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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015044 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/11/2021 |
| NAME OF PROVIDER OR SUPPLIER Caregivers of Pleasant Grove, Inc | | STREET ADDRESS, CITY, STATE, ZIP CODE 700 First Avenue Pleasant Grove, AL 35127 | |

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) |
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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and a review of a facility policy titled HIPPA (Health Insurance Portability and Accountability Act) PRIMARY RULES EMPLOYEE SECURITY AND CONFIDENTIALITY AGREEMENT, the facility failed to ensure a Registered Nurse (RN) Employee Identifier (EI) #9, did not leave the Electronic Medication Administration Record (EMAR) screen visible and unattended which exposed Resident Identifier (RI) #17 personal information and medications.</p> <p>This deficient practice affected RI #17. One of five residents observed during the medication administration pass, and EI # 9 one of four nurses observed administering medication.</p> <p>Findings Include:</p> <p>Review of the facility's undated HIPPA PRIMARY RULES EMPLOYEE SECURITY AND CONFIDENTIALITY AGREEMENT revealed, . 2. I will treat all information received in the course of my employment with the provider, which relates to the residents of the provider, as confidential and privileged information.</p> <p>RI #17 was admitted to the facility on [DATE] with a diagnosis of Schizoaffective Disorder, Depressive Type.</p> <p>On 3/09/2021 at 10:00 AM, the surveyor observed a MAR screen left unattended and open for public view with RI #17's personal information, primary contact, primary physician, diagnosis, current medication (Zyprexa and Lexapro) and other information exposed. EI #9 a Registered Nurse was observed walking out of RI #17's room to the unattended cart. The surveyor pointed at the screen and asked EI #9 what information was shown on the screen. EI #9 stated, patient information. The surveyor asked EI #9 why was the screen left open to view by anyone in the hall. EI #9 stated, she should have minimized her screen prior to leaving the medication cart. The surveyor asked EI # 9 why was it important to utilize the privacy screen when administering medication. EI #9 stated, anyone could walk by and view personal information and that was a HIPPA violation.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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** Based on interview, medical record review and a review of the CMS's (Center for Medicare Services) Long-Term Care Facility RAI (Resident Assessment Instrument) 3.0, User's Manual Version 1.17.1 October 2019, the facility failed to:</p> <p>1) accurately code RI (Resident Identifier) #38 Admissions MDS's (Minimum Data Set) to reflect he/she was receiving dialysis,</p> <p>2) accurately code RI #17's Quarterly MDS as having an indwelling catheter.</p> <p>This deficient practice affected two of 21 sampled residents whose MDS's were reviewed.</p> <p>1) A review of the CMS's, RIA 3.0 User's Manual, Chapter 3, . MDS Items (O) documented: . O0100J, Dialysis Code . renal dialyses which occurs . at another facility record treatment of hemofiltration . in this item .</p> <p>RI #38 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a Diagnosis of End Stage Renal Disease and Chronic Kidney disease.</p> <p>RI #38's March 2021 Physician's order documented: . Dialysis . one time a day every other day . Order date 11/01/2020.</p> <p>RI #38's admission MDS 's dated 12/28/20 and 1/13/21 were not code for dialysis.</p> <p>On 3/10/21 at 3:34 PM, an interview was conducted with EI (Employee Identifier) #6, LPN, (Licensed Practical Nurse), MDS Coordinator. EI #6 was asked if RI #38 was on dialysis. EI #6 said yes. EI #6 was asked if RI #38 was coded for dialysis on Section O of his/her admission MDS dated [DATE]. EI #6 said no he/she was not. EI #6 was asked should RI #38 had been coded for dialysis. EI #6 said, yes he/she should have. EI #6 was asked if RI #38 was coded for dialysis on the Section O for his /her admission MDS dated [DATE]. EI #6 said no he/she was not. EI #6 was asked should RI #38 had been coded for dialysis. EI #6 yes, she/he should have been. EI #6 was asked why RI #38 was not coded for dialysis. EI #6 said she did not know why. EI #6 was asked what was the importance of having an adequately coded MDS. EI #6 said to paint a picture of the resident and for payment.</p> <p>2) RI #17 was admitted to the facility on [DATE]. Diagnoses included abnormal posture and muscle weakness.</p> <p>A review of RI #17's Active Orders As Of: 3/20/2021 revealed a prescriber written order . Change suprapubic catheter . (Q) month and as needed (PRN) . dated 10/30/2020.</p> <p>A review of RI #17's Quarterly MDS with a date of 12/1/2020 revealed the resident was coded for an indwelling urinary catheter in Section H.</p> <p>On 3/09/21 at 9:34 AM RI #17 was observed to have an indwelling urinary catheter.</p> <p>(continued on next page)</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>On 03/10/21 at 3:57 PM an interview was conducted with EI #4, Registered Nurse, Director of Clinical Services, former MDS coordinator. EI #4 was asked, when was RI #17's suprapubic catheter inserted. EI #4 replied, he/she was admitted with it on 12/14/18. EI #4 was asked, who was responsible for accurately completing the MDS. EI #4 replied, the MDS coordinator. EI #4 was asked, when was she the MDS coordinator. EI #4 replied, 2019 until November, 2020. EI #4 was asked, when different staff from different departments are completing sections of the MDS, who was ultimately responsible for accuracy of MDS. EI #4 replied, she was or whoever submitted it. EI #4 was asked, what was the date on the most recent MDS for RI #17. EI #4 replied, December 1, 2020. EI #4 was asked, what did that MDS indicate for section H.0100 question A. EI #4 replied, it said no, which indicated that he/she did not have an indwelling catheter. EI #4 was asked, did he/she have an indwelling catheter at that time. EI #4 replied, yes. EI #4 was asked, who completed the MDS dated [DATE]. EI #4 replied, the nursing department completed it and she locked and signed it. EI #6 was asked, what was the potential harm to a resident, with an indwelling urinary catheter or suprapubic urinary catheter, when the MDS indicated the resident did not have a urinary catheter. EI #4 replied, the data would have been entered by error or mistake and it would not give an accurate picture of the resident.</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure Resident Identifier's (RI) #17, 34, and 29's, residents with urinary catheters, had a care plan specific enough to guide urinary catheter care, and RI #6 had a care plan for oxygen use.</p> <p>This affected three of three sampled residents with urinary catheters, and one of one sampled residents with oxygen.</p> <p>Finding Include:</p> <p>1) RI #17 was admitted to the facility on [DATE]. Diagnoses included abnormal posture and muscle weakness.</p> <p>A review of RI #17's Active Orders As Of: 3/20/2021 revealed a prescriber written order . Change suprapubic catheter . (Q) month and as needed (PRN) .dated 10/30/2020.</p> <p>On 3/9/21 at 9:34 AM RI #17 was observed with an indwelling catheter.</p> <p>2. RI #34 was admitted to the facility on [DATE] and had diagnosis that included Neuromuscular dysfunction of the bladder.</p> <p>A review of RI #34's Active Orders As Of 3/11/2021 revealed an order . Change suprapubic catheter . monthly . and as needed (PRN) dated 10/30/2020.</p> <p>On 3/9/21 at 2:21 PM catheter bag was observed hanging at bedside.</p> <p>3. RI #29 was admitted to the facility on [DATE] with diagnosis that included Neuromuscular dysfunction of bladder.</p> <p>A review of RI #29's Active Orders As Of 3/10/2021 revealed an order . Change suprapubic catheter . each month . and as needed (PRN) dated 11/20/2020.</p> <p>On 3/9/21 at 2:46 PM RI #29's urinary catheter site was observed.</p> <p>On 3/10/21 at 12:11 PM an interview was conducted with EI #21, Certified Nursing Assistant (CNA), a staffing agency CNA. EI #21 was asked, how did she know which residents required catheter care during her shift. EI #21 replied, the nurse told her.</p> <p>On 3/10/21 at 3:48 PM an interview was conducted with EI #20, CNA. EI #20 was asked, how did she know which residents needed catheter care. EI #20 replied, she was familiar with the residents that needed catheter care. EI #20 was asked, when agency staff were there, how did they know which residents required catheter care and when it was to be performed. EI #20 replied, the agency staff were given verbal instructions. EI #20 was asked, did CNAs use care plans to guide care. EI #20 replied, yes, it was on the kiosk. EI #20 was asked, was catheter care on the kiosk. EI #20 replied, the kiosk did not indicate if the resident had a catheter.</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 - Some</p> | <p>On 3/10/21 at 3:57 PM an interview was conducted with EI #4, Registered Nurse (RN), Director of Clinical Services, previous Minimum Data Set (MDS) Coordinator. EI #4 was asked, when was RI #17's suprapubic catheter inserted. EI #4 replied, he/she was admitted with it on 12/14/18. EI #4 was asked, who was responsible for ensuring residents' care plans were comprehensive to their needs. EI #4 replied, each department did their own; EI #6 did the nursing sections. EI #4 was asked, when should a resident with a catheter have a care plan addressing the urinary catheter. EI #4 replied, anytime the resident had a catheter. EI #4 was asked, what interventions would be included on a care plan for a urinary catheter. EI #4 replied, cleaning information, monitoring for infection, notification of physician if removed, and emptying every shift.</p> <p>On 3/10/21 at 4:29 PM during an interview with EI #6, EI #6 was asked, did RI #29 have a care plan for urinary catheter and urinary catheter care specific enough to guide the provision of care. EI #6 replied, no. EI #6 was asked, why not. EI #6 replied, it did not have frequency for catheter care.</p> <p>On 3/11/21 at 9:32 AM an interview was conducted with EI #6. EI #6 was asked, what was the purpose of care plans in the facility. EI #6 replied, to paint an adequate picture so staff can provide care to the resident. EI #6 was asked, when should a care plan be specific enough to guide the provision of catheter care. EI #6 replied, when the resident had a catheter. EI #6 was asked, did RI #34 have a suprapubic catheter. EI #6 replied, yes, he/she had it since she was hired in 11/2019. EI #6 was asked, did RI #34 have a care plan for urinary catheter care specific enough to guide the provision of care. EI #6 replied, no. EI #6 was asked, what did the care plan not include. EI #6 replied, how often to perform suprapubic catheter care. EI #6 was asked, when should the catheter care of cleaning the catheter be performed. EI #6 replied, every day. EI #6 was asked, as of 3/10/21, did RI #17, 29, or 34 have a care plan specific enough to guide the provision of catheter care. EI #6 replied, not until 3/10/21. EI #6 was asked, did RI #17, 29, or 34 have a care plan that included measurable objectives and timeframes to meet their need of catheter care, cleaning of the catheter. EI #6 replied, no. EI #6 was asked, when should a resident with an indwelling catheter not have a care plan or physician's order for catheter care to be performed at least daily. EI #6 replied, they should not.</p> <p>On 3/11/21 3:08 PM an interview was conducted with EI #2, RN, Director of Nursing (DON). EI #2 was asked, what was the purpose of care plans in the facility. EI #2 replied, to document the care that was needed for residents. EI #2 was asked, when should a resident with an indwelling urinary catheter have a care plan for catheter. EI #2 replied, when it was placed, and the care plan should be re-assessed and changes made as necessary. EI #2 was asked, what interventions should the catheter care plan include. EI #2 replied, monitoring for redness and infection, and cleaning the catheter daily or as needed. EI #2 was asked, when should a care plan be specific enough to guide the provision of catheter care including cleaning the catheter. EI #2 replied, always. EI #2 was asked, why was important to have a care plan specific enough to guide the provision of catheter care that included cleaning the catheter. EI #2 replied, the care plan communicated with staff how to care for the catheter and prevent infection. EI #2 was asked, what was the potential harm to a resident with an indwelling urinary catheter and without a care plan that addressed cleaning the catheter. EI #2 replied, higher risk for infection.</p> <p>4. RI #6 was admitted to the facility on [DATE] and had a diagnosis of Chronic obstructive pulmonary disease (COPD).</p> <p>A review of RI #6's Medication Administration Record for March 2021 revealed . Oxygen at two (2) liters (L) as needed (PRN) . Start date 2/8/2021.</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 - Some</p> | <p>On 3/11/21 at 8:31 AM an observation was made of RI #6 with oxygen infusing through a nasal cannula.</p> <p>On 3/11/21 at 9:25 AM an interview was conducted with EI #6, LPN, MDS Coordinator. EI #6 was asked, did RI #6 receive oxygen. EI #6 replied, yes. EI #6 was asked, should a resident receiving oxygen continuously or as needed be care planned. EI #6 replied, yes. EI #6 was asked, to present the care plan for oxygen use. EI #6 replied, it was not there. EI #6 was asked, should RI #6 have a care plan. EI #6 replied, yes. EI #6 was asked, what was the purpose of a resident having a care plan. EI #6 replied, to paint a picture of the resident so staff can adequately take care of their needs. EI #6 was asked, who was responsible for ensuring he/she had a care plan. EI #6 replied, herself.</p> | | |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of a facility policy titled WEIGHT LOSS INTERVENTION, the facility failed to recognize and assess a ten pound weight loss over eight days for Resident Identifier (RI) #200. This affected one of four residents sampled for weight loss.</p> <p>This deficient practice was cited as the result of the investigation of complaint/ report number AL00041289.</p> <p>Findings Include:</p> <p>A review of a facility policy titled, WEIGHT LOSS INTERVENTION POLICY & PROCEDURE with an effective date of 12/1/2010 revealed: Purpose: To intervene in unplanned weight loss process and prevent further decline in weight status and/or restore weight back to usual body weight .</p> <p>RI #200 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Unspecified Convulsions, Epilepsy and Spina Bifida.</p> <p>A review of a facility form titled Weights and Vitals Summary revealed weights for RI #200 for the month of January 2021: 1/21/21 105 pounds and 1/29/21 95.4 pounds. This documentation revealed a ten pound weight loss in eight days.</p> <p>On 3/11/21 at 2:15 PM, an interview was conducted with Employee Identifier, (EI)#5, Dietary Consultant. EI #5 was asked, what was RI #200's admission weight. EI #5 replied, 119 pounds and 64 inches on 1/18/19. EI #5 was asked, what were RI #200's weight concerns. EI #5 replied, fluctuating weight which was addressed several times in November 2020, January and February of this year. EI #5 was asked, how often did she assess residents. EI #5 replied, monthly, with readmissions, and as needed. EI #5 was asked, what was RI #200's January 2021 weights. EI #5 replied, she assessed the resident's weight of 105 on 1/29/21, the staff gave her a weight of 105. EI #5 was asked, what about the weight of 95 pounds on 1/29/21. EI #5 replied, she was not aware of a weight of 95 pounds, the staff gave her a weight of 105, and she did her assessment based on that weight. EI #5 was asked, why was RI #200's weight of 95 pounds in January not addressed. EI #5 replied, she was not aware of a 95 pound weight.</p> <p>On 3/11/21 at 2:30 PM an interview was conducted with EI #1, Administrator and EI #2, Director of Nursing was present. EI #1 was asked, who did the weights. EI #1 replied, the Certified Nursing Assistants (CNA), there was inconsistencies with which CNAs did them. EI #1 was asked, what was the process for obtaining weights. EI #1 replied, the CNA gets the weight and gives it to the nurse or the dietary manager for them to record it in the resident record. EI #1 was asked, who entered RI #200's weight of 95 pounds on 1/29/21 in the record. EI #1 replied, EI #8, the Dietary Manager. EI #1 was asked, why was the ten pound weight loss not addressed. EI #1 replied, she did not know; it must have been an oversight; had they realized it, it would have been addressed. EI #1 was asked, when the weight was discovered at a ten pound loss, what should have been done. EI #1 replied, re-weigh the resident to determine if it was actual weight and assess the nutritional status. EI #1 was asked, what would the harm be in not recognizing a weight loss of ten pounds in a week. EI #1 replied, there could be continued weight loss and not identifying a change in the resident's nutritional needs.</p> <p>(continued on next page)</p> | | |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 3/11/21 at 3:15 PM, an interview was conducted with EI #8, Dietary Manager. EI #8 was asked, who entered RI #200's weights to the record on 1/21/21 and 1/29/21. EI #8 replied, she did. EI #8 was asked, why was the weight of 95 pounds, a ten pound loss not identified. EI #8 replied, it was an oversight. When she entered the weight of 95 pounds only that weight was seen and not the previous ones. EI #8 was asked, what was the policy for addressing weight loss. EI #8 replied, assess the weights on admit and on readmit, then refer to the dietary consultant. EI #8 was asked, what was the harm in not recognizing a ten pound weight loss on a resident. EI #8 replied, it could result in malnutrition.</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>Based on observations, interviews and a review of the facility's documents titled, Resource: Taking Accurate Temperatures, Proper Handwashing Technique, and Receiving And Storing Foods, the facility failed to ensure on 3/8/21 and 3/9/21:</p> <ol style="list-style-type: none"> 1. dietary staff did not sanitized the food thermometer in the red bucket sanitizing solution and ensure staff washed her hands after using the cloth from the red bucket solution; and 2. food in the deep freezer was labeled with an open and use by date. <p>This had the potential to affect 41 of 41 residents who received meals from the kitchen.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. A review of a policy titled, Resource: Taking Accurate Temperatures with a date of 2017 revealed .Taking Accurate Temperatures using metal stem thermometers 1. To take temperatures, a clean, rinsed, sanitized and air-dried thermometer that is the metal stem type, .Thermometers should be sanitized thermometers may be sanitized using a dish machine or three sink method. In between uses at one meal, an alcohol swab may be used to sanitize . <p>A review of a facility document addressing proper handwashing technique revealed, .Objective The attendee will understand the importance of following proper handwashing techniques in order to prevent the spread of foodborne pathogens that are major cause of foodborne, illnesses. It is important to wash their hands when performing the following activities: . After using any cleaning, polishing or sanitizing solution .</p> <p>On 03/09/21 at 10:46 AM, the staff was observed using the cleaning cloth from the red sanitizing buckle to clean the side of the mash potatoes pot. Employee Identifier (EI) #7 (the cook) did not wash her hands after squeezing the cloth out. EI #7 was also observed cleaning off the top of grill with the cloth from the solution bucket. EI #7 did not wash her hand after cleaning the top of the grill. EI #7 cleaned the preparation table with the cloth from the sanitizer bucket and put the cloth back in the bucket. EI #7 did not wash her hands after using the cloth. Also, during this observation EI #7 was observed dipping a thermometer in the red bucket after taking it out of the mash potatoes. EI #7 put the thermometer holder back on the thermometer and put it in her apron pocket. At 10:56 AM, EI #7 used the thermometer from her pocket and placed it in the mash potatoes again. Afterward, she dipped the thermometer in the red bucket and placed the cap back on it and put it back in her apron pocket. EI #7 took the temperature of the collard greens and dipped the thermometer in the solution bucket and placed the thermometer back in her apron pocket.</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Caregivers of Pleasant Grove, Inc | | STREET ADDRESS, CITY, STATE, ZIP CODE 700 First Avenue Pleasant Grove, AL 35127 | |
| 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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>On 03/10/21 at 8:42 AM, an interview was conducted with EI #7, first shift cook. EI #7 was asked how should the thermometer be sanitized. EI #7 replied, the thermometers are placed in a solution from the third compartment sink in a cup. EI #7 was asked how did she sanitize the thermometer on 3/9/21. EI #7 replied, on yesterday, she did it incorrectly. EI #7 stated she used the sanitizing bucket. EI #7 stated, she dipped the thermometer in the sanitizer solution bucket used for the tables. EI #7 was asked why did she sanitize the thermometer by dipping it into the red bucket solution. EI #7 replied, she was trying to get the food on the line. EI #7 continued to say she was in a hurry. EI #7 was asked when the water was put in the red bucket. She replied she put it in there in the morning when she got there at 6am. When asked if the water was changed prior to the lunch meal, she replied she did not change it. EI #7 was asked what was in the red bucket. EI #7 replied, a towel and solution. EI #7 was asked what kitchen equipment did she wipe down with the cloth from the red bucket. EI #7 replied, the counter top where she was cooking and the grill area. EI #7 was asked what did she do with the cloth after wiping down kitchen equipment. EI #7 replied, she put it back in the red bucket. EI #7 was asked what food temperatures did she take after dipping the thermometer in the red bucket. EI #7 replied, pork chop, mash potatoes, greens, and the hamburger patties. EI #7 replied, basically all of her food. EI #7 was asked when wiping down the preparation table, and the grill in the kitchen was the water solution in the red bucket clean. EI #7 replied, no ma'am. EI #7 was asked why was it important that the thermometer be sanitized properly before taking food temperatures. EI #7 replied, because of cross contamination. EI #7 continue to say if it was not clean you would contaminate the second food item that she was trying to take the temperature. EI #7 was asked what was the facility's policy on sanitizing thermometer. EI #7 replied, put in a cup with the sanitizing solution. EI #7 was asked how had she been trained to sanitize the food thermometer. EI #7 replied, put it in the solution water. EI #7 was asked did she wash her hands after using the cloth from the red bucket solution. EI #7 replied, no ma'am. EI #7 was asked did she wash her hands each time she used the cloth from the sanitizer solution bucket. EI #7 replied, no ma'am. EI #7 was asked why did she not wash her hands after using the cloth from the red solution bucket. EI #7 replied, she forgot to.</p> <p>On 3/10/21 at 9:11 AM, an interview was conducted with EI #8, Dietary Manager. EI #8 was asked should staff wash their hands after using the cloth from the red bucket solution. EI #8 replied, yes. EI #8 was asked why should staff wash their hands after using the cloth from the red bucket solution. EI #8 replied, because the solution have chemical in it and it could contaminate the food.</p> <p>2. A review of a facility document revealed, . Outline Proper receiving and storing procedures are essential to safe food handling and the first control point in the facility. Receiving . Label items with the date of delivery and the use by date.</p> <p>On 3/8/21 at 05:10 PM., a tour of the kitchen was conducted. The surveyor along with EI #8, observed chicken fingers in the chest freezer out of the original box with no used by date on it. There were about 30 chicken fingers in a bag. There was diced ham in a medium bag with no name of what it was and no use by date.</p> <p>(continued on next page)</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>On 3/10/21 at 9:11 AM, an interview was conducted with EI #8. EI #8 was asked what food items was in the freezer with no label on it. EI #8 replied, the chicken fingers and diced ham. EI #8 was asked, was the chicken fingers out of the original container. EI #8 replied, yes ma'am. EI #8 was asked, why was there no label on the food items. EI #8 replied, they (staff) intended to put the label on the food but probably got redirected. EI #8 was asked, who was responsible for labeling food items before placing them into the freezer. EI #8 replied, the cook. EI #8 was asked what did the facility policy say regarding labeling food items when placing them in the freezer. EI #8 replied, once the food comes in they need to be dated with a date and a use by date. EI #8 was asked why was it important to label food items before placing them in the freezer. EI #8 replied, so they can tell how long to keep the food and when to discard it.</p> |