

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2024
NAME OF PROVIDER OR SUPPLIER Thomasville Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Skyline Drive Thomasville, GA 31757	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42463</p> <p>Based on observations, staff interviews, record review, and review of the facility's policy titled, Promoting/Maintaining Resident Dignity, the facility failed to promote, maintain, and protect residents' dignity for two of three residents (R11, R20) with an indwelling urinary catheter.</p> <p>Findings include:</p> <p>Review of the facility's undated policy titled, Promoting/Maintaining Resident Dignity under the section titled Policy revealed, It is the practice of this facility to protect and promote residents rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.</p> <p>1. Review of R11's Face Sheet revealed diagnoses that included but not limited to, cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant, retention of urine, disorders of urinary system, and obstructive and reflux uropathy.</p> <p>Review of R11's Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C-Cognition: Brief Interview of Mental Status (BIMS) score of 11 indicating moderate cognitive impairment; Section GG-Functional Status: resident requires total assistance with all Activities of Daily Living (ADL's); Section H-Bowel and Bladder: resident had indwelling urinary catheter and was always incontinent of bowel; Section M-Skin: resident is at risk for pressure ulcers and had a diabetic foot ulcer.</p> <p>Review of R11's Physician's orders included but not limited to an order dated 8/10/2024 for [Name of catheter] catheter care every shift every eight hours and an order dated 1/19/2024 to change [Name of catheter] cath #20 French on the 19th of each month in the morning starting on the 19th and ending on the 19th every month.</p> <p>Review of R11's Care Plans revealed, a plan in place dated 6/14/2024 that indicated [R1 Name] has a urinary catheter and is at risk for urinary tract infections and injury. Urinary catheter related to obstructive uropathy with urine retention.</p> <p>An observation of R11 on 8/9/2024 at 8:20 am revealed, the resident had an indwelling urinary catheter attached to a urinary catheter bag with yellow urine noted inside. The catheter bag was not covered and was visible from the door.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation of R11 on 8/9/2024 at 9:26 am revealed the resident had an indwelling urinary catheter attached to a urinary catheter bag with yellow urine noted inside. The catheter bag was not covered and was visible from the door.</p> <p>An observation and interview on 8/10/2024 at 8:38 am with Registered Nurse (RN) BB in R11's room revealed, the resident had an indwelling urinary catheter attached to a urinary catheter bag with yellow urine noted inside. The catheter bag was not covered and was visible from the door. RN BB immediately pulled the dignity bag over the catheter bag down and confirmed the catheter bag should have been covered because it was a dignity issue.</p> <p>An interview on 8/10/2024 at 10:57 am with Licensed Practical Nurse, Unit Manager CC stated her expectations of staff was to ensure catheter bags were covered and not visible at all times. She stated the Certified Nursing Assistants should be doing this when rounding and as needed.</p> <p>36377</p> <p>2. Record review of R20's medical record revealed the following diagnoses but not limited to chronic kidney disease Stage 3, and diabetes.</p> <p>Record review revealed a physician order dated 8/10/2024 for [Name of catheter] catheter care every shift every 8 hours. There was no active order for an indwelling catheter.</p> <p>The Significant Change MDS date 7/24/2024 assessed a BIMS score of unable to detect (which indicates severe cognition impairments) and an assessment for indwelling catheter use.</p> <p>Record review of the care plan created on 7/12/2024 stated that R20 has a urinary catheter and is at risk for urinary tract infections. Urinary catheter related to neurogenic bladder with urine retention and open wounds. The following intervention listed stated: Provide urinary catheter care per facility practice.</p> <p>An observation on 8/9/2024 revealed R20 lying in bed with the room door open. Continue observation revealed an indwelling catheter attached to a urinary catheter bag with yellow color urine noted inside. The catheter bag was not covered and was visible from the door.</p> <p>An observation on 8/9/2024 at 2:44 pm revealed R20 sitting upright in a Geriatric chair in his room with an indwelling catheter attached to a urinary catheter bag with yellow color urine noted inside. The catheter bag was not covered and was visible from the door.</p> <p>An observation on 8/10/2024 at 9:50 am revealed that R20 had an indwelling catheter attached to a urinary catheter bag with yellow color urine noted inside. R20 was observed lying in bed in his room with the room door open. The catheter bag was not covered.</p> <p>Interview on 8/10/2024 at 9:59 am, RN DD confirmed that the catheter bag was not covered with a dignity bag. She confirmed that this was a dignity issue for the resident. Interview on 8/10/2024 at 9:59 am, RN DD confirmed that the catheter bag was not covered with a dignity bag. She confirmed that this was a dignity issue for the resident.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on record review and staff interviews, the facility failed to obtain a concurring Physician's signature on a Do Not Resuscitate (DNR) order for one resident (R) (R29) of two residents reviewed for DNR.</p> <p>Findings include:</p> <p>Record review of R29's medical record revealed the following diagnoses but not limited to Alzheimer 's Disease, paranoid schizophrenia, and hyperlipidemia.</p> <p>Record review revealed that R29's original admitted to the facility was 5/4/2022 and Re-admitted was 11/22/2023. R29's face sheet and medical record revealed that resident did not have a Power of Attorney (POA) or Legal Guardian listed.</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status Score (BIMS) of four which indicated severe cognitive impairment. The most recent Annual MDS assessment dated [DATE] indicated a BIMS score of two which also indicated severe cognitive impairment.</p> <p>Review of copy of Do Not Resuscitate Order (DNR) indicated the signature of an Authorized Person was a guardian over R29. This document was signed on 5/4/2022 by the Authorized Person and signed by one Physician on 5/7/2022. Further review of the medical record did not indicate any documentation that anyone served as Guardian, Power of Attorney (POA), or any other type of healthcare agent for R29.</p> <p>Interview on 8/10/2024 at 10:53 am with Family Member A of R29's, revealed that neither herself nor any other member of the family of R29 had legal guardianship or had been appointed as POA. She stated R29 's preference would be to remain a DNR.</p> <p>Interview on 8/10/2024 at 11:01 am with Unit Manager Registered Nurse (RN) BB and Unit Manager Licensed Practical Nurse (LPN) CC who confirmed that there was no evidence that R29 had a healthcare agent and R29's code status was changed to Full Code.</p> <p>Surveyor was unable to reach Family Member B of R29 to determine her POA or Guardianship status for R29.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on observations and staff interviews, the facility failed to ensure a consistent home-like environment free from missing floor tiles, peeling paint on walls, rust on resident equipment (raise toilet seats), and an odor-free environment in which odors were consistently present where residents resided on one of two halls (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and shower room on 300 hall) .</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation of room [ROOM NUMBER]'s bathroom on 8/9/2024 at 8:26 am and 2:00 pm and 8/10/2024 at 8:13 am and 2:00 pm revealed the frame of a raised toilet seat coated with dark brown substances. 2. Observation of room [ROOM NUMBER]'s bathroom on 8/9/2024 at 8:27 am and 8/10/2024 at 8:14 am revealed the frame of a raised toilet seat coated with dark brown substances. Continued observation revealed missing shower fixture (missing shower head) protruding from the wall with ragged edges, stained tiles covered with dark sticky brown substances on the tile around the commode. A strong urine odor was observed in bathroom and the smell overflowed into the resident room. 3. Observation of room [ROOM NUMBER] on 8/9/2024 at 8:26 am and 8/10/2024 at 8:12 am revealed peeling paint on the wall above Bed A. 4. Observation of room [ROOM NUMBER] on 8/10/2024 at 8:14 am revealed dark grayish and brown color substances on the ceiling tile above Bed A. 5. Observation of room [ROOM NUMBER]'s bathroom on 8/9/2024 at 8:33 am and 3:10 pm, 8/10/2024 at 8:16 am and 2:11 pm, and 8/11/2024 at 9:37 am revealed a strong urine odor, stained tiles, missing paint on the ceiling and walls, and light fixture cover coated with dark yellowish and dark grayish colors. 6. Observation of one of two shower rooms on 8/9/2024 at 9:30 am, 8/10/2024 at 11:00 am, and 8/11/2024 at 10:23 am revealed missing tiles on the floor by the shower bed revealing an overlayer of dark brownish substances on the floor. There was a shower chair with a hard white substance coating, buildup of dirt, and brown substances coating the frame and the back rest of the shower chair. <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The environmental tour began on 8/11/2024 at 9:36 am on the 300 hall with the Registered Nurse Supervisor (RN) BB, the Maintenance Director, and Housekeeper Supervisor. All staff acknowledged the odor and identified odor as urine. RN Supervisor BB reported that the urine smell in the bathroom and resident rooms were offensive to residents and visitors. She stated that no residents should have to smell a strong urine odor. The Maintenance Supervisor and Housekeeper Supervisor confirmed that odor was embedded in the bathroom tiles and the tiles should be replaced. The Maintenance Supervisor reported any needed repairs should be completed on a maintenance repair form and the forms are located at the nurse stations. He stated that he was unaware of the needed repairs with the bathroom tiles. RN Supervisor BB confirmed the bath shower chair was covered with dirt and had calcium buildup. She stated that the chair should be replaced. All staff confirmed the brown substances on the raised toilet seat frame and shower chair as rust. Maintenance Director reported that he would try to remove the rust off of the resident equipment.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914</p> <p>Based on staff interviews, record review, and review of the facility policies titled, Assessment Frequency/Timelines and Discharge Planning Process, the facility failed to ensure a discharge Minimum Data Set (MDS) assessment was completed and transmitted within 14 days of discharge for one Resident (R) (R37).</p> <p>Review of the facility's undated policy titled, Assessment Frequency/Timelines revealed under Policy: The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual. Under Policy Explanation and Compliance Guidelines: 6. A OBRA discharge assessment will be completed within 14 days of the discharge.</p> <p>Review of the undated facility policy titled Discharge Planning Process under Procedure: number 11. The evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record.</p> <p>Record review for R37 revealed the resident was admitted to the facility on [DATE] and discharged on [DATE] with the diagnosis of lipoprotein deficiency, essential hypertension, low back pain, dementia, major depressive order, and altered mental status.</p> <p>Interview on [DATE] at 2:33 pm with the Unit Manager revealed R37 was admitted to the facility in February of 2024 and expired in March of 2024 after the resident's family took resident out of the facility against medical advice. During the interview it was also disclosed that there was not a discharge assessment that was completed after the resident discharged from the facility, nor was there any documentation of the residents stay in the facility's medical record system.</p> <p>Interview on [DATE] at 9:13 am with the Minimum Data Set (MDS) Coordinator revealed there was no information in the facility system in reference to R37. Continued interview also revealed that when a resident is discharged from the facility, the discharge assessment is implemented and should be completed and transmitted within 14 days. Further interview confirmed there was no indication that a discharge Assessment had been completed for R37.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42463</p> <p>Based on observations, record review, staff interviews, and review of the facility's policy titled, Comprehensive Care Plans, the facility failed to follow the care plan for one of 26 sampled residents (R) (R31). Specifically, the facility failed to follow the care plan for R31's hemodialysis.</p> <p>Findings include:</p> <p>Review of the facility's undated policy titled Comprehensive Care Plans under the section titled, Policy revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objective and timeframes to meet a resident 's medical ,nursing , and mental and psychosocial needs that are identified in the resident 's comprehensive assessment. Under the section titled Policy Explanation and Compliance Guidelines revealed, (2). The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. (3) a. The services that are to be furnished to attain or maintain the resident 's highest practicable physical, mental, and psychosocial well-being. (8). Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p> <p>1. Review of the Face Sheet for R31 revealed, diagnoses that included but not limited to type 2 diabetes mellitus with other diabetic kidney complication, end stage renal disease, and anemia in chronic kidney disease.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment for R31 dated 6/14/2024 revealed, Section O (Special Treatments and Programs) documented that R31 received hemodialysis while a resident.</p> <p>Review of the Electronic Medical Record (EMR) for R31 revealed, a physician's order dated 9/5/2023 that revealed R31 received dialysis on Monday, Wednesday, and Fridays.</p> <p>Review of care plan dated 6/12/2024 for R31 revealed, under Focus indicated the resident needed hemodialysis related to end stage renal disease. The interventions included but not limited to, Assess AV (arteriovenous) shunt for bruit and thrill every shift. maintain communication with dialysis center, monitor/document/report to md (medical doctor) prn (as needed) any s/sx (signs and symptoms) of infection to access site: redness, swelling, warmth or drainage, monitor/document/report to md prn for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds.</p> <p>Review of the Administration Record dated 8/1/2024 - 8/31/2024 for R31' revealed, there were no orders or documentation for ongoing monitoring and treatment for R31's dialysis access site.</p> <p>Review of the R31's Progress Notes from 9/5/2023 through 8/9/2024 revealed, the lack of consistent documentation and proof of ongoing monitoring for R31's dialysis access site and communication with the dialysis center.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/10/2024 at 11:18 am with MDS, Licensed Practical Nurse (LPN) LL revealed, she was responsible for developing care plans for residents and that R31 had a care plan to address his hemodialysis needs and that staff should follow it.</p> <p>During an interview on 8/11/2024 at 8:30 am with Registered Nurse (RN) BB, a record review of the Dialysis Communication Sheets for R31 that was kept in book at the nurses station revealed, missing and incomplete dialysis communication sheets ranging from 9/11/2023-8/2/2024. RN BB confirmed some of the dialysis communication sheets were missing or incomplete nor were there documentation or proof of ongoing monitoring and treatment for R31's dialysis access site and communication with the dialysis center found in the progress notes.</p> <p>During an interview on 8/11/2024 at 9:07 am with LPN Unit Manager (UM), CC revealed, her expectations of nurses were to follow the care plans for residents.</p> <p>Cross Reference F698</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>36377</p> <p>Based on observation, staff interviews, record review, and the facility policy titled, Oxygen Concentrator, the facility failed to ensure an environment free from potential accident hazard by failing to ensure an oxygen cylinder was secure in a cylinder holder for one resident (R), R20 out of ten residents receiving oxygen therapy.</p> <p>Findings include:</p> <p>Record review of the facility policy titled Oxygen Concentrator stated 2. Oxygen is administered under orders of the attending physicians, except in the case of an emergency. 6. Oxygen warning signs must be placed on the door of the resident 's room where oxygen is in use. 8. Storage of oxygen shall be in accordance with the facility Oxygen Safety Policy.</p> <p>Observation on 8/9/2024 at 9:33 am pm revealed an unsecured oxygen cylinder sitting on the floor of R20's room in front of an adjoining bathroom door. If the bathroom door was open the oxygen cylinder tank could have easily been tipped over. At the time of the observation, R20 was observed lying in bed in his room and receiving oxygen via a nasal cannula.</p> <p>Record review of R20's medical record revealed the following diagnoses but not limited to acute hypoxemic respiratory failure.</p> <p>Record review of R20's Physician Order Form (POF) revealed an order dated 7/14/2024 which stated O2 via N/C (oxygen by nasal cannula) Simple Mask @ 2-4 LPM PRN (at 2-4 liter per minute as needed) for O2 Sat < than 90% or SOB (less than 90 percent short of breathe) every 2 hours as needed.</p> <p>Interview with Housekeeper Supervisor on 8/9/2024 at 9:33 am, she reported entering the resident room to clean the room and observing the oxygen cylinder tank on the floor.HK Supervisor reported not considering free standing oxygen as a risk.</p> <p>Interview at the time of observation on 8/9/2024 at 9:34 am with Licensed Practical Nurse (LPN), LPN II confirmed that the oxygen cylinder was sitting on the floor. She removed the cylinder from the room immediately. LPN II confirmed that this is considered a hazardous situation, because if tipped over (referring to the oxygen cylinder) it could result in an explosion injuring residents and others. She reported that oxygen cylinder was placed in the resident's room on Monday by the Hospice Nurse, due to expected inclement weather from an upcoming storm in the area. She reported entering the resident's room earlier this morning with the nightshift nurse at the change of shift. LPN II reported that she did not observe the cylinder in the room at that time.</p> <p>Interview on 8/9/2024 at 9:36 am, Certified Nursing Assistant (CNA) FF reported feeding the resident breakfast and providing Activities of Daily Living Care (ADL) to R20. She reported observing the O2 tank sitting in the room. She reported being unaware of the danger of not having the oxygen cylinder tank freely standing and not in a cylinder holder.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on observations, staff interviews, record review, the facility failed to have a Physician's order for one resident (R,) R20, of eight residents with indwelling catheters. In addition, the facility failed to ensure that R20's catheter tubing was not coiled and correctly position to prevent obstruction of urinary flow.</p> <p>Findings include:</p> <p>Record review of R20's medical record revealed the following diagnoses but not limited to retention of urine unspecified and chronic kidney disease. Record review revealed that resident has a history of urinary tract infections and sepsis.</p> <p>Record review did not reveal an active order for an indwelling catheter.</p> <p>Record review of Significant Change Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview Mental Status Score (BIMS) that indicated severe cognitive impairment. Section H revealed an assessment for catheter use.</p> <p>Observation on 8/9/2024 at 8:10 am revealed R20 lying in bed with catheter attachment and tubing touching the floor.</p> <p>During a secondary observation on 8/9/2024 at 2:44 pm R20's tubing was coiled and the catheter bag was hanging on the arm rest of the chair obstructing urine flow.</p> <p>Observation on 8/10/2024 at 9:50 am revealed R20 sitting in a geriatric chair with catheter attachment. R20 was observed sitting on the tubing and tubing positioned on the arm rest of the chair (above waist). Continued review revealed no flow of urine in a downward position (obstruction of urine flow).</p> <p>Interview on 8/10/2024 at 9:11 am, with Registered Nurse (RN) DD revealed confirmed no order for the catheter. She reported that resident was readmitted to the facility after a hospital stay with the catheter.</p> <p>Interview on 8/10/2024 at 9:15 am, Licensed Practical Nurse (LPN) II confirmed no active order for catheter. She reported that the catheter order per record review was put in place on 7/9/2024 and discontinued by error on 7/10/2024. She reported that the positioning of the tubing is important to prevent the risk for possibility of urinary tract infection and sepsis.</p> <p>8/10/2024 at 9:59 am R20 was observed sitting in his Geri chair and tubing on the floor and cord underneath the Geri Chair, wheel of the chair on the cord. RN DD repositioned the tubing by removing the tubing. RN DD reported that the risk is that the tubing can dislodge from the resident. She reported that she would re-educate the assigned certified nursing assistant (CNA) about the correct positioning of the tubing.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor returned to resident room at 8/10/2024 at 2:00 pm and 3:00 pm, each time the resident was observed with the catheter hanging on the arm rest of the chair and sitting on the tubing. The MDS Coordinator was summoned to the room by the surveyor to observe the deficient practice. The MDS Coordinator repositioned the catheter and repositioned the resident to prevent the resident from sitting on the tubing.</p> <p>Observation of R20 with RN BB and Unit Manager LPN CC on 8/11/2024 at 9:01 am, both staff observed R20 sitting in an upright position in his geriatric chair with the catheter tubing cord hanging on the arm rest of the chair. Continued observation revealed R20 sitting on the catheter tubing. LPN CC reported being upset about the positioning of the resident. LPN CC stated that the CNA was informed not to do this anymore. Both staff immediately began to reposition the resident.</p> <p>Interview with 8/11/2024 at 10:01 am, CNA FF confirmed receiving inservice about the positioning of the catheter and the tubing. However, she reported being unaware that hanging the catheter tubing on the arm rest of the chair could obstruct urine flow. She reported failing to observe R20 sitting on the catheter tubing.</p> <p>Interview on 8/11/2024 at 10:03 am, RN BB revealed that her expectation is for the licensed nurse to review the hospital record at the time of the resident's admission and contact the physician if there is not order for a catheter. She reported being unaware of R20 not having an order for a catheter.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on observations, staff and resident interviews, record review, and review of the facility policy titled, Oxygen Concentrator, the facility failed to ensure oxygen (O2) was administered in accordance with the physician order for one of eight residents (R) R20 receiving oxygen therapy. In addition, the facility failed to ensure that oxygen signage was placed on the resident 's door. The deficient practice had the potential for respiratory difficulty for R20.</p> <p>Findings include:</p> <p>Record review of the facility policy titled Oxygen Concentrator stated 2. Oxygen is administered under orders of the attending physicians, except in the case of an emergency. 4. Use of the Concentrator (a). The nurse shall verify physician 's orders for the rate of flow and route of administration of oxygen (mask, nasal cannula).</p> <p>6. Oxygen warning signs must be placed on the door of the resident 's room where oxygen is in use.</p> <p>8. Storage of oxygen shall be in accordance with the facility Oxygen Safety Policy.</p> <p>Record review of R20's medical record revealed the following diagnoses but not limited to acute respiratory hypoxemic.</p> <p>The Significant Change Minimum Data Set (MDS) dated [DATE] assessed a Brief Interview Mental Status Score of unable to tract. A score of 0 out of 15 indicates severe cognitive impairment. Section O assessed oxygen therapy.</p> <p>Review of orders listed an active order dated 7/14/2024 for O2 via for N/C/Simple Mask @ 2-4 LPM PRN for O2 Sat < than 90% or SOB every 2 hours as needed (oxygen by nasal cannula with simple mask at two to four liters per minute as needed for O2-oxygen saturation less than 90 % every two hours or shortness of breath).</p> <p>Observation on 8/9/2024 at 8:10 am revealed R20 lying in bed receiving oxygen by oxygen concentrator and via nasal cannula at 1.5 LPM (liters per minute). Resident stated that he is not feeling well. No signage on door indicating oxygen usage.</p> <p>Observation on 8/9/2024 12:48 pm, revealed R20 lying in bed and being fed by Certified Nursing Assistant (CNA) LL. Surveyor observed R20 receiving oxygen by via nasal cannula at 1.5 at LPM while being assisted with his meal.</p> <p>Interview at the time of observation on 8/9/2024 at 12:51 pm with Licensed Practical Nurse (LPN), LPN II. LPN II reviewed record with surveyor and confirmed that O2 should be set at 2-4 LPM. She reported that she was prn nurse and was not aware until brought to her attention by the surveyor. She adjusted the O2 Sat</p> <p>Observation on 8/10/2024 at 8:19 am and 10:36 am, revealed R20 lying in bed receiving oxygen by oxygen concentrator and via nasal cannula at 2 LPM. No signage on door indicating oxygen usage.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview at the time of observation on 8/10/2024 at 10:36 am with Register Nurse (RN), RN DD no signage on door to indicate oxygen usage was confirmed. She reported being unaware of this deficient practice until brought to her attention by the surveyor. She reported that she would now instruct the Maintenance Director to put a sign on the door. RN DD reported that the importance and purpose of the oxygen sign is to prevent risk of visitors smoking in the room while the resident is using oxygen.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42463</p> <p>Based on observations, record review, staff interviews, and review of the facility's policy titled, Hemodialysis, the facility failed to provide evidence of ongoing monitoring and care of a dialysis access site and failed to ensure ongoing communication and collaboration with the dialysis center for one of one resident (R) (R31) reviewed for dialysis services. This deficient practice had the potential to place R31 at risk for medical complications, unmet needs, and a diminished quality of life.</p> <p>Findings include:</p> <p>A review of the facility's policy titled Hemodialysis, dated 2/12/2022, under the section titled Policy revealed, This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental and psychosocial needs of residents receiving hemodialysis. Under the section titled Purpose revealed, The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Under the section titled Compliance Guidelines revealed, number 8. The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications.</p> <p>Review of R31's Face Sheet revealed diagnoses that included but not limited to type two diabetes mellitus with other diabetic kidney complication, end stage renal disease, and anemia in chronic kidney disease.</p> <p>Review of R31's quarterly Minimum Data Set (MDS) dated [DATE] revealed Section O (Special Treatments and Programs) documented that R31 received hemodialysis while a resident.</p> <p>Review of R31's Electronic Medical Record (EMR) revealed a physician's order dated 9/5/2023 that read, Resident will have dialysis with [Name of dialysis facility] M/W/F (Monday, Wednesday, and Friday). Further review of physician orders revealed there were no orders for ongoing monitoring and care for R31's dialysis access site.</p> <p>Review of R31's Administration Record dated 8/1/2024 - 8/31/2024 revealed, there were no orders for ongoing monitoring and care for R31's dialysis access site.</p> <p>Review of the R31's Progress Notes from 9/5/2023 through 8/9/2024 revealed, the lack of consistent documentation and proof of ongoing monitoring for R31's dialysis access site in addition to not communicating and collaborating with the dialysis center on the resident's scheduled dialysis days.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/10/2024 at 8:31 am with Registered Nurse (RN) DD and Licensed Practical Nurse (LPN) EE R31's medical records were reviewed, which revealed there were no physician orders that addressed the monitoring and care for the resident's dialysis access site. RN DD revealed that she and the charge nurses were responsible for monitoring the dialysis site each shift ensuring that it remained dry and intact. LPN EE revealed the dialysis staff access R31's dialysis port, and should the facility nurses need to do anything with it they would call the doctor and get an order.</p> <p>During an interview on 8/10/2024 at 8:36 am with RN BB, R31's medical records were reviewed. RN BB verified there were no orders that addressed nursing care and monitoring for the resident's dialysis port. RN BB stated that it was the responsibility of the nurses at the facility to ensure the dressing at the dialysis access site was dry and intact every shift and as needed.</p> <p>Observation on 8/10/2024 at 8:40 am with RN BB of R31 revealed the resident had a dialysis port that was intact to the right chest wall with a dry dressing covering it. RN BB confirmed there should have been dialysis orders written to address monitoring and care for the dialysis port.</p> <p>Interview on 8/10/2024 at 10:58 am with LPN Unit Manager (UM), CC revealed that her expectations of nurses were to make sure orders were in place for dressing changes and to monitor dialysis access sites for residents on dialysis.</p> <p>During an interview on 8/11/2024 at 8:30 am with RN BB, a record review of the Dialysis Communication Sheets for R31 that was kept in the book at the nurses' station revealed missing and incomplete dialysis communication sheets ranging from 9/11/2023-8/2/2024. RN BB confirmed some of the dialysis communication sheets were missing and/or were not completed. She revealed that the facility nurses were to complete the pre-dialysis information and send the form with R31 to dialysis and that the dialysis staff were to complete the post dialysis information and send it back with the resident, but they had not been sending this information back. She reported that most of the time, the facility nurse would call the dialysis center to get a report on the resident. When questioned why the post dialysis information reported from the dialysis center was not documented, she stated she was not sure why. She reported receiving training on dialysis care and understands the importance of communication and collaboration between the facility and dialysis staff.</p> <p>Interview on 8/11/2024 at 9:07 am with LPN Unit Manager (UM), CC stated her expectations of nurses were to complete the dialysis communications sheet and to make sure that R31 returned with the dialysis communication sheet with the post dialysis information completed. She revealed if the post-dialysis sheet was not returned or completed, they were to call and get a report and document this on the communication sheet and/or nurse notes.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>42463</p> <p>Based on record review, staff interviews, and review of the Payroll-Based Journal (PBJ) Staffing Data Report [NAME] Report 1705D Fiscal Year (FY) Quarter 2 2024 (January 1 - March 31), the facility failed to provide Registered Nurse (RN) coverage for 8 hours within a 24-hour period on 1/7/2024, 1/21/2024, 2/4/2024, 2/18/2024, 3/3/2024, 3/17/2024 and 3/31/2024. The facility census was 40 residents.</p> <p>Findings include:</p> <p>Review of the most recent PBJ Staffing Data Report CASPER Report 1705D FY Quarter 2 2024 (January 1 - March 31) revealed the facility triggered for No RN Hours which indicated four or more days within the Quarter with no RN hours for the following dates: 1/7/2024, 1/21/2024, 2/4/2024, 2/18/2024, 3/3/2024, 3/17/2024 and 3/31/2024.</p> <p>Review of the form titled, [Facility Name] Daily Nursing Sheet, dated 1/7/2024 revealed, there was not a registered nurse scheduled on the 1st, 2nd, or 3rd shifts. Further review revealed on 1/21/2024, 2/4/2024, 2/18/2024, 3/3/2024, 3/17/2024, and 3/31/2024 there was RN coverage eight hours on 1st shift.</p> <p>Review of the form titled, Daily Staffing Schedule dated 1/7/2024, 1/21/2024, 2/4/2024, 2/18/2024, 3/3/2024, 3/17/2024 and 3/31/2024 revealed, RN HH was scheduled to work on 1st shift.</p> <p>Review of the payroll Timecard Report for RN HH revealed, the total number of hours worked on 1/7/2024 (7.67 hours), 1/21/2024 (8.22 hours), 2/4/2024 (7.55 hours), 2/18/2024 (7.47 hours), 3/3/2024 (7.80 hours), 3/17/2024 (7.43 hours) and 3/31/2024 (7.68 hours).</p> <p>Interview on 8/10/2024 at 10:05 am with the Business Office Manager (BOM) revealed, she was responsible for human resources and payroll. She confirmed there was no RN coverage for eight full hours for the following dates (1/7/2024, 1/21/2024, 2/4/2024, 2/18/2024, 3/3/2024, 3/17/2024 and 3/31/2024) indicated on the PBJ report. The BOM revealed they had RN coverage scheduled on those days however the time clock system automatically deducted 30 minutes for lunch. She stated they were aware that RN HH who worked on those dates did not work the full eight hours and that this had been addressed with the Administrator. She reported they try to staff at least two RNs daily to meet the requirements.</p> <p>Interview on 8/10/2024 at 2:00 pm with the Administrator revealed, she was aware of the discrepancy with the RN hours indicated on the PBJ report. She revealed that she knew it would potentially trigger the report. She revealed the facility staff are required to take 30 minute lunch breaks and two 15 minute breaks during an eight hour period. She revealed she had discussed this with corporate so that they could produce a resolution. She reported she was aware that there should be RN coverage a full eight hours within a 24 hour period.</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 8/10/2024 at 3:22 pm with Licensed Practical Nurse (LPN) Unit Manager revealed, that she was responsible for staffing RN coverage for eight hours per day. She reported that the new time clock system automatically clocks them out regardless of whether the nurse took the lunch or not. LPN Unit Manager stated her expectations of the RNs was to work at least 8.5 hours to ensure a full eight hours daily as required.</p>		

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<p>F 0770</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914</p> <p>Based on staff interviews and record review, the facility failed to ensure laboratory orders were obtained as ordered by the physician for one of 13 residents (R) (R21). This failure resulted in actual harm on 9/19/2023 when R21 was admitted to the local hospital and required a blood transfusion after the facility failed to obtain ordered labs for March 2023 and June 2023 facility received lab results on September 19, 2023, indicating R21 had a hemoglobin level of 5.9 g/dl (grams per deciliter) normal range was 13.5 - 17.5 g/dl.</p> <p>Findings:</p> <p>Record review revealed R21 was admitted to the facility with the diagnosis of but not limited to, Idiopathic gout, cerebral infarction, aphasia, hemiplegia, Diabetes mellitus, chronic systolic congestive heart failure, hypertensive heart disease, hypercholesterolemia, angina pectoris, major depressive disorder, and epilepsy. Physician order dated 3/7/2023 indicated to collect labs CBC (complete blood count) w (with) diff Q (every) three months March/June/September/December. There was no indication the ordered labs were obtained for March 2023 and June 2023.</p> <p>Review of the laboratory results dated [DATE] revealed a CBC was obtained with a result of Hemoglobin (HGB) 5.9 g/dl.</p> <p>Review of R21 progress notes dated 9/19/2023 revealed resident has a critical lab with a hemoglobin of 5.9 (-) on call for Medical Director (MD) wanted to send to emergency room (ER) notified family member and called report to ER was transported by Emergency Medical Service (EMS).</p> <p>Interview on 8/10/2024 at 2:37 pm with Unit Manager revealed that R21 received the diagnosis of Iron Deficiency anemia after he was admitted to the hospital and received two units of blood for a hemoglobin of 5.9. The order to collect the CBC was a routine blood draw that the facility physician would order for all residents. The results for the CBC that was ordered for March 2023 and June 2023 were not completed, and results were unable to be located in the electronic Laboratory system or in the R21 medical record.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>41914</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, staff interviews, and review of facility documents, the facility failed to ensure recipe for puree carrots and chicken were followed to preserve nutritional value of food for residents receiving a pureed diet. The facility also failed to ensure residents consuming a puree diet were served the recommended three ounces (oz) of protein during meal service.</p> <p>Findings:</p> <p>Review of the untiled document submitted by the Dietary Manager with scoop number, diameter capacity (in ounces) and color (color of scoop handle) revealed the number 16 scoop that was used to measure the puree foods had the following: Number 16 -Diameter 2 1/4 inches/5.72 cm (Centimeters), Capacity - 2 3/4 Oz. The number 16 scoop did not provide the needed three ounces of protein per resident.</p> <p>Review of the document titled, Quantified Recipe (Recipe #220) for baked chicken revealed the following: portion size: number 8 scoop, serving utensil #8 scoop, baked chicken 30z SCR. 1. Prepare according to ground recipe. Stock Chicken/soup base for thinning. Recipe #249 Seasoned carrots, portion size #16 scoop (1/2 cup), serving utensil #16 scoop.1. Prepare according to regular recipe. There was no indication to add any type of liquids during the puree process</p> <p>Puree observation on 8/10/2024 at 10:45 am revealed [NAME] AA poured measured carrots into food processor and began blending food. During blending staff member went over to the vegetable sink next to blending station and retrieved tap water from the sink faucet and proceeded to add to the carrots during the mixing process. This step was repeated one more time until desired consistency was met. After carrots were completed [NAME] AA proceeded to prepare the diced chicken for the puree residents in the same manner of adding water to the mixture until desired consistency was met.</p> <p>Interview on 8/10/2024 at 11:00 am with [NAME] AA revealed that the facility currently had three residents that were on puree diets. It was reported that the recipe for pureeing foods is in the menu book that is kept on the shelf above the milk cooler. During the interview staff member was asked how many ounces (oz) of protein should each resident on a puree diet receive and staff member was unable to verbalize the amount needed for each resident to receive the appropriate nutritional value was met. [NAME] AA stated, The puree residents have a divided plate and I just make sure that one of the squares is full when I scoop the food into the plate, and sometimes I will put a little more in it. Further interview also revealed that [NAME] AA stated that she uses the number 16 scoop to measure the portions before pureeing the food but was unable to verbalize what the measurement of the scoop used was.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 8/10/2024 at 11:30 am with the Dietary Manager revealed that there are recipes that are to be followed that are located in the kitchen, but the staff that is currently working in the kitchen have been there for a while and are aware of which scoop to use for measuring foods to ensure nutritional value is met. During interview, the Dietary Manager was asked how the staff know which scoop to use and she stated that the scoops are color coded and there use to be a guide posted on the wall in the kitchen that indicates the amount in ounces of each scoop by the color of the handle. Further interview also revealed that sometimes during the puree process the cooks will add water or milk to ensure the right consistency is obtained. Dietary Manager confirmed the scoop used by [NAME] AA was not the correct scoop to obtain the recommended three ounces of vegetables and protein for residents consuming a puree diet.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914</p> <p>Based on observations, staff interviews, and review of the facility policy titled, Used By Dating Guideline, the facility failed to ensure food items were properly labeled and dated, failed to discard expired foods by expiration date, and failed to ensure ice machine was kept clean and free of lime and calcium buildup. The deficient practice had the potential to affect 36 of 40 residents receiving an oral diet.</p> <p>Findings:</p> <p>Review of the facility policy titled, Used By Dating Guideline Dated [DATE] revealed under Section 1: foods that have been mixed with other ingredients, prepared in any way, or portioned out include, but are not limited to juices, thickened beverages, canned fruit, unused portions, prepared salads, cut fruits/vegetables, roasted/sliced meats use by date-three days after preparation.</p> <p>Observation on [DATE] at 7:50 am revealed in the reach in cooler located to the right of the main kitchen a small steamtable pan of tuna salad that was unlabeled and dated, a bag of cooked macaroni noodles that were not label or dated, 16 oz (ounce) bottle of opened Zesty Italian dressing that was not labeled or dated, 22 oz bottle of opened strawberry syrup not labeled or dated.</p> <p>Observation on [DATE] at 7:51 am revealed on the steel table at the back of the main kitchen in a large gray plastic container was an opened half bag of brown sugar that was not labeled or dated, a bag of unknown substance that was wrapped in plastic wrap unlabeled and undated, a opened half bag of fried onions with a use by date of [DATE].</p> <p>Observation on [DATE] at 7:53 am revealed in the reach in cooler located to the left of the kitchen by the steam table a large chef salad unlabeled with no expiration date, chef salad in a small white bowl unlabeled and not dated, medium size steamtable pan of macaroni salad with the expiration date of [DATE], half a bag of shredded white cheese not labeled or dated, half a bag of opened cheese cubes unlabeled and undated.</p> <p>Observation on [DATE] at 11:10 am revealed the facility ice machine located in the staff break area there were white chalky streaks noted streaming down the back, front and side of the machine, there was also a thick layer of white chalky substance that was noted in right upper crevices on the front side of the machine. Observation on the inside of the ice machine also revealed a thin layer of black substance on the plastic white panel on the inside of the machine.</p> <p>Interview on [DATE] at 11:15 am with the Administrator revealed the ice machine should be cleaned by the dietary staff daily and maintenance cleans the filter and the motor parts quarterly. A further interview also revealed that the expectation is that the machine is cleaned at least monthly.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2024
NAME OF PROVIDER OR SUPPLIER Thomasville Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Skyline Drive Thomasville, GA 31757	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on [DATE] at 11:25 am with Dietary Manager revealed that she will wipe down the ice machine daily but has been on vacation for the last week. Maintenance is responsible for cleaning the inside of the machine to include the white plastic panel on the inside of the machine. Further interview also revealed that all foods should be labeled and dated when put in the cooler and any leftover food should be discarded after three days. The Dietary Manager also confirmed all unlabeled and expired foods as well as the ice machine that were observed during the initial tour.</p> <p>Interview on [DATE] at 11:57 am with the Maintenance Director revealed that he was responsible for cleaning the ice machine quarterly and the last time it was cleaned was in [DATE]. A further interview revealed that the last quarter's cleaning was not completed, and the machine is currently being cleaned. During the interview it was also revealed that when the machine is cleaned the ice bin is emptied, the filters are cleaned, and the outside of the machine is de limered.</p>