STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105970	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marianna Nursing and Care Center	2600 Forest Glen Trail Marianna, FL 32446

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. Based upon observations, interviews and review of facility kitchen policy, the facility failed to provide clean and sanitary conditions in food service areas to prevent contamination of food and food storage areas. The facility failed to follow proper sanitation guidelines for kitchen equipment. The findings include: On 5/12/25 at 10:40 AM an initial observation tour of the kitchen area was conducted with the Dietary Manager. The dishwasher area had a black hose across the floor, connected to the opposite wall of the dish room to a dishwasher leaking water, with water flowing onto the floor. A clear plastic covering was observed over the hose and faucet connector. The Dietary manager stated it's been like that becuase they can't find a hose to fit the connection properly. (photo obtained) It was also noted that a discolored black substance was on the wall behind and in between the dish room area where dishes entered into thedishwasher. A red bucket was observed on the floor under the dish room sink, with a drainage area observed to have a dark discolored substance around the drainage grate and floor tiles. A discolored black substance was noted below the table on pipes, tile floor, and wall. A discolored area with a rust like appearance with black colored particles was observed on the wall, the aluminum backing, and on the top covering of the dishwasher table. The table on the opposite side of the dishwasher where the dishes exit was observed with a brownish discolored substance on the table, underneath the table on the bottom shelf where a bin of multiple bowls was stacked into it, sitting on a rust like discolored shelf. Upon exiting the dishwasher area, a dietary cart was observed sitting in the kitchen area with a clear plastic container of unidentifiable items and a bin with multiple bowls stacked inside the bin at different angles on the top shelf of the cart, the bottom shelf contained an oblong aluminum container with a paint brush and miscellaneous items stacked into it with yellow food particles observed on the railing of the cart. The stove and oven appeared to have cooking pans stacked on top of the burners, and beside the burners. A dark discoloration was observed on the range, around the burners, and on the backsplash of the stove. The oven doors appeared to have a grease like brown substance on them. The fryer baskets next to the stove and oven had food particles along the side of the fryer splash guard with a black and brown discoloration on it and in the grooves of the fryer. One fryer basket had food left in the basket. The standing mixer had multiple items stacked on top of it with attachments sitting in the bowl, dried food particles on the attachments. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The food prep table shelves were observed with miscellaneous items sitting on them. The shelves have a rust-like appearance. The food warmer and tray line table have a rust like appearance on the doors, shelves, and bottom of the table. The glass surrounding the top of food warmer had food particles splattered on them. The floor tiles under and bedside the refrigerator near the drain lines appear to be greenish black, with drain areas noted with cracked tile surrounding the drain, with dark brown, black discoloration surrounding drain and on the exposed pipes from the refrigerator. The ice machine was observed to be full of ice, but the lid was noted with a foam like seal with a discolored black, dark green substance on it. Inside the ice machine on the back and sides of ice machine a discolored black substance was noted on them. The Dietary Manager revealed that the dietary staff is responsible for the daily cleaning of all kitchen equipment and is done on a daily basis. When asked about cleaning logs for the kitchen, the Dietary Manager responded, We don't do the cleaning logs, its just part of our daily chores to do. When asked about the last time the kitchen was cleaned and floors cleaned, she responded that maintenance is supposed to come pressure wash the floors, but she did not know when it would happen next. On 5/12/25 at 11:45 AM, a dining room observation revealed 22 residents were in the dining room. A staff member entered the dining room sorting and distributing meal tickets without washing her hands. A dietary staff member from the kitchen brought a dietary cart into the dining room. The cart was observed with multiple filled glasses with ice in them. The glasses did not have any lids sitting on top of the cart. A staff member filled glasses with tea and distributed them to residents without washing her hands. A second staff member entered the dining room at 12:05 PM using appropriate hand sanitizer prior to and in between each resident she served. Staff member B (a Registered Nurse) entered the dining room area without washing or sanitizing her hands and assisted a resident with opening his milk carton using her bare hands and uses her index finger to pull and open the milk carton for resident to drink his milk from the spout of the milk carton. Then she proceeded to another resident at another table and performed the same task without washing or sanitizing her hands. Staff member J (another Registered Nurse) entered the dining room and observed residents being served meals and assised as needed without washing or sanitizing her hands. Hand-sanitizer dispensers were available for staff on the walls in the dining room in between the kitchen dietary doors and the opposite wall. A follow-up kitchen tour was completed on 5/13/25 and 5/14/25 with the Dietary Manager and Staff Member G (Dietary). They revealed that cleaning is done on a daily basis, but no cleaning schedule is posted. The manager stateds everyone knows what they need to do. An interview was conducted on 5/14/25 with the Dietitian. She revealed her expectation of cleaning and sanitation practices of the kitchen and that food service areas should be up to state and federal standards or above those standards. Upon describing and sharing findings of the kitchen and food service areas on day one of the survey, she acknowledged that the kitchen and food service areas were not up to or above state and federal guidelines. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy and procedures for cleaning and sanitation of food services areas on 5/13/25 stated, food service staff will maintain the sanitation of the dining and food service areas through compliance with a written comprehensive cleaning schedule. Procedure for cleaning and sanitation: the food service manager will record all cleaning and sanitation tasks needed for the department, a cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks as completed. Ice machine policy revealed ice will be produced and handled in a manner to keep it free from contamination with the procedure listing to include ice machines will be maintained in a clean and sanitary condition to prevent ice contamination. Policies for food safety and sanitation revealed that all local, state, and federal standards and regulations are followed in order to assure a safe and sanitary food service department. Food service managers responsibility included sanitary conditions are maintained in the storage, preparation, and serving areas. Personnel follow sanitary practices and follow proper cleaning and sanitizing instructions for all kitchen equipment. Cleaning schedules are posted and followed. Regular inspections are made by the food service manager or designee to assure food safety. A review of policy for maintenance of dish machine stated, the dish machine will be regularly cleaned and de-limed as needed. Dish machine general cleaning in-service includes deliming of the machine should take place once a week to prevent scale build up and keep water flowing properly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Resident #45 An observation of Resident #45 was conducted on 5/12/25 at 1:14 PM. Signage indicating contact precautions were in place and that staff should clean hands then don gown and gloves prior to entering the room were observed on the resident's room door. Employee C (agency Certified Nursing Assistant) was observed to enter Resident #45's room to serve the resident's lunch meal. Employee C did not don a gown or gloves prior to entering the resident's room. Employee C was observed to touch the resident's overbed table with her bare hands while serving the resident's lunch meal. A review of Resident #45's record revealed a current physician's order for contact isolation beginning on 5/11/25. The record revealed the resident was placed on contact isolation due to ESBL bacteria (extended-spectrum beta-lactamase) being detected in the urine. An interview was conducted with Employee C on 5/12/25 at 2:55 PM. She stated she forgot to apply a gown and gloves prior to entering Resident #45's room to serve the lunch meal. An interview was conducted with Employee D (Infection Preventionist) on 5/14/25 at 10:06 AM. Employee D stated all staff should don a gown and gloves when entering the contact precautions room to serve trays, especially if they make contact with the resident or environmental surfaces. She stated the facility provides this education to agency staff when they are utilized in their package for working in the facility. A review of Employee C's temporary Certified Nursing Assistant education packet revealed she had education regarding infection control prevention and hand hygiene competency dated 2/4/25. The education did not specifically speak to contact precautions however; the instructions were on the resident's door. Review of the facility policy for Categories of Isolation Precautions (November 2019) revealed staff should wear a gown and gloves when entering a contact precautions isolation room. Based on observations, interviews and facility policy review, the facility failed to implement contact isolation procedures for 1 of 1 resident sampled for contact isolation (Resident #25) and failed to implement infection control techniques for 1 of 1 resident sampled for enteral feeding. (Resident # 204) The findings include: Resident #204 Resident #204's medical record revealed a physician's order to give a bolus of enteral feeding (a medical procedure that provides nutrients directly into the gastrointestinal (GI) tract through a tube). The physician's order stated Enteral Feed Order five times a day; Enteral Feeding: Nutren 1.5 bolus 1 carton 5x/day with 150cc H2O flush before and after each feeding. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 4:15 PM, an observation was conducted with Staff A, Licensed Practical Nurse (LPN). She was observed washing her hands and donning clean gloves. She had a container on a clean towel over the bedside table. She grabbed the container with the left hand and touched the bathroom door with the right hand. She filled the container with water from the bathroom's sink. She proceeded with the feeding after filling the container with tap water without changing gloves. On 5/13/25 at 6:02 PM, an interview was conducted with Staff A, LPN. She stated she takes responsibility of her actions and states she should have changed gloves after touching the bathroom's sink. A review of facility policy Feeding Systems dated October 2019 was conducted. Policy stated Protective barriers that may be needed: handwashing and gloves (as indicated). Facility policy further stated Procedure guidelines for bolus feedings: wash hands.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to ensure each resident bedroom was equipped to provide full visual privacy for 2 of 19 sampled resident rooms. (rooms [ROOM NUMBERS]) The findings include: An observation of room [ROOM NUMBER] bed B (occupied) was conducted with the Director of Environmental Services on 5/14/25 at 2:41 PM. The privacy curtain was measured and it was about 4 feet too short in width to provide full privacy. He stated he was not aware of a facility process to check the curtains to ensure they provided full visual privacy to the resident. An observation of room [ROOM NUMBER] bed B (occupied) was conducted with the Director of Maintenance on 5/14/25 at 4:23 PM. The privacy curtain was measured and the curtain was about 4 feet too short in width to provide full visual privacy to the resident. An interview was conducted with the Administrator on 5/14/25 at 4:28 PM. She stated she was not sure of the facility process for checking privacy curtains and the housekeeping director was new and had started in January.