STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675037	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PITTSBURG NURSING CENTER	123 PECAN GROVE PITTSBURG, TX 75686

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 interview and record review the facility failed to ensure the right to formulate an advance directive was provided for 1 of 2 residents reviewed for advanced directives. (Resident #19) The facility did not have a valid Out of Hospital Do Not Resuscitate (OOH-DNR) form for Resident #19. This failure could place residents at risk of having life prolonging measures performed against their wishes. Findings included: A physician order [REDACTED].#19 was a [AGE] year-old female readmitted [DATE] and had [DIAGNOSES REDACTED]. A physician order [REDACTED].#19 was a DNR. An OOH-DNR dated [DATE] for Resident #19 had an adult child marked as the person making the decision for the DNR but did not have a signature, date signed, or printed name. During an interview on [DATE] at 10:43 a.m. the administrator said she did the OOH-DNRs. She said the OOH-DNR had to filled out completely or it was not valid. She said with Resident #19's son not signing or dating her DNR it was not valid and therefore the resident was not able to formulate an advance directive. An undated Living Will/Advance Directives policy indicated: Procedure: 1. Follow State Regulations An OOH-DNR form accessed at https://dshs.texas.gov/emstraumasystems/dnr.shtm on [DATE] indicated: Figure: 25 TAC 157.25 (h)(2) OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER TEXAS DEPARTMENT OF STATE HEALTH SERVICES C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's: spouse, adult child, parent, OR nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code 166.088. To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation. Signature_____ Date _____ Printed Name_____
F 0644 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments for the PASARR (Pre-Admission Screening and Resident Review) program for 1 of 4 residents reviewed for PASARR. (Resident #25) The facility did not submit THHS Form 1012 for Resident #25 after the she was diagnosed with [REDACTED]. This failure could place residents with mental illness at risk for not receiving appropriate services and decreased quality of life. Findings included: A Physician order [REDACTED].#25 was a [AGE] year-old female admitted [DATE] and had [DIAGNOSES REDACTED]. A significant change MDS dated [DATE] indicated Resident #25 had an active [DIAGNOSES REDACTED].#25 had a [DIAGNOSES REDACTED]. A PASRR level 1 Screening dated 11/18/19 indicated Resident #25 had no mental illness. The clinical record dated 11/08/19 through 03/04/20 for Resident #25 did not indicate a PASRR Evaluation was completed. During an interview on 03/04/19 at 10:20 a.m. the MDS nurse said she was responsible for the PASRRs. She said the [DIAGNOSES REDACTED]. She said she thought she already filled out the form for the resident to be evaluated by the local mental health authority but evidently did not because there was nothing in the LTC portal. An undated PASRR policy did not address what the facility was to do if a resident who admitted with a negative PASRR was later diagnosed with [REDACTED].
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary services to maintain acceptable personal hygiene and grooming for 2 of 25 residents reviewed for ADL's. (Resident #45 and Resident #7) The facility did not clean and trim Resident #45's fingernails. The facility did not clean Resident #7's hair and fingernails and provide hygiene to prevent body odors. This failure could place dependent residents who require assistance from staff for personal hygiene at risk of not receiving care and services to meet their needs, infections or decreased quality of life. Findings included: 1. Physicians orders dated 2/4/2020-3/4/2020 indicated Resident #45 was [AGE] years old, admitted [DATE] and had [DIAGNOSES REDACTED]. The MDS dated [DATE] indicated Resident #45 was understood and usually understood others. The MDS indicated Resident #45 required 2+ persons physical assist for transfers and required the extensive assistance of 1 person for personal hygiene including combing hair, brushing teeth, shaving, and washing/drying face and hands. The care plan dated 3/4/2020 indicated Resident #45 had ADL selfcare performance deficit including bed mobility, transfers, eating, bathing, dressing, and personal hygiene. During an observation on 3/3/2020 at 8:42 a.m., Resident #45 was sitting up in his wheelchair and had long nails approximately 0.5 cm in length with a black substance noted under the nails. During an observation on 3/4/2020 at 10:38 a.m., Resident #45 was sitting up in his wheelchair and the nails on both hands were approximately 0.5 cm in length with a black substance noted under the nail. During an interview on 3/4/2020 at 10:40 a.m., CNA E said Resident #45 did not have a history of refusing care. She said CNA's provided nail care unless the resident was diabetic then the nurse had to provide the nail care. During an interview on 3/4/2020 at 10:47 a.m., the RN O said resident #45 never refused to allow him to provide care. RN O said the CNA's provided nail care on the weekend shift. During an interview on 3/4/2020 at 12:42 p.m., CNA G said the CNA's provided nail care on the weekends and as needed. During an interview on 3/4/2020 at 12:58 p.m., CNA H said she provided nail care for non-diabetic residents on their shower days. She said Resident #45 would occasionally refuse showers but was not aware of him refusing to have nails cleaned or trimmed. During an interview on 3/4/2020 at 1:09 p.m., the DON said nails should be cleaned and trimmed when needed. All aides and nurses should be providing nail care for residents. During an interview on 3/4/2020 at 1:26 p.m., the administrator said she expected that the nurses and aides to keep residents' nails clean and trimmed unless the resident refused the care. 2. A Physician order [REDACTED].#7 was a [AGE] year-old male admitted [DATE] and had [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #7 had minimal difficulty hearing, had clear speech, could make himself

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) understood, could usually understand others, had moderately impaired cognition, had no behavior of rejection of care, required extensive assistance of 1 person for dressing and personal hygiene, required physical help of 1 person in part of bathing activity, and was frequently incontinent of bladder and bowel. A care plan dated 12/10/19 indicated Resident #7 had an ADL Self Care Performance (Bed Mobility, Transfers, Eating, Bathing, Dressing, and Personal Hygiene) with the following interventions: *Dressing: Resident needs supervision assistance with dressing, encourage and allow resident to make decision about clothing to wear, offer 1-2 item weather appropriate choices as needed, provide verbal cue and encouragement for him to complete tasks. * Personal Hygiene: Check nail length and trim and clean per facility guidelines and as necessary * Personal Hygiene: independent/supervision with personal hygiene; ensure that hygiene items are available for use; provide reminders, verbal cue and encouragement as needed * Showering/Bathing: Resident required physical assistance with part of bathing/showering, provide showers/bathing per schedule and as needed, provide for dignity as safety allows, encourage and allow resident to bath self as able and provide assistance as needed to complete. *The care plan did not indicate Resident #7 refused care. During an observation and interview on 03/02/20 at 09:48 a.m. Resident #7 was in bed. He was disheveled. His nails were approximately 1cm long, jagged and were dirty; his hair was oily and he had a strong lingering body odor. He said he was not happy being here and his daughter won't let him go home. He would not respond when asked about his care. During an observation on 03/02/20 at 02:56 p.m. Resident #7 was walking through the dining room. He had a strong lingering body odor; his finger nails were untrimmed, jagged, and dirty; and his hair was oily. He was wearing blue plaid pajama bottoms and a blue shirt with a red t-shirt over the blue one. During an observation on 03/03/20 at 10:09 a.m. Resident #7 had a strong lingering body odor; his fingernails were untrimmed, jagged, and dirty; his hair was oily; and he was wearing the same plaid pajama bottoms and blue shirt as the day before. During an observation on 03/03/20 at 04:01 p.m. Resident #7 was sitting in the front lobby with a strong lingering body odor; his fingernails were untrimmed, jagged, and dirty; his hair was oily; and he was wearing the same plaid pajama bottoms and blue shirt. During an observation on 03/04/20 at 09:24 a.m. Resident #7 was outside smoking. He had a strong lingering body odor; his fingernails were untrimmed, jagged, and dirty; his hair was oily; and he was wearing the same plaid pajama bottoms and blue shirt he wore the last 2 days. During an interview on 03/04/20 at 09:26 a.m. CNA A said he refused showers at times. She said he had a skin condition on his left hand and did not like staff touching his hand. CNA A she clicked his shower on 03/03/20 in the computer because the shower aide was going to shower him but he refused. She said the documenting system would not allow her to correct it. The clinical record dated 02/04/20 through 03/04/20 for Resident #25 did not indicate any documentation of refusal of showers. During an interview on 03/04/20 at 01:09 p.m., the DON said nails should be cleaned and trimmed when needed. All aides and nurses should be providing nail care for residents. An undated policy titled Care of fingernail and toenails indicated it was the responsibility of the licensed nurse and nursing assistant to provide the nail care. The policy indicated the purpose of the policy was as follows: to clean the nail bed, to keep nails trimmed, and to prevent infection; To aid in the prevention of skin problems around the nail bed; to prevent accidental scratching and injuring skin from rough/jagged nails.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure [MEDICAL TREATMENT] service was provided consistently with professional standards for practice for 1 of 1 resident reviewed for [MEDICAL TREATMENT] services. (Resident #45) The facility did not make alternate arrangements for transportation when the facility van was not available to transport Resident #45 to [MEDICAL TREATMENT]. This failure could place residents who receive [MEDICAL TREATMENT] at risk for complications and not receiving proper care and treatment to meet their needs. Findings included: Physicians orders dated 2/4/2020-3/4/2020 indicated Resident #45 was [AGE] years old, admitted [DATE] with [DIAGNOSES REDACTED]. The orders indicated Resident #45 went to [MEDICAL TREATMENT] on Mondays, Wednesdays and Fridays. The most recent MDS dated [DATE] indicated Resident #45 was understood and usually understood others. The MDS indicated Resident #45 required 2+ persons physical assist for transfers. The MDS indicated Resident #45 had a [DIAGNOSES REDACTED]. The care plan dated 3/4/2020 indicated Resident #45 had an ADL selfcare performance deficit including bed mobility, transfers, eating, bathing, dressing, and personal hygiene. The care plan indicated Resident #45 required a mechanical sling lift for transfers when having increased weakness. An undated face sheet indicated Resident #45's daughter was designated as his responsible party and emergency contact. A progress note dated 2/26/2020 at 11:00 a.m. indicated the transport van had not returned(NAME)to transport Resident #45 to his [MEDICAL TREATMENT] treatment. The progress note indicated the RN O called the [MEDICAL TREATMENT] center and requested a later appointment. A progress note dated 2/26/2020 at 12:56 p.m. indicated the RN O spoke with the [MEDICAL TREATMENT] center and a later chair time was not available the same day and the [MEDICAL TREATMENT] center would call back to set up an appointment for Saturday. The progress note indicated Resident #45's daughter was notified. A progress note dated 2/26/2020 at 1:28 p.m. indicated the [MEDICAL TREATMENT] center called the facility and rescheduled Resident #45's [MEDICAL TREATMENT] appointment for Saturday at 11:50 a.m. and he would also have [MEDICAL TREATMENT] on Friday. The note indicated the daughter was notified. During an interview on 3/2/2020 at 10:52 a.m., RN O said the facility currently only had one working van. He said last week the one working van had to transport a resident to(NAME)and did not make it back in time to transport a resident to [MEDICAL TREATMENT]. RN O said he contacted the [MEDICAL TREATMENT] center to try and get the resident a later appointment for the same day but was unable. The RN said the [MEDICAL TREATMENT] center rescheduled Resident #45's appointment for Saturday of that week and that he notified the residents family of the change. During an interview on 3/4/2020 at 1:12 p.m., the DON said if a resident could safely be transferred into a personal vehicle she would transfer the resident to an appointment if the van was not available once receiving permission from corporate office. She said Resident #45 sometimes had days where he was weaker than others and may not be safe to transfer into a car. During an interview on 3/4/2020 at 1:13 p.m., the corporate nurse said the facility could get permission to use a personal care very quickly and could assess the resident and if able to transfer to private vehicle could be taken to their appointment. During an interview on 3/4/2020 at 1:27 p.m., the administrator said if there was enough time allotted between the time the facility knew the van was not going to be available and the time the resident had to leave for their appointment the facility could attempt to get medical transportation to pick up the resident. The administrator said the facility could ask for permission from the corporate office to transport a resident to an appointment by personal vehicle if the resident was capable of being transported by car. The administrator said she was made aware of the situation that occurred last week when the van was unavailable to transport Resident #45 to [MEDICAL TREATMENT] approximately one hour prior to his scheduled [MEDICAL TREATMENT] appointment. The administrator said she could have contacted the family to see if they could assist with transporting the resident to [MEDICAL TREATMENT]. A contract titled SNF Outpatient [MEDICAL TREATMENT] agreement dated 6/24/2019 indicated the nursing facility shall be responsible for arranging for suitable and timely transportation of the resident to and from the [MEDICAL TREATMENT] unit, including the selection of the mode of transportation, qualified personnel to accompany the resident, transportation associated with this type of transfer or referral in accordance with the applicable federal and state laws and regulations and all costs or transportation expenses associated with such transfer. An undated policy titled Transportation policy indicated in a non-emergency, when the facility vehicle, transportation service or taxi is unavailable, the facility may obtain authorization to use an employee vehicle for resident transport for medical purposes . An undated policy titled [MEDICAL TREATMENT] indicated the resident may be transferred in private vehicle, by ambulance, or by the facility as policy allows. The facility was asked for additional information at exit, no additional information was provided.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, interview, and record review, the facility failed to ensure the menu was followed for 1 of 1 meal reviewed for menus and nutritional adequacy. (Lunch meal 03/03/20) Cook B did not serve the correct portion size of braised beef tips with gravy to residents receiving regular diets. This failure could place residents at risk for weight loss and altered nutrition. Findings included: The planned menu dated 03/03/20 for the noon meal was braised beef tips with gravy, buttered parsley noodles, black-eyed peas, slice of bread, and pineapple upside down cake for dessert. Cornbread was substituted for sliced bread for regular and mechanical soft diets. The diet spreadsheet for 03/03/20 indicated the portion size for the braised beef tips with gravy on the regular diet was a 6-ounce (oz) serving. During an observation of the meal

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F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) service on 03/03/20 at 11:54 a.m. Cook B placed the serving utensils into the food items on the steam table. She said the utensil used to serve the regular diet beef tips with gravy was a 4 oz. serving. During an observation and interview on 03/03/20 at 12:15 p.m. Cook B was serving the regular diets a 4 oz. serving of braised beef tips with gravy. During an interview on 03/03/20 at 12:15 p.m. The DM reviewed the diet spreadsheet and said the serving size was supposed to be a 6 oz serving. Cook B said she would have run out of the braised beef tips with gravy if she served a 6 oz. serving because there was not enough prepared.
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, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the kitchen. The facility did not prevent the following: * the milk box had 4 gallons of expired milk; and * 3 large muffin pans and 1 small muffin pan were stacked together with carbon build up on them. This failure could place residents who ate food from the kitchen at risk of foodborne illness. Findings included: During an observation and interview on [DATE] at 08:45 a.m. there were 4 gallons of whole milk with an expiration date of [DATE] in the milk box. The DM said the milk was delivered before they arrived and the delivery people did not check the milk on hand for expiration dates. During an observation and interview on [DATE] at 11:20 a.m. there were 3 large muffin pans and 1 half muffin pan stacked together. The bottom of the muffin cups had carbon buildup on them. The DM said they either needed to be scrubbed or replaced. According to the Texas Food Establishment Rules dated [DATE]: 228.113. Cleaning of Equipment and Utensils. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils. (1) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (2) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations
F 0849 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** Based on interview and record review, the facility failed to obtain communication from hospice for 1 of 2 residents reviewed for hospice records. (Resident #32) The facility did not have current clinical documentation of visits from the hospice service for collaborative care for Resident #32. This failure could affect residents receiving hospice care at risk of not receiving coordination of care and treatment. Findings included: The hospice chart for Resident #32 indicated the care plan for certification period starting 02/03/20 listed a skilled nurse visit 2 times a week; a hospice aide visit 3 times a week; and a social service visit 1 time a month. The hospice chart for Resident #32 indicated the last visit by a skilled nurse was on 02/08/20, the last visit by the hospice aide was on 01/24/20, and the last visit by the social worker was 11/21/19. During an interview on 03/04/20 at 01:13 p.m. the ADON said she did not know whose responsibility it was to audit the chart and ensure updated information was obtained from hospice. She said she did not know how often updated information was placed on the chart. A hospice contract dated 11/07/19 indicated 1. Responsibilities of Hospice: 1.03 Information/Documentation provided to Facility on admission and on-going: Copies of clinical notes after each visit .2. Responsibilities of the Facility: 2.07 Maintain an accurate medical record that included all services and events provided. All services will be furnished according to agreement. Required documentation provided by Hospice will be included in a designated area/section. Facility will ensure that these forms are not removed
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection control program to provide safe, comfortable, and sanitary environment to help prevent the development and transmission of disease for 1 of 2 residents reviewed for incontinent care (Resident #39), for 1 of 1 laundry room and 1 of 1 meal service in the dining area for infection control (Resident #47 and Resident #33). CNA N did not sanitize hands or change gloves throughout incontinent care. MA M did not wash or sanitize her hands between residents during medication pass. The facility staff did not intervene when Resident #47 took a drink from Resident #33's glass of tea. The facility did not maintain separation between the clean side and dirty side of the laundry room; provide a clean fan in the clean side of the laundry room; and did not keep clothing off of the PPE used for handling isolation laundry. This failure could place residents at risk for infection, illness and decreased quality of life. Findings included: 1.The consolidated physicians orders 2/4/20-3/4/20 indicated Resident #39 was [AGE] years old and admitted [DATE] with [DIAGNOSES REDACTED]. The MDS dated [DATE] indicated Resident #39 made herself understood and understood others. The MDS indicated Resident #39 required the extensive assistance of 1 person for personal hygiene and dressing and the extensive assistance of 2 persons for toileting. The care plan dated 2/28/2020 indicated Resident #39 had an ADL self-care performance deficit related to right leg fracture, weakness, and post-polio syndrome. During an observation on 3/3/2020 at 3:02 p.m., CNA N removed Resident #39's brief, cleaned the resident, discarded the dirty wipes and the dirty briefs and placed a clean brief on the resident without changing gloves and sanitizing hands throughout. During an interview on 3/3/2020 at 3:19 p.m., CNA J said when providing incontinent care, she normally washed her hands prior to the start of care, changed gloves and sanitized her hands when going from clean to dirty and washed her hands prior to leaving the room. During an interview on 3/4/2020 at 10:53 a.m., RN O said when providing incontinent care, the aides and nurses should wash their hands before and after the care and should remove their gloves and sanitize their hands when going from dirty to clean. During an interview on 3/4/2020 at 1:10 p.m., the DON said nurses and aides should wash their hands when entering the room, when going from dirty to clean and when leaving the room. 2. During an observation on 3/3/2020 at 2:29 p.m., MA M passed medications to 3 different residents on hall 6 without washing or sanitizing her hands between residents. During an interview on 3/3/2020 at 2:57 p.m., MA M said she washed her hands after every third resident when passing medications. She said she had washed her hands just prior to the surveyor coming to watch the medication pass. MA M said after she used hand sanitizer twice she washed her hands. During an interview on 3/2/2020 at 8:30 a.m., MA F said she sanitized her hands between each resident when passing medications and washed her hands with soap and water before and after medication pass and after every third resident. During an interview on 3/4/2020 at 1:10 p.m., the DON said that she expected both nurses and aides to wash their hands when entering a room, when moving from dirty to clean and when leaving a resident's room. An undated policy titled Hand washing indicated hand washing will be regarded by the facility as the single most important means of preventing the spread of infections. The policy indicated that hands should be washed for twenty seconds under the following conditions: Before preparing or handling medications. After contact with blood, body fluids, excretions, secretions, mucous membranes, or nonintact skin. After handling items potentially contaminated with blood, body fluids, excretions or secretions. After removing gloves and whenever in doubt. 3. During a dining observation on 03/02/20 at 12:11 p.m. Resident #47 was observed in the main dining room. She picked up her table mate Resident #33's glass of tea and drank some of the tea. She then put the glass down, mixed in sweetener, and gave the glass back to Resident #33 for her to drink. Several staff members in the dining room observed the exchange and did not get a new glass of tea for Resident #33. During an interview on 03/03/20 at 09:19 a.m. CNA A said Resident #47 said she was related to Resident #33. She said Resident #47 always did things like taste the tea and switch deserts. During an interview on 03/04/20 at 10:09 a.m. Resident #47 said she tasted Resident #33's tea because she complained it wasn't sweet enough. She said she had been in the hospital recently for respiratory infection and did not think about it when she tasted the tea. 4. During an observation and interview on 03/04/20 at 01:13 p.m. the LS indicated a material shower curtain separated the clean and dirty area in the laundry room. The shower curtain was twisted up and on top of the washer next to the opening between the clean and dirty areas. The LS said the shower curtain should not be opened and placed on top of the washer; she untwisted it and opened it up closing off the opening between the clean and dirty laundry. A box fan was in the dryer room pointing towards the opening between the clean and dirty side of the laundry room with dusty, dirty fan blades. The LS said the box fan needed to be taken and cleaned. A hooded sweatshirt jacket was hanging on the PPE utilized for isolation laundry. The LS said the jacket on the PPE and it should not be there.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3)
F 0908 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Keep all essential equipment working safely.** Based on observation and interview, the facility failed to maintain all mechanical and electrical equipment in safe operating condition for 1 of 1 kitchen stoves reviewed for equipment. (4 of 6 burners) The facility did not ensure 1 of the burners on the commercial gas range functioned properly. Findings included: During an observation and interview on 03/02/20 at 08:55 a.m. the middle 2 and right 2 burners on the stove would not light when the knobs were turned on. During an observation and interview on 03/03/20 at 11:32 a.m. the middle back burner and the 2 right burners on the stove would not light. During an observation and interview on 03/03/20 at 11:50 a.m. the maintenance director was trying to light the pilot light on the 2 right burners. He said the pilot would not light. During an interview on 03/04/20 at 03:39 p.m. the administrator said they had ordered the part needed for the stove burners.