STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015211	A. Building B. Wing	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Oaks Rehabilitation and Healthcare Center	857 Crawford Lane Mobile, AL 36617

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interviews, and review of a facility policy titled MEDICATION STORAGE IN THE FACILITY, the facility failed to ensure stock Ativan (Lorazepam), a controlled medication, was stored in the medication refrigerator in a secured non-removable container, this was observed on 10/26/2023. This affected one of two medication refrigerators reviewed. Findings include: A facility policy titled MEDICATION STORAGE IN THE FACILITY with a revised date of 08/2014 documented: . CONTROLLED SUBSTANCE STORAGE . Policy Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, . Procedures . C. Controlled-substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator. On 10/26/2023 at 8:30 AM, the medication room on 100 hall was observed with Employee Identifier (EI) #9 Licensed Practical Nurse (LPN). EI #9 removed from the medication refrigerator a plastic storage box with a red lock tag containing two vials of Ativan along with other medications that were not controlled. EI #9 was asked where the ativan was. EI #9 replied, in the plastic box. EI #9 said, there was a secured non-removable box in the refrigerator and it had nothing in it. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/26/2023 at 8:35 AM, EI #2, Director of Nursing (DON), came to the medication room and observed the removal plastic storage box. EI #2 said, the two vials of Ativan was included in the stock medication in the box. EI #2 said, the Ativan should be stored in the non-removable secured box in the refrigerator. EI #2 said, the harm in the Ativan not being secured in the non-removable secured locked box was that, anyone with a key to the medication room and refrigerator could take the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, resident record review, and review of facility policies titled Hand Hygiene, Standard Precautions, and Infection Prevention and Control Program the facility failed to ensure staff provided care to residents, handled soiled linen, lift slings, and mechanical lifts, in a manner to prevent the spread of infection in the facility. On 10/24/2023 during surveyor observations, staff failed to: wash or sanitize hands between residents; dispose of lift slings appropriately after resident use; sanitize the mechanical lift appropriately after resident use. This had the potential to affect Resident Identifier (RI) #81, RI #20, RI #3, and RI #19, four of 28 sampled residents. A facility policy titled Standard Precautions revised 09/2010 documented: . 1. Hand Hygiene a. Wash hands after touching . contaminated items . 5. Resident-Care Equipment . a. Handle used resident-care equipment soiled with blood, body fluid, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of other microorganisms to other residents and environments. b. Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed . A facility policy titled Hand Hygiene dated 05/2020 revealed: . PURPOSE: To provide guidelines to employees for proper and appropriate hand hygiene techniques that will aide in the prevention of the transmission of infections. Hand hygiene should be performed using Alcohol Based Hand Rub (ABHR) . Before and after touching residents . On 10/24/2023 at 9:19 AM Employee Identifier (EI) #4 CNA was observed making RI #81's bed and touching RI #81's bedside table and remote control. EI #4 then, without washing or sanitizing her hands, assisted in making RI #20's bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/2023 at 9:25 AM EI #4 placed the mechanical lift with the used lift sling, that had been used to transfer RI #81, down the hallway in the education/restorative room without sanitizing the mechanical lift or disposing of the used lift sling. EI #8 CNA pushed the unsanitized mechanical lift and the dirty lift sling up against the wall in the education room and closed the door. On 10/24/2023 at 10:36 AM EI #6 CNA took the mechanical lift, along with the used lift sling still hanging on the lift, from the education room to RI #3's room. The used lift sling was then placed under RI #3 and the mechanical lift was used by EI #6 and EI #7 to transfer RI #3 to a wheelchair. The unsanitized mechanical lift was then left in the hallway with the used lift sling hanging on the lift. On 10/24/2023 at 10:44 AM EI #6 CNA wiped the mechanical lift with bleach wipes and left the used lift sling hanging on the lift. EI #7 CNA came and got the lift with the dirty sling and pushed it to RI #19's room. On 10/24/2023 at 11:01 AM RI #19 was transferred using the mechanical lift then EI #7 cleaned the mechanical lift in the hallway with bleach wipes. EI #7 cleaned part of the mechanical lift, moved the used lift sling to the clean side, and continued to wipe the mechanical lift with the bleach wipes. On 10/24/2023 at 10:07 AM EI #4 CNA was asked about the lift sling and mechanical lift. EI #4 stated, she did not sanitize the mechanical lift before removing it from RI #81's room or before pushing it into the education room. EI #4 stated, she was supposed to put the lift sling down the laundry shoot. EI #4 stated, she did not have a reason why she did not dispose of the used lift sling and left the lift sling hanging up on the mechanical lift. EI #4 said, the risk of leaving the used lift sling on the mechanical lift was infection control and cross contamination. EI #4 stated, putting an unsanitized lift and a dirty lift sling in the education room was a risk of cross contamination and infection control issue. EI #4 was asked when she sanitized her hands after caring for RI #81 before assisting with RI #20's bed. EI #4 replied, she did not and and it was a cross contamination and infection control issue. On 10/24/2023 at 09:51 AM EI #8 CNA asked about the mechanical lift. EI #8 stated, she pushed the mechanical lift up against the wall in the education room. EI #8 stated, the mechanical lift is mostly used for restorative but at times other staff members use the mechanical lift. EI #8 stated, there was a lift sling hanging on the mechanical lift. On 10/24/2023 at 10:47 AM EI #6 stated, she used the lift sling that was hanging on the mechanical lift. EI #6 stated, after she used the lift sling for RI #3 she put the lift sling back on the lift. EI #6 stated, the lift sling was considered dirty after use and she did not know why she put it back on the lift. EI #6 stated, the residents could get sick and cross contamination from using dirty lift slings. On 10/24/2023 at 11:15 AM EI #7 CNA stated, she used the lift pad that was already on the lift when she got it out of RI #3's room. EI #7 stated, she should have used a clean lift sling from the linen cart for RI #19. EI #7 stated, when cleaning the mechanical lift and putting the used lift sling on the sanitized area, she would consider the lift contaminated. EI #7 stated, using the dirty lift sling was a risk for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/26/2023 at 8:45 AM an interview was conducted with EI #3 Assistant Director of Nursing (ADON)/Infection Control (IP). EI #3 was asked, after the mechanical lift was used by a staff member for a resident what was the procedure. EI #3 replied, the lift sling should be thrown down to laundry and then the lift wiped down with sanitizing wipes. EI #3 said, lifts should be wiped down before leaving the resident's room. EI #3 stated, taking a lift out of a room that had not been sanitized was a risk of spreading infection. EI #3 stated, after the use of a lift sling staff should put it in a bag and throw it down the laundry shoot. EI #3 stated, touching dirty equipment and not sanitizing hands was a risk for spreading infection. EI #3 was asked, what was the risk of the lift not being cleaned before taking it out of the room. EI #3 replied, the risk of spreading infection. EI #3 was asked, what was the risk of a lift having a dirty sling stored on the lift. EI #3 replied, risk of spreading infection. EI #3 was asked, what was the risk of utilizing a dirty lift sling on different residents. EI #3 replied, risk of spreading infections. EI #3 was asked, when should staff go from making one residents bed and then start touching another residents bed without sanitize or washing their hands. EI #3 stated, never, you should always wash or sanitize hands between residents. On 10/26/2023 at 10:04 AM an interview was conducted with EI #2 Director of Nursing (DON). EI #2 said, they should clean the lift between uses, after use, and before they come out of the room. EI #2 was asked, what should staff do with the lift sling after use. EI #2 replied, leave under resident or send down to laundry. EI #2 was asked, how should the staff clean the lift. EI #2 replied, sanitizing wipes. EI #2 was asked, what was the risk of using the same lift slings on multiple residents. EI #2 replied, infection control issue. EI #2 was asked, when a staff member went from making one resident's bed to another resident's bed what should they do. EI #2 replied, hand sanitize in between. EI #2 was asked, what was the risk of not washing or sanitizing hands between changing or making different residents beds. EI #2 replied, infection control issue.