STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015169	A. Building B. Wing	01/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florence Nursing and Rehabilitation Ctr, LLC	2107 Cloyd Blvd Florence, AL 35630

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, review of a facility policy titled, Labeling and Dating Foods (Date Marking), Cleaning Instructions: Ice Machine and Equipment, Cleaning Instructions: Slicer, and review of the 2017 U.S. (United States) Public Health Service Food Code, the facility failed to ensure: 1. outdated food was not stored in the walk-in cooler; 2. the ice machine was clean and free of a build-up of black substance; and 3. the meat slicer was clean and free from food particles between uses. These failures had the potential to affect 135 of 135 residents who received meals from the kitchen. Findings Include: 1)The facility policy titled, Labeling and Dating Foods (Date Marking), dated 2016, . Prepared food or opened food items should be discarded when: The food item is leftover for more than 3 days . A record review of the 2017 Food Codeby United State Public Health Service (USPHS), and the Food and Drug Administration (FDA) included the following: 3-501-17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (B) .(G) of this section, refrigerated, READY-TO-EAT-TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and packaged by a FOOD PROCESSING PLANT shall be clearly marked (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use by-by date on FOOD SAFETY. A review of the 2017 U.S. Public Health Service Food Code revealed: . 3-5 LIMITATION OF GROWTH OF ORGANISMS OF PUBLIC HEALTH CONCERN . 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . (B) . FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES . On 01/12/20 at 12:17 p.m., the surveyor and Employee Identifier (EI) #4, Dietary Cook, observed the following food items in the walk-in-cooler: (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- four heads of cabbage with black leaves on the outer layer with a discard date of 12/25/19 and - prepared fruit cobbler covered and labeled with a discard date of 1/10/20. On 01/12/20 at 12:17 a.m., an interview was conducted with EI #4, the Dietary Cook. EI #4 was asked what was the discard date on the four heads of cabbage. EI #4 stated 12/25/19. EI #4 was asked what was the discard date on the prepared fruit cobbler. EI #4 stated 01/10/20. EI #4 was then asked should these out dated food items be in the walk-in cooler. EI #4 stated no. EI #4 was then asked what was the potential harm in having outdated food items in the walk in cooler. EI #4 stated it could possibly be served to the resident and make someone ill. On 01/14/20 at 10:42 a.m., an interview was conducted with Employee Identifier (EI) #5, Certified Dietary Manager (CDM). Surveyor went over the items observed on 1/12/20 by surveyor and cook in the walk in cooler with the CDM: - four heads of cabbage with black leaves on the outer layer with a discard date of 12/25/19 and - prepared fruit cobbler covered and labeled with a discard date of 1/10/20. EI #5 was asked should these food items be in the walk in cooler. EI #5 stated no; they should have been discarded. EI #5 was asked what was the potential harm in having these items in the walk in cooler. EI #5 stated if it had been used it could have caused a resident to become sick. 2) A review of the facility policy titled Cleaning Instructions: Ice Machine and Equipment, dated 2016, documented: Guideline: Ice machine and equipment will be kept clean . 3. Wash inside . On 01/12/20 at 12:55 p.m., during the initial kitchen tour, the surveyor and EI #5, CDM, observed the inside of the ice machine. A black substance inside the top right side of the ice machine was observed. The surveyor observed EI #5 use her bare hand to wipe black substance off the ice machine. EI #5 was asked what was the black substance on the ice machine. EI #5 stated it may be dirt. EI #5 was asked do you serve ice out of the machine to the residents. EI #5 stated yes. EI #5 was then asked what was the potential harm of the black substance being inside the ice machine. EI #5 stated it could get into the ice and be served to the resident. 3) A review of the facility policy titled Cleaning Instructions: Slicer, dated 2016, documented: Guideline: Slicer will be cleaned and sanitized after each use . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/12/20 at 01:01 p.m., during the initial kitchen tour, the surveyor and EI #5, CDM, observed the meat slicer covered with a plastic wrap. Surveyor asked EI #5 if the meat slicer was clean. EI #5 stated yes. The Surveyor then asked EI #5 to remove the plastic wrap covering. Surveyor and EI #5 observed a food particle (a piece of meat) on the slicer near the blade and food debris on the top inner side of meat slicer. Surveyor pointed to the item/substance on the meat slicer and asked EI #5 what it looked like. EI #5 stated it was a piece of meat. EI # 5 was then asked should the piece of meat be there. EI #5 stated no. EI #5 was then asked if the meat slicer was clean. EI #5 stated no. EI #5 was asked what was the potential harm in the piece of meat being left there and the meat slicer not being cleaned properly. EI #5 stated it could make someone sick. EI #5 was asked what was your policy regarding cleaning and sanitizing the meat slicer. EI #5 stated the policy was to clean and sanitize after each use.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, medical review, and a facility document titled Hand Hygiene in Healthcare Settings, the facility failed to ensure: 1. a Licensed Practical Nurse (LPN), Employee Identifier (EI) #1, washed or sanitized her hands after she gave Resident Identifier (RI) #87's oral medication, and prior to administering (RI) #87's eye drop medication, and 2. a Registered Nurse (RN), EI #2, did not wash or sanitize her hands after she removed her gloves from giving RI #110's oral medications, and prior to opening RI #110's door, and placing RI #110's inhalation medications in the medication cart drawer. This affected two of six residents observed during medication pass and two of six nurses observed during medication pass. Findings Include: A review of a facility document titled Hand Hygiene in Healthcare Settings, with last reviewed date of 4/29/2019, revealed . When to Perform Hand Hygiene . After touching a patient or a patient's immediate environment . Immediately after glove removal . 1. RI #87 was readmitted to the facility on [DATE] with diagnoses to include Dry Eyes and Conjunctivitis. On 01/13/2020 at 8:40 a.m., the surveyor observed EI #1, a LPN, during the medication administration pass. EI #1 gave RI #87's oral medications with her gloved hands. EI #1 did not remove her gloves and wash or sanitize her hands, prior to administering an eye drop medication to RI #87's right and left eye. On 01/13/2020 at 2:39 p.m., an interview was conducted with EI #1, LPN. EI #1 was asked what did you do after you gave RI #87's oral medications with your gloved hands during the medication pass. EI #1 stated she administered RI #87's eye drop medication with the same gloves and did not wash or sanitize her hands prior to giving RI #87 the eye drop medications, but she should have. EI #1 was asked what would be the concern in not washing or sanitizing your hands after you gave RI #87's oral medication with both gloved hands, and prior to administered RI #87's eye drop medication. EI #1 stated this could cause an infection to the residents. On 01/13/2020 at 5:43 p.m., an interview was conducted with EI #3, Infection Control Preventionist, Registered Nurse. EI #3 was asked what would be the concern if a licensed nurse did not wash or sanitize her hands after she gave RI #87's oral medication with both gloved hands, and prior to administering RI #87's eye drop medication. EI #3 stated there could be bacteria on the licensed nurse's gloves or her hands. EI #3 stated this could have transferred germs to RI #87 and could cause an infection to RI #87. 2. RI #110 was readmitted to the facility on [DATE] with diagnoses to include Chronic Obstruction Pulmonary Disease (COPD) and Rhinitis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/13/2020 at 9:00 a.m., the surveyor observed EI #2, RN, during medication administration pass. EI #2 removed her gloves after she administered RI #110's inhalation, nasal, and oral medications. EI #2 did not wash or sanitize her hands prior to leaving RI #110's room. EI #2 left RI #110's room, closed the door with both ungloved hands, opened the medication cart drawer with both ungloved hands, and placed RI #87's inhalation and nasal medication in the medication drawer. On 01/13/2020 at 2:15 p.m., an interview was conducted with EI #2, RN. EI #2 was asked what did you do after you gave RI #110's oral medications and removed your gloves. EI #2 stated she opened RI #110's door without washing or using hand sanitizer before leaving RI #110's room. EI #2 stated she went to the medication cart, opened the drawer to the medication cart, and placed RI #110's inhalation medication in the drawer. EI #2 stated she signed out RI #110's medication that was given on the computer using the keyboard with her ungloved hands. EI #2 was asked what she should have done after she gave RI #110's oral medications, prior to leaving the room. EI #2 stated she should have washed or sanitized her hands before she left RI #110's room. EI #2 was asked what would be the concern in not washing or sanitizing your hands after you removed your gloves from giving RI #110's oral medications and prior to opening RI #110's door and placing RI #110's inhalation medications in the medication cart drawer. EI #2 stated it could cause cross contamination between residents. EI #2 stated this could cause an infection to a resident. On 01/13/2020 at 5:43 p.m., an interview was conducted with EI #3, Infection Control Preventionist, RN. EI #3 was asked what would be the concern if a licensed nurse did not wash or sanitize her hands after she removed her gloves from giving RI #110's oral medications, and prior to opening RI #110's door, and placing RI #110's inhalation medications in the medication cart drawer. EI #3 stated if the licensed nursed picked up any bacteria from RI #87's room, this could have transferred germs to the medication cart. EI #3 stated this could cause an infection to other residents.