facility at the time of the survey. The findings include: Review of the facility's Policy & Procedure Topic for Safety, dated September 2020, revealed: the facility promotes an optimal safe work environment in daily work routines and equipment operation. Food and Nutrition Services follows the Occupational Safety and Health Administration (OSHA) standards. Safety precautions are followed during use of kitchen equipment. Record review revealed on 8/26/2020, an equipment servicing company conducted a gas leak investigation in the kitchen. The report completed by the equipment company for the kitchen dated 8/26/2020 revealed, no gas leak was observed no ignition light flashing, so this was an assumed leak. Unit working at this time, but I have suggested parts to solve the issue. Review of report by an equipment servicing company dated 09/03/2020, indicated repair work was done to the top oven. On 09/22/2020 at 6:19 AM, during observation of the kitchen, the Cook,(Staff B) was preparing breakfast. The surveyor noted a gas odor and Staff B acknowledged the odor. On 09/22/2020 at 6:30 AM, Staff B, stated that the gas smell noted in the kitchen was because the vent was off. Staff B proceeded to show the surveyor how the vent was turned on and off. On 09/22/2020 at 6:38 AM, the Food Manager reported being called once by staff regarding a gas smell in the kitchen, but nothing was turned on in the kitchen and the Fire Department did not find anything in the kitchen. On 09/22/2020 at 9:06 AM, Staff D, a Certified Nursing Assistant (CNA) revealed that she smelled gas in the facility the week before on a Saturday and reported it to Staff F, a Licensed Practical Nurse (LPN). On 09/22/2020 at 9:29 AM, during a telephone interview Staff F, Licensed Practical Nurse (LPN) revealed that a CNA had reported a gas smell but it was not in September. Staff F stated that she went to the supervisor (Staff G) and reported it, and they called maintenance and the kitchen. On 09/22/2020 at 12:18 PM, during telephone interview in the presence of the Director of Nursing and infection Preventionist, the supervisor (Staff G) stated that she never had a staff that complained about gas smell and she had never heard anything about that. On 09/22/2020 at 12:42 PM, the Administrator and the Maintenance Assistant were informed of the concerns related to the gas odor. The Maintenance Assistant stated that in the morning, the Cook (Staff B) told him that they had a gas smell in the kitchen because the pilot light was out. The Administrator revealed that, the Fire Department came to the facility on [DATE] and no report was left, because no problems were found in the kitchen. The Administrator stated that on 8/26/2020, a gas leak investigation by an equipment servicing company was done to check the pilot light and everything was okay. On 09/22/2020 at 1:20 PM, Staff B reported that as soon the surveyor left the kitchen in the morning with concerns about the gas smell, the pilot light was checked and it was noted that the right pilot light of the grill was out.

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.