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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015133	A. Building B. Wing	02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Ridge	420 Dean Drive Gardendale, AL 35071

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33415 Based on interviews and review of Resident Identifier (RI) #52's medical record, the facility failed to notify the physician of bruising on RI #52's inner right groin area in a timely manner. On 1/4/2018, it was documented RI #52 had bruising on the right inner groin area, that continued to spread. Five days later, on 1/9/2018, the bruising was reported to the physician, at which time he ordered X-rays that revealed a fractured femur. This affected RI #52, one of one sampled residents reviewed for notification. Findings include: RI #52 was admitted to the facility on [DATE] with a primary diagnosis of Late Onset Alzheimer's Disease. RI #52 has a medical history to include: Joint Stiffness, Abnormal Posture, Osteoarthritis and Muscle Weakness. The Magnolia Ridge Progress Notes for RI #52 documented: . 1/4/2018 17:13 (5:13 PM) . bruising noted on (RI #52's) inner right groin area . 1/5/2018 08:46 (8:46 AM) . Bruising still noted to right groin area . 1/8/2018 12:04 (12:04 PM) . pt (patient) has yellow bruising to R (right) thigh . 1/9/2018 10:22 (10:22 AM) . bruising appears to have spread on the inner right groin and buttock area, (doctor) notified, will obtain xrays of the pelvis and bilateral hips to r/o (rule out) any fractures . 1/9/2018 12:08 (12:08 PM) . Requested by bath team to check upper inner thighs. purplish in color. Dr. (EI #11) in to assess. X-rays ordered . RI #52's X-ray report of the bilateral hips dated 1/9/2018, revealed an acute fracture of the proximal right femur. In a telephone interview on 1/31/2018 at 5:20 PM, Employee Identifier (EI) #11, RI #52's Attending/Primary Physician was asked, when was the first time he was made aware by facility staff of bruising to RI #52's groin and thigh area. EI #11 answered, the first time he was aware was the day the fracture was found (1/9/2018). (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/1/2018 at 9:45 AM, EI #9, a Licensed Practical Nurse (LPN) stated she was off for the Christmas holiday and returned to work on 1/2/2018. EI #9 was asked was she told RI #52 had bruising when she returned to work on 1/2/2018. EI #9 said, no ma'am not at that time. When asked when she first was made aware of bruising on RI #52, EI #9 explained that on 1/4/2018 she was called into the shower room and it was bought to her attention. EI #9 stated the purplish blue in color bruising was on RI #52's right inner thigh, from the front perineal area, pelvic area to the buttocks. EI #9 said she told the unit manager, EI #10, and she thought EI #10 notified the doctor. In a follow-up telephone interview on 2/1/2018 at 5:35 PM, EI #11, RI #52's Attending/Primary Physician was asked when did he observe bruising on RI #52. EI #11 said he came to see the resident the day the X-ray was ordered (1/9/2018). According to EI #11, he asked EI #10 (Unit Manager) via text how RI #52 got the bruise on the perineal and right leg but got no answer. EI #11 was asked to verify that he did not know about RI #52's bruising in the perineal area until 1/9/2018. EI #11 stated, That is my recollection. This deficiency was cited as a result of the investigation of complaint/report number AL00035547.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33415 Based on interview and review of the facility's Abuse Prohibition policy and Resident Identifer (RI) #52's medical record, the facility failed to report injury of unknown source to the State Survey Agency. On 1/4/2018, RI #52, a cognitively impaired resident with no speech, had bruising on the right inner groin area, that continued to spread. Five days later, on 1/9/2018, the bruising was reported to the physician, at which time he ordered X-rays that revealed a fractured femur. This deficient practice affected RI #52, one of one sampled residents reviewed for injuries of unknown source. Findings include: The facility's Abuse Prohibition policy with a revised date of 11/28/2017 documented . The Center will implement an abuse prohibition program through the following: . Reporting of incidents, investigations, and Center response to the results of their investigations. Federal Definitions: Injuries of unknown source are defined as an injury with both of the following conditions. * The source of the injury was not observed by any person or the source of the injury could not be explained by the patient; and * The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time . PROCESS . 6. 6.3 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property not later than two hours after the allegation is made if the event results in serious bodily injury . 6.4 Report allegations involving neglect, exploitation or mistreatment (including injuries or unknown source) and misappropriation of resident property within 24 hours if the event does not result in serious bodily injury . RI #52 was admitted to the facility on [DATE] with a primary diagnosis of Late Onset Alzheimer's Disease. RI #52 has a medical history to include: Joint Stiffness, Abnormal Posture, Osteoarthritis and Muscle Weakness. RI #52's Minimum Data Set (MDS) with an assessment reference date of 12/28/2017, revealed RI #52 was severely impaired cognitive skills for daily decision making. The MDS indicated RI #52 had no speech. The Magnolia Ridge Progress Notes for RI #52 documented: . 1/4/2018 17:13 (5:13 PM) . bruising noted on (RI #52's) inner right groin area . 1/5/2018 08:46 (8:46 AM) . Bruising still noted to right groin area . 1/8/2018 12:04 (12:04 PM) . pt (patient) has yellow bruising to R (right) thigh . 1/9/2018 10:22 (10:22 AM) . bruising appears to have spread on the inner right groin and buttock area, (doctor) notified, will obtain xrays of the pelvis and bilateral hips to r/o (rule out) any fractures . 1/9/2018 12:08 (12:08 PM) . Requested by bath team to check upper inner thighs. purplish in color. Dr. (EI #11) in to assess. X-rays ordered . RI #52's X-ray report of the bilateral hips dated 1/9/2018, revealed an acute fracture of the proximal right femur. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/1/2018 at 7:15 PM, Employee Identifier (EI) #1, the Administrator was asked to define and injury of unknown origin. EI #1 replied, an injury that can not be explained. When asked which injuries of unknown origin are reportable to the State Survey Agency, EI #1 said all are reportable. When asked if the bruising to RI #52's right inner groin and subsequent fractured femur was reported to the State Survey Agency, EI #1 said it was not bought to his attention. EI #1 explained that he was not made aware that RI #52 had bruising to the right inner groin. This deficiency was cited as a result of the investigation of complaint/report number AL00035547.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33415 Based on interviews, review of Resident Identifier (RI) #52's medical record, the RMS (Risk Management System) Event Summary Report, FUNDAMENTALS OF NURSING and RI #52's emergency room (ER) record, the facility failed to develop individualized care plans with resident centered interventions on the level of staff assistance needed when the staff provided a bath to RI #52, a resident with spastic-type movements who required the use of wedges/positioning devices. During the provision of a bed bath on 12/30/2017, positioning devices were not utilized and the resident slid off the bed and sustained a laceration to the head and a skin tear to the arm. This deficient practice affected RI #52, one of two sampled residents whose care plans were reviewed. Findings included: Page 241 of Chapter 18 titled Planning Nursing Care of FUNDAMENTALS OF NURSING with a copyright date of 2017, documented . Planning requires critical thinking applied through deliberate decision making and problem solving. Perhaps the most important principle to learn about planning is the need to individualize a plan of care for a patient's unique needs. This requires communicating closely with patients, their families and the health care team and ongoing consultation with team members. The nursing diagnoses that you identify direct your selection of individualized nursing interventions and the goals and outcomes you hope to achieve . RI #52 was admitted to the facility on [DATE] with a primary diagnosis of Late Onset Alzheimer's Disease. RI #52 has a medical history to include: Joint Stiffness, Abnormal Posture, Osteoarthritis and Muscle Weakness. RI #52's Minimum Data Set (MDS) with an assessment reference date of 12/28/2017, revealed RI #52 was severely impaired cognitive skills for daily decision making. RI #52 was assessed as requiring extensive assistance for all Activities of Daily Living (ADLs), with the exception of walking in room and corridor, which did not occur and bathing as this task did not occur during this assessment period. The MDS indicated RI #52 had functional limitations in range of motion on both sides in the upper and lower extremities. There were no individualized interventions or instructions for using positioning devices (i.e. wedges, pillows) when RI #52 had spastic-type movement on RI #52's FALL: Resident is at risk for falls: Advanced dementia. Contractures upper and lower ext (extremities), Dependent with daily needs. Impaired mobility care plan that was initiated on 4/12/2017, and revised on 10/23/2017. There were no individualized interventions or instructions on how to position RI #52 when in bed, how to bathe RI #52 when in bed, or the number of staff needed to safely provide RI #52 a bath when in bed on RI #52's ADL's . care plan that was initiated on 4/12/2017 and last revised 10/23/2017. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	The RMS Event Summary Report for RI #52 revealed on 12/30/2017 at 9:15 AM, . CNA reports that while she was cleaning resident up for AM (morning) care she went into the bathroom to get a wash cloth the resident started sliding off the side of the bed. CNA states that she had to put the lower part of (RI #52's) body back in bed and that what caused the skin tear to (RI #52's) left arm . Daughter request resident be transferred to ER for further evaluation . resident has spastic movements of all 4 extremities, all 4 extremities are severely contracted, . Summary of investigation: Root cause/conclusion: resident health and mental status, staff handling Corrective Actions: . inservice staff on proper handling, 2 person staff assistance The local Hospital's emergency room record revealed on 12/30/2017, RI #52 was seen in the ER with a chief complaint of EMS (Emergency Medical Services) stated pt (patient) was sent here from Magnolia Ridge with lacerations (to) the scalp . RI #52's Magnolia Ridge Progress Notes dated 12/30/2017 6:09 PM, documented . Resident has returned to the facility via ambulance stretcher. Resident has 3 staples in the left side of the top of (his/her) head. (RI #52) has a dressing with zerofoam and kerlix on (his/her) left upper arm . In an interview on 2/1/2018 at 11:40 AM, Employee Identifier (EI) #5, the CNA who provided care to RI #52 on 12/30/2017 when the accident occurred was asked, how often she took care of RI #52. EI #5 replied, on Tuesdays and Thursdays. EI #5 was asked what was on the care plan that would explain what to do for RI #52 for a bed bath. EI #5 said, she never looked at that because RI #52 did not get a bed bath often. During an interview on 2/1/2018 at 12:15 PM, EI #7, a CNA said she used to take care of RI #52 all the time. EI #7 was asked what she did to position RI #52 to make sure the resident was safe. EI #7 said, she made sure the resident was in the middle of the bed and turned to the side. When asked what would happen if RI #52's back was placed in the middle of the bed, EI #7 said, without any support the resident would roll to one side or the other. EI #7 further stated, RI #52 had pillows and wedges used for support. In an interview on 2/1/2018 at 12:20 PM, EI #8, a CNA stated she took care of RI #52 often. When asked what kind of movements RI #52 would make, EI #8 stated, the resident would sometimes jerk a little, like a shiver. EI #8 was asked what was required for positioning RI #52 in bed. EI #8 replied, RI #52 would have a wedge on each side and due to the contractures the resident could not really be positioned on his/her back. When asked what would happen if RI #52 was positioned in the middle of the bed without any support devices, EI #8 said, RI #52 would not stay in that position without the wedges. When asked if RI #52 could support himself/herself, EI #8 said no. On 2/1/2018 at 7:30 PM, an interview was conducted with EI #3, the Registered Nurse (RN) MDS Coordinator. EI #3 was asked what was included on a resident's care plan that described the level of assistance the CNA provided during a bath. EI #3 replied, the care plan was not specific. EI #3 was asked why RI #52's care plan did not include the level of care required for the bath care. EI #3 replied, the nurses could add it to the tasks list. On 2/1/2018, the Magnolia Ridge Task List Report for RI #52 was provided to the State Surveyor. There was no individualized, person centered care interventions or instructions for the CNA staff on the level of assistance RI #52 required for bathing. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	This deficiency was cited as a result of the investigation of complaint/report number AL00035547.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33415 Based on interviews, review of Resident Identifier (RI) #52's medical record, RI #52's emergency room record and the RMS (Resident Management System) Event Summary Report, the facility failed to ensure Employee Identifier (EI) #5, a Certified Nursing Assistant (CNA), had all necessary bath equipment when she provided a bed bath to RI #52, a resident identified as being at risk for falls, on 12/30/2017. EI #5 left the severely contracted resident with spastic movement in all four extremities, unattended and without positioning devices, when she left to get a washcloth. RI #52 slid off the bed and sustained a laceration to the head and a skin tear to the arm. This affected RI #52, one of three sampled residents reviewed for accidents. Findings include: RI #52 was admitted to the facility on [DATE] with a primary diagnosis of Late Onset Alzheimer's Disease. RI #52 has a medical history to include: Joint Stiffness, Abnormal Posture, Osteoarthritis and Muscle Weakness. RI #52's Minimum Data Set (MDS) with an assessment reference date of 12/28/2017, revealed RI #52 was severely impaired cognitive skills for daily decision making. RI #52 was assessed as requiring extensive assistance for all Activities of Daily Living (ADLs), with the exception of walking in room and corridor, which did not occur and bathing as this task did not occur during this assessment period. The MDS indicated RI #52 had functional limitations in range of motion on both sides in the upper and lower extremities. There were no individualized interventions or instructions for using positioning devices (i.e. wedges, pillows) when RI #52 had spastic-type movement on RI #52's FALL: Resident is at risk for falls: Advanced dementia. Contractures upper and lower ext (extremities), Dependent with daily needs. Impaired mobility care plan that was initiated on 4/12/2017, and revised on 10/23/2017. There were no individualized interventions or instructions on how to position RI #52 when in bed, how to bathe RI #52 when in bed, or the number of staff needed to safely provide RI #52 a bath when in bed on RI #52's ADL's . care plan that was initiated on 4/12/2017 and last revised 10/23/2017. The RMS Event Summary Report for RI #52 revealed on 12/30/2017 at 9:15 AM, . called to Room (RI #52's room) by the CNA, (EI #5), to assess the resident. CNA reports that while she was cleaning resident up for AM (morning) care she went into the bathroom to get a wash cloth the resident started sliding off the side of the bed. CNA states that she had to put the lower part of (RI #52's) body back in bed and that what caused the skin tear to (RI #52's) left arm . Daughter request resident be transferred to ER for further evaluation . resident has spastic movements of all 4 extremities, all 4 extremities are severely contracted, . Activity during incident: resident slid off the bed Was fall related to seating/positioning: Yes Explain: resident slid off the bed . Summary of investigation: Root cause/conclusion: resident health and mental status, staff handling Corrective Actions: . inservice staff on proper handling, 2 person staff assistance (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 1/31/2018 at 8:15 AM, Employee Identifier (EI) #5, the CNA who provided care to RI #52 on 12/30/2017 when the accident occurred was asked, what happened. EI #5 said, she was giving RI #52 a bed bath on the right side of the bed. EI #5 explained that she went to grab a wash cloth from the sink in the bathroom, RI #52 had clinched up both upper and lower extremities, as the resident normally did, so EI #5 placed RI #52 on his/her back in the middle of bed. EI #5 said before she could get to the sink she heard the resident. When asked what she heard, EI #5 replied, a thump and when she turned around RI #52's legs were hanging off the bed and the resident's head was resting on the bed rail that was in the up position on the right side of the bed. EI #5 stated, she placed RI #52's legs back onto the bed and grabbed the resident's arms to position the resident back over in the bed. According to EI #5, RI #52's family had provided pillows to put all around RI #52 to position the resident. In a follow-up interview on 2/1/2018 at 11:40 AM, EI #5 was asked, how often she took care of RI #52. EI #5 replied, on Tuesdays and Thursdays. EI #5 was asked what was on the care plan that would explain what to do for RI #52 for a bed bath. EI #5 said, she never looked at that because RI #52 did not get a bed bath often. When asked why she did not have everything she needed to give the bed bath, EI #5 replied, she thought she was close enough to maneuver around the room without incident. EI #5 was asked what she should have done to prevent RI #52 from falling off the bed. EI #5 stated, she should have had all the supplies at the bedside and she should have never left the resident unattended. EI #5 explained she thought RI #52 would be okay on his/her back in the middle of the bed. When asked what the facility's procedure was for a bed bath, EI #5 said to get all your supplies ready before the bath. During an interview on 2/1/2018 at 2:15 PM, EI #2, the Director of Nursing was asked how the accident with RI #52 on 12/30/2017 could have been prevented. EI #2 said, it was possible that if the CNA had gathered all her supplies it would have prevented the accident. The local Hospital's emergency room record revealed on 12/30/2017, RI #52 was seen in the ER with a chief complaint of EMS (Emergency Medical Services) stated pt (patient) was sent here from Magnolia Ridge with lacerations (to) the scalp . RI #52's Magnolia Ridge Progress Notes dated 12/30/2017 6:09 PM, documented . Resident has returned to the facility via ambulance stretcher. Resident has 3 staples in the left side of the top of (his/her) head. (RI #52) has a dressing with zerofoam and kerlix on (his/her) left upper arm . This deficiency was cited as a result of the investigation of complaint/report number AL00035547.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38279 Based on interview, record review, and a review of the facility's policy titled, Disposal/Destruction of Expired or Discontinued Medication, the facility failed to ensure licensed staff recorded two signatures on the non narcotic drug destruction records for the months of July, August, and [DATE]. This affected three of ten months reviewed for non narcotic drug destruction. Findings Include: A review of the facility's policy titled,Disposal/Destruction of Expired or Discontinued Medication, with a revision date of [DATE] revealed: .PROCEDURE .5. Facility should destroy non-controlled medications in the presence of a registered nurse and witnessed by one other staff member, in accordance with Facility policy or Applicable Law. A review of the facility's non-controlled drug destruction records was performed on [DATE] at 9:30 a.m. and revealed there was only one signature recorded for the months of July, August, and [DATE]. An interview was conducted on [DATE] at 3:55 p.m. with Employee Identifier (EI) #2, a Registered Nurse/Director of Nursing (RN/DON). EI #2 was asked how many signatures should be recorded on the non-controlled drug destruction record. EI #2 replied,Two. EI #2 was asked if there were two signatures recorded for the months of July, August, and [DATE]. EI #2 replied, No.

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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. 01706 Based on observations, interview and review of the 2013 Food Code and Quat (Quaternary Ammonium Compounds) Sanitizer Technical Data Sheet, the facility failed to ensure: 1) ice cream remained frozen; 2) sectional plates were cleaned, not chipped and air-dried; 3) the juice dispenser nozzle was clean; 4) the chemical concentration solution was 200 parts per million (ppm); and 5) cleaning cloths were stored in the sanitizing solution when not in use. These deficient practices had the potential to affect all 111 residents in the facility, who received food from the kitchen. The RESIDENT CENSUS AND CONDITIONS OF RESIDENTS (Form CMS-672) indicated the facility had a total of 125 residents, with 14 residents receiving tube feedings. Findings include: 1) The 2013 Food Code by the United States Public Health (USPH) and the Food and Drug Administration (FDA) documented . Temperature and Time Control 3-501.11 Frozen Food. Stored frozen foods shall be maintained frozen . On 1/09/18 at 2:50 PM, an observation was made of individual cups of ice cream stored in the walk-in freezer. The ice cream was soft to touch and left finger indentations in the Styrofoam. 2) The 2013 Food Code by the USPH and the FDA documented . 4-6 CLEANING OF EQUIPMENT AND UTENSILS . Frequency 4-602.11 Equipment Food-Contact Surfaces and Utensils (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean . On 1/10/18 at 11:45 AM, sectional plates stored at the trayline were examined. Four of five plates were observed with the following: one plate was not air dried and had water on it; one plate was chipped in the cross section and two plates contained food debris. At this time, EI #6, Director of Dining Service, was asked what was the potential risk for unclean plates. EI #6 replied bacterial contamination. EI #6 was asked why the sectional plates were compromised. EI #6 said staff was not inspecting and paying attention to detail. 3) The 2013 Food Code by the USPH and the FDA documented . 4-6 CLEANING OF EQUIPMENT AND UTENSILS . Frequency 4-602.11 Equipment Food-Contact Surfaces and Utensils . (E) . (4) In Equipment such as ice bins and Beverage dispensing nozzles . (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold . On 1/09/18 beginning at 2:35 PM, the tip of the juice dispenser nozzle was removed and revealed a build-up of a solid substance that adhered to the inside area. When asked why there was a build-up, EI #6, the Director of Dining Service stated a lack of routine cleaning. 4) The Quat Sanitizer Technical Data Sheet revealed . Testing Parameters .7. Single concentration (minimum-maximum level =200 ppm) quats should test as close as reasonably possible to 200 ppm . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/01/2018
NAME OF PROVIDER OR SUPPLIER Magnolia Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 420 Dean Drive Gardendale, AL 35071	

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	During the initial tour of the kitchen 1/09/18 at 2:50 PM, a red bucket was stored beneath a counter. EI #6, Director of Dining Service was asked to test the chemical solution. The test strip indicated the solution was 100 parts per million (ppm). 5) The 2013 Food Code by the USPH and the FDA revealed: .3-304.14 Wiping Cloths, Use Limitation . (B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified . During the initial tour of the kitchen 1/09/18 at 2:50 PM, a cloth was observed on top of the counter, not in the sanitizing solution. On 1/10/18 at 11:45 AM, two wiping cloths were observed on the counter across from the range, not stored in the sanitizing solution.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/01/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 37292 Based on observation, interview and review of facilities policies titled, Hand Hygiene and Tracheostomy Care, the facility failed to ensure a Registered Nurse (RN) washed her hands after performing Tracheostomy care for Resident Identifier (RI) #119 before applying clean gloves. This affected RI #119, one of two residents sampled with Tracheotomies and one nurse observed during Tracheostomy care. Findings Include: A review of the facility's policy and procedure titled, Hand Hygiene with a revised date of 11/28/17, revealed the following: POLICY Adherence to hand hygiene practices is maintained by all Center personnel. PURPOSE To improve hand hygiene practices and reduce the transmission of pathogenic microorganisms. PROCESS 1. Perform hand hygiene: .1.3 After any contact with blood or other body fluids, even if gloves are worn; . A review of a facility's policy and procedure titled, Tracheostomy Care with a revised date of 12/08/14, documented the following: .12. Remove soiled dressing and inner cannula . 14. Remove gloves. Discard in waste bag and cleanse hands. RI #119 was admitted to the facility on [DATE] with diagnoses including: Quadriplegia, Unspecified, Respiratory Failure, Unspecified, Brain Stem Stroke Syndrome and Encounter For Attention To Tracheostomy. On 01/11/18 at 7:39 a.m. during observation of Tracheostomy care for RI #119, Employee Identifier (EI) #4, was observed to remove her gloves worn during Tracheostomy care and apply a clean pair of gloves without washing her hands. On 01/11/18, at 3:40 p.m. an interview was conducted with EI #4. EI #4 was asked, did she wash her hands after providing Tracheostomy care for RI #119 before she applied a clean pair of gloves. EI #4 answered, no. EI #4 was asked, what kind of issue was that. EI #4 said, an infection control issue.