STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115540	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin View Health and Rehab	211 Mathis Avenue Twin City, GA 30471

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27669 Based on observations, staff and resident interviews, record review, and review of the facility policy titled Answering the Call Light, the facility staff failed to ensure resident call lights were within reach for three of 18 sampled residents (R) (R5, R46, R70). This failure placed R5, R46, and R70 at risk of accident, injury, and/or unmet needs related to an inability to call for staff assistance. Findings include: A review of the facility policy titled Answering the Call Light, with a review date of 9/2023, revealed: General Guidelines 5. When a resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. 1. A review of R5's quarterly Minimum Data Set (MDS), dated [DATE], revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 10 (indicating moderate cognitive impairment), and section GG (Functional Abilities and Goals) documented the resident required supervision with Activities of Daily Living (ADLs). During the initial tour of the facility, on 6/18/2024, at 9:40 am, R5 was observed lying in bed watching television (TV), and her call light was not within sight of the surveyor. During an interview conducted at the time of the observation, R5 stated she was not sure where her call light was. The resident's call light cord was observed draped over the headboard of her bed, with the call light pendant out of reach of the resident. 2. A review of R46's annual MDS, dated [DATE], revealed section GG (Functional Abilities and Goals) documented the resident was dependent on staff with Activities of Daily Living (ADLs). During the initial tour of the facility on 6/18/2024 at 10:10 am, and during an additional tour conducted on 6/19/2024 at 10:20 am, R46 was observed lying in bed resting with eyes closed, and the resident's call light pendant was observed laying on the floor beside the bed, out of sight and out of reach of the resident. 42991 3. A review of R70's admission MDS, dated [DATE], revealed section GG (Functional Abilities and Goals) documented the resident was dependent on staff with Activities of Daily Living (ADLs). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115540	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Twin View Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Mathis Avenue Twin City, GA 30471	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/19/2024 at 9:48 am, R70 was observed lying in bed with the call light hanging under the bed and not within reach of the resident. During an interview on 6/21/2024 at 10:57 am, Certified Nurse Assistant (CNA) EE stated they were to answer call lights immediately. When asked about the call light not being in reach for R70 on 6/19/2024 at 9:47 am, CNA EE stated they kept it in reach and did not know why it was not.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42991 Based on observations, staff interviews, and review of the facility policy titled Safe, Clean, Comfortable, Homelike Environment F584, the facility failed to ensure that maintenance services necessary to maintain a sanitary, orderly, and comfortable interior environment were provided. Specifically, 11 of 38 resident rooms were found in disrepair. These deficient practices had the potential to place residents at risk for the use of unsanitary and unsafe equipment and a potential for diminished quality of life. Findings include: A review of a facility policy titled Safe, Clean, Comfortable, Homelike Environment F584, dated effective 9/2023, revealed: Policy Statement: F 584 Residents have the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports [sic] for daily living safely. Policy Interpretation and Implementation: 1. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 5. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order; b. Comfortable (minimum glare yet adequate (suitable to the task) lighting; c. Inviting colors and decor; d. Personalized furniture and room arrangements; e. Pleasant, neutral scents; f. Plants and flowers, were appropriate; g. Sufficient individual closet space; h. Comfortable temperatures; and i. Comfortable noise levels. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of room [ROOM NUMBER] on 6/19/2024 at 9:47 am, a 6.5-inch-long by approximately 3-inch-wide hole was observed on the wall next to the left side of Bed 2. The wall near the head of the bed and behind the headboard had plaster missing and scrapes that were approximately 12 inches long and 3.5 inches wide and included multiple scrapes. During an observation of room [ROOM NUMBER] on 6/20/2024, at 11:52 am, observation revealed a white plaster patch was visibly covering most of the hole in the wall, and there were about two inches of wall not covered by plaster. Plaster was pulled up on the top left corner. During an interview on 6/21/2024 at 10:57 am, Certified Nurse Assistant (CNA) EE stated they also saw holes in the wall but were unsure of how long they were present. CNA EE stated they informed the nurse and maintenance verbally but were unsure when they told them. CNA EE then stated they did not use a computerized maintenance reporting system. During an interview on 6/21/2024 at 11:11 am, the Plant Operations Director stated they had fixed the wall in R70's room. When asked about the plaster not covering up the hole after the repair was made on 6/20/2024, the Plant Operations Director stated they would have to repair the wall again and use a board that would cover the entire hole. The Plant Operations Director further stated they were working on repairing walls, painting, patching up spots and tears on walls, repairing window seals and light fixtures, and replacing blinds. The Plant Operations Director stated they also had an assistant to help get some of the tasks completed in a timely manner. 27669 On 6/18/2024 at 10:00 am, during the initial tour of the facility, observation of room [ROOM NUMBER] revealed the walls were marred throughout the room. There was exposed sheetrock, peeled/cracked paint around the air vent in the ceiling, missing molding, and areas of unfinished wall repairs/painting. Observation on 6/18/2024 at 10:10 am revealed multiple areas in room [ROOM NUMBER] had unfinished wall repairs. There was exposed sheetrock, missing crown molding, chipped/peeled paint around the air vent in the ceiling surrounding the vent between beds B/C, and the wall was marred. In an interview on 6/19/2024 at 2:00 pm, the Assistant Director of Nursing (ADON) stated that the Maintenance staff was currently at another facility assisting with their facility repairs for an extended period. 16683 An observation on 6/18/2024 at 11:16 am of room [ROOM NUMBER] revealed the following: - Behind the headboard of Bed 2 were multiple, vertical scrapes of various depths across the width of the headboard (approximately 36 inches). In places, the scrapes abraded through only the paint. In other places, the scrapes went through the outer paper layer of the drywall, leaving behind shreds/curls of the outer paper. At their greatest depth, the scrapes dug into the gypsum. The largest area of abraded/exposed gypsum was estimated to be approximately 12 inches by 18 inches. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The headboard of Bed 2 had a length of gray, open-cell foam wrapped around the outer edge of the board. The appearance of the length of open-cell foam was consistent with that of pipe insulation. The foam was torn in places. - The wall behind Bed 1 (the bed by the door) was similarly damaged, with vertical scrapes of various depths across the width of the headboard, through the paint, the outer paper layer of the drywall, and/or the gypsum. - The wall behind the headboard of Bed 3 (the bed by the window) was also marred, not patched/repaired, and had been painted over where the scrapes had abraded the outer layer of the drywall paper and had dug into the gypsum. - Between Bed 2 and Bed 3 was a wall-mounted television (TV). The power cord to the TV was plugged into an electrical outlet. A coaxial cable was dangling loosely from the TV and was not long enough to reach a cable outlet. - An observation of the side wall next to Bed 1 found two (2) holes in a vertical line that completely penetrated through the drywall. Each hole was approximately 1 inch in diameter. In an interview on 6/19/2024 at 4:00 pm, the surveyor reported to the Administrator that the TV in room [ROOM NUMBER] room was not working, with the coaxial cable dangling from the TV and unable to be connected to a cable outlet. The Administrator stated that, if it were her, she would like to be able to watch TV in her room. Observations of Rooms 33 through 40 were made between 12:13 pm, and 12:35 pm on 6/20/2024. The observations were made in the company of Licensed Practical Nurse (LPN) CC, who confirmed the findings. The findings included: - Wall marring, including penetrations and scrapes of various depths through the paint, the outer paper layer of the drywall, and/or into the gypsum layer (all rooms observed) - Walls missing the outer paper layer of drywall, especially around wall-mounted soap dispensers and paper towel dispensers in bathrooms (multiple rooms) - Unsealed/unpainted oriented strand board sheathing covering tiled openings similar in size to that of single shower stalls (bathrooms of rooms [ROOM NUMBERS]) - Damage to bathroom doors through the outer layer of veneer, exposing the hardwood layer (multiple rooms, with the most extensively damaged surfaces on both sides of the bathroom door in room [ROOM NUMBER]) - Broken window blinds (multiple rooms) - Broken wooden windowsills (rooms [ROOM NUMBERS]) - Missing wooden baseboard (room [ROOM NUMBER]) - Missing paper towel dispenser (shared bathroom between rooms [ROOM NUMBERS]) (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Rusted metal door frames to bathrooms (multiple rooms) - Rusted grab bar (shared bathroom between rooms [ROOM NUMBERS]) - Rusted and/or broken wall-mounted toilet paper holders (bathroom of room [ROOM NUMBER] and shared bathroom between rooms [ROOM NUMBERS]) - Rusted ceiling-mounted tracks for privacy curtains (room [ROOM NUMBER]) - The wall behind the toilet where the exposed, manual flush valve of the toilet was mounted was damaged, with the outer paper layer of the drywall hanging loosely from the wall (shared bathroom between rooms [ROOM NUMBERS]) - Broken nightstand (behind the door to room [ROOM NUMBER]) and a chest of drawers with missing drawer pulls (behind the door in room [ROOM NUMBER]) - Splatters of a beige-colored substance on the ceiling above Bed 2 (the middle bed of a three-bedroom in room [ROOM NUMBER]) - Broken electrical outlet (behind Bed 1 in room [ROOM NUMBER]) - Blue paper painter's tape on walls (room [ROOM NUMBER]) During an interview on 6/21/2024 at 1:35 pm, the Administrator stated she and the Plant Operations Director completed a walk-through on 6/10/2024 and identified rooms that needed to be repaired. The Administrator stated the facility's goal was to complete all repairs by October 2024.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16683 Based on observations, staff interviews, review of facility-posted signage and temperature logs, and a review of the facility policy titled 5.3 Storage and Expiration Dating of Medications, Biologicals, the facility failed to store vaccines under proper temperature controls with twice daily monitoring and failed to remove from use medications, needles, and laboratory supplies that were kept past their expiration dates in one of one medication storage room and one of two medication carts reviewed. This deficient practice created the potential for residents to receive vaccinations with altered effectiveness and the potential for the use of expired medical and laboratory supplies. Findings include: The facility policy titled 5.3 Storage and Expiration Dating of Medications, Biologicals, revised [DATE], stated: APPLICABILITY: This Policy 5.3 sets forth the procedures related to the storage and expiration dates of medications, biologicals, syringes and needles. PROCEDURE: . 4. Facility should ensure that medications and biologicals that (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened [sic]. 5.1 Facility staff may record the calculated expiration date based on the date opened on the primary medication container [sic]. 5.2 Medications with a manufacturer's expiration date expressed in month and year (e.g. May, 2022) will expire on the last day of the month . 5.4 When an ophthalmic solution or suspension has a manufacturers [sic] shortened beyond use dated once opened, facility staff should record the date opened and the date to expire on the container . 10. Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. Facility Staff should monitor the temperature of vaccines twice daily . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10.3.2 Facility should monitor cold storage containing vaccines two times a day per CDC guidelines. An observation of the medication room for Unit 1 was conducted in the presence of the Director of Nursing (DON), beginning at 9:37 am on [DATE]. Observation found the following stock medications kept past their expiration dates and available for use: - Two 16-ounce bottles of Enulose 10 grams (GM) / 15 milliliters (ML) with expiration dates of ,d+[DATE]. - Two 16-ounce bottles of Biotene Dry Mouth Oral Rinse with expiration dates of [DATE]. The above were confirmed by the DON at the time of the observations. An observation of the medication refrigerator in the Unit 1 medication room, in the presence of the DON, at 10:01 am on [DATE], found four vials of pneumococcal vaccine polyvalent Pneumovax 23 vaccine, all with an expiration date of [DATE]. Posted on the cabinet door above the refrigerator was a sign that stated: FRIDGE TEMPS ARE TO BE RECORDED TWICE A DAY EVERY DAY. Review of the refrigerator's temperature logs for [DATE] found the following instructions: Completing the temperature long: Check the temperatures in both the freezer and the refrigerator compartments of your vaccine storage units and least twice each working day. Review of the information recorded on the [DATE] temperature logs found that twice daily recordings were not recorded for the following 10 dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. The above observations were confirmed by the DON at the time of the observations. An observation of the medication cart for Unit 3 was conducted in the presence of Licensed Practical Nurse (LPN) CC, beginning at 10:25 am on [DATE]. Observation found the following prescription medications in the medication cart kept past their expiry or use by dates and which were available for use: - One (1) bottle of Systane Lubricant Eye Drops for Resident (R)38 with an expiration date of ,d+[DATE]. - One (1) bottle of Travatan Travoprost Ophthalmic Solution for R30 with an expiration date of 2024-APR. - One (1) bottle of latanoprost ophthalmic solution for R31 marked [DATE] and with a label stating: Discard after 42 days Exp. Date [DATE]. Additionally, the following supplies were found on Unit 3's medication cart and available for use: - One (1) Vacutainer tube with an expiration date of [DATE]. - One (1) filter needle with an expiration date of ,d+[DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One (1) safety needle with an expiration date of [DATE]. - One (1) Bluewing Safety Blood Collection Set w/ Luer Adapter with an expiration date of 240505 [[DATE]]. - One (1) Eclipse blood collection needle with an expiration date of [DATE]. All the above observations were confirmed by LPN CC at the time of the observations.

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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. 43637 Based on observations, staff interviews, and review of the facility policies titled Food Preparation and Service F804 F812 and Refrigerators and Freezers F812, the facility failed to store foods in accordance with professional standards for food service safety. Additionally, the facility staff failed to record the daily temperatures of the refrigerator and freezer for two of two observed for temperature logs. The deficient practices had the potential to place 75 residents who received an oral diet from the kitchen at risk of contracting a foodborne illness. Findings include: A review of the facility policy titled Food Preparation and Service F804 F812, last revised 10/23, revealed: Residents are provided with meals that are prepared by methods that conserve value, flavor, and appearance. Residents are provided with food and drink that is palatable, attractive, and at a safe and appetizing temperature. On 6/18/2024, at 9:30 am, during the initial tour of the kitchen with the Dietary Manager (DM), one pack of moldy sub sandwich rolls [six-count] was observed stored with ready-to-eat breads. The DM confirmed the bread was moldy and removed it from the bread rack. On 6/18/2024, at 9:44 am, observation of the temperature logs of the reach-in refrigerator revealed no documentation of the refrigerator temperature for 6/9/2024 and 6/10/2024 for the am shifts or for 6/1/2024, 6/5/2024, 6/10/2024, and 6/11/2024 for the pm shifts. On 6/18/2024, at 9:45 am, observation of the temperature logs of the reach-in freezer revealed no documentation of the freezer temperature for 6/9/2024 and 6/10/2024 for the am shifts or for 6/1/2024, 6/2/2024, 6/3/2024, and 6/5/2024 for the pm shifts. This observation was confirmed by the DM during an interview at the same time the observation occurred. On 6/19/2024 at 12:15 pm, observations of multiple eight-ounce (oz) glasses of juice, tea, and water were observed uncovered. The cups were to be transported to residents in the dining area and to residents who ate in their rooms. The DM stated, in an interview during the observation, that the glasses should have been covered after they were prepared. The DM further stated the dietary aides should not transport the drinks without a lid or cover.

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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. 16683 Based on observation, staff interview, record review, and review of the facility policy titled Handwashing/Hand Hygiene F 880, the facility failed to ensure staff administered medications via gastrostomy tube (G-Tube) (a tube surgically placed through the skin into the stomach to provide nutrition, hydration, and medication) to one resident (R) (R46) in a manner to prevent the development and transmission of infections. This deficient practice placed R46 at risk of contracting avoidable infections. Findings include: The facility policy titled Handwashing/Hand Hygiene F 880, effective date 9/2023, stated: Guidelines: . 2. Staff shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 6. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub [ABHR]. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents; b. Before donning sterile gloves; c. Before performing any non-surgical invasive procedures; d. Before preparing or handling medications; e. Before handling clean or soiled dressings, gauze pads, etc.; f. Before moving from a contaminated body site to a clean body site during resident care. g. After contact with a resident's intact skin; h. After handling used dressings, contaminated equipment, etc.; i. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and j. After removing gloves . 8. The use of gloves does not replace handwashing/hand hygiene. Record review revealed R46 had active diagnoses that included dysphagia [difficulty swallowing], gastrostomy status [presence of a feeding tube], and overactive bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of medication administration to R46, beginning at 8:10 am on 6/19/2024, Licensed Practical Nurse (LPN) AA used alcohol-based hand rub (ABHR) for hand hygiene and prepared R46's medications by expelling each oral tablet into separate 30 milliliters (ml) medication cups. She then placed each cup on top of the cart without first sanitizing or placing a barrier on the top of the cart. Observation of the top of the medication cart found dried, circular rings and light debris on the surface of the cart, which suggested the top of the cart was not clean. LPN AA crushed all tablets separately and placed each crushed tablet in its own 30 ml, graduated medication cup. LPN AA then donned a pair of disposable gloves without performing any hand hygiene, opened four capsules, and poured the contents of each capsule into a 30 ml graduated medication cup. LPN AA also poured two oral medications and liquid protein into separate 30 ml medication cups and measured and poured one capful of a powder medication into a water cup. After preparing all the medications, LPN AA stacked the graduated medication cups containing the medications such that the bottom of each stacked cup came into contact with the contents of the cup beneath it. LPN AA entered the resident's room, carrying in her still gloved hands, the stacked medicine cups, as well as a tongue depressor, and several additional cups, including those cups containing the oral solutions and the powder medication. As LPN AA approached the resident's bed, she picked up a folded towel that had been sitting on the seat of the resident's manual wheelchair, draped the towel across an empty portion of the resident's overbed table, and placed the cups of medication on the towel. LPN AA then walked back to the entrance of the room, doffed her gloves, donned a gown that she had previously hung on a hook by the entrance to the room, used ABHR from a wall-mounted dispenser in the hallway outside the door, re-entered the room, and donned a pair of disposable gloves that she pulled out of the pockets of her uniform. At 8:26 am on 6/19/2024, while wearing the new pair of gloves, LPN AA handled the overbed table to move it closer to the resident's bed and stated the need to obtain water for medication administration. LPN AA carried empty water cups to the closed bathroom door, knocked on the door, turned the doorknob to open the door, turned on the water faucet, filled two cups with water at the sink, turned off the water faucet, and carried the cups of water to the overbed table. Without changing gloves and performing hand hygiene after having touched multiple environmental surfaces (e.g., overbed table, bathroom doorknob, water faucet, etc.), LPN AA removed a piston syringe from an open wrapper that had been stored at the bedside and attached the tip of the syringe to a port on the resident's G-Tube. After verifying the placement of the G-Tube, LPN AA instilled a water flush and then proceeded to administer the medications with additional water flushes between each medication. At 8:36 am on 6/19/2024, after administering a final water flush after the last medication was given, LPN AA detached the syringe and capped the port of the G-Tube. LPN AA used the bed controller to lower the height of the resident's bed to its lowest position before carrying the piston syringe with the plunger to the bathroom. Wearing the same gloves, LPN AA knocked on the closed bathroom door, turned the doorknob to open the door, turned on the water faucet, rinsed the syringe and plunger, turned off the water faucet, and carried the piston syringe back to the resident's bedside. LPN AA placed the still wet syringe and plunger in an open wrapper and walked away from the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115540	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Twin View Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 211 Mathis Avenue Twin City, GA 30471	

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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	At 8:42 am on 6/19/2024, observation revealed the inside of the wrapper revealed multiple visible drops of a light, beige-colored liquid consistent with the appearance of an enteral nutritional product, and the tip of the syringe barrel contained a white substance consistent with the appearance of an incompletely dissolved tablet. LPN AA verified that the inside of the wrapper was wet and not clean. During an interview at 8:46 am on 6/19/2024, LPN AA confirmed stacking cups containing medications that had been placed on the top of the medication cart that had not been sanitized could contaminate the contents of the cups. LPN AA also confirmed her gloves should have been changed after contact with environmental surfaces, with hand hygiene performed between glove changes. During an interview with the Director of Nursing, Infection Preventionist, and Advanced Practice Registered Nurse at 9:03 am on 6/19/2024, all parties agreed the medication cups should not have been stacked, the piston syringe should not have been stored wet inside an unclean wrapper, and glove changes with hand hygiene should have occurred when gloves became contaminated from touching environmental surfaces.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115540	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 43637 Based on observations, staff interviews, and review of the facility policy titled Sanitation F812, the facility failed to ensure doors in the main kitchen remained in good repair to prevent pests from invading the main kitchen and one of two dining areas. This failure had the potential for pests to transfer harmful microorganisms to food leading to foodborne illness for the 75 residents receiving food from the kitchen. Findings include: A review of the facility's policy titled Sanitation F812, effective 10/23, revealed: 1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. Observation of the main kitchen on 6/18/2024 at 10:00 am, 6/19/2024 at 11:00 am, and 6/19/2024 at 12:15 pm revealed a substantial number of live flies in the kitchen area. This observation was confirmed in the presence of the Dietary Manager (DM), who was interviewed. On 6/18/2024 at 10:00 am, observation found the back door in the main kitchen was slightly open, with an opening at the top of the door. The DM revealed the door had been broken and had needed a repair for a while. Observation of the main dining hall between Unit 1 and Unit 2 on 6/18/2024 at 12:23 pm revealed multiple live flies around the area while residents were eating lunch. Several unidentified residents were observed swatting the flies away while eating lunch. On 6/19/2024 at 12:15 pm, observations found multiple eight-ounce (oz) glasses of juice, tea, and water were uncovered. Several insects were observed flying over the uncovered glasses. The DM acknowledged the insects during an interview conducted at the time of the observation. The DM further stated in an interview during the observation that the glasses should have been covered after they were prepared. On 6/20/2024 at 2:30 pm, the Maintenance Director (MD) revealed pest control treated the kitchen and dining area at least once a month. The MD stated the cause of the flies was a result of the back kitchen door not being replaced and further stated he was unaware the door needed to be replaced. The MD stated he could put a weather strip to cover the opening of the kitchen door until an order was placed for a new door. The MD revealed the back kitchen door had an air curtain (to prevent insects from coming into contact with the kitchen area and dining area), and he stated that, sometimes, the air curtain was turned off by staff.