STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015113	A. Building B. Wing	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Center	1350 Fourteenth Avenue Southeast Decatur, AL 35601

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 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** Based on observations, interviews, review of the facility's document, and facility policy review, it was determined the facility failed to ensure a clean and comfortable environment free of the growth of a black substance on three air conditioning units: six overbed tables missing vinyl covering. All located in nine of 39 rooms located on the Solona unit and the East hallway (short hall). Findings include: On 04/29/21 at 09:00 AM a tour was performed, with Employee Identifier (EI) #21, the Maintenance Supervisor (MS). Observations of the East Hall and the Solana Unit revealed the following: 1. room [ROOM NUMBER], the overhead air conditioning (AC) unit was found to have dirt, dust, and a black substance covering the air vent. 2. room [ROOM NUMBER], the overhead AC unit was found to have dirt, dust, and a black substance covering the air vent. 3. room [ROOM NUMBER], the overbed table was found to have multiple tears in the vinyl covering with some vinyl missing. 4. room [ROOM NUMBER], the overhead AC unit was found to have dirt, dust, and a black substance covering the air vent. 5. room [ROOM NUMBER], the overbed table was found to have multiple tears in the vinyl covering with some vinyl missing. 6. room [ROOM NUMBER], the overbed table was found to have multiple tears in the vinyl covering with some vinyl missing. 7. room [ROOM NUMBER], the overbed table was found to have multiple tears in the vinyl covering with some vinyl missing. 8. room [ROOM NUMBER], the overbed table was found to have multiple tears in the vinyl covering with some vinyl missing. 9. room [ROOM NUMBER], the overbed table was found to have multiple tears in the vinyl covering with some vinyl missing. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/29/21 at 09:25 AM, EI #21 confirmed the AC units had a black substance, and dirt covering the air vent and need to be cleaned. EI #21 stated, the overbed tables cannot be properly cleaned due to the vinyl tears and missing vinyl. A review of the facility un-named and undated maintenance monthly check list indicated, HVAC (Heating, Ventilation, Air Conditioning) RTU (Roof Top Unit), Clean / change air filter and verify unit operation. A review of the undated facility's policy titled, 5-Step Daily Room Cleaning indicated, .2. Horizontal Surfaces - disinfected.Using a solution of properly diluted germicide, sanitize all horizontal surfaces.Table tops, headboards, window sills, chairs - should all be done.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and staff interview, the facility failed to notify the Ombudsman of a resident's transfer to the hospital for three of three residents (Resident Identifier (RI) #27,112 and 72) reviewed who were transferred to the hospital. Findings include: Review of RI #27's Electronic Medical Record (EMR) revealed an admission date of 10/26/16 with diagnoses including dementia, Parkinson's Disease and bipolar disorder. The EMR stated RI #27 was transferred and admitted to the hospital on [DATE] and returned on 04/14/21. Review of RI #73's EMR revealed an admission date of 09/21/16 with diagnoses including diabetes, anxiety and gastroesophageal reflux. RI #73 was transferred and admitted to the hospital on [DATE] and returned on 04/06/21. Review of RI #112's EMR revealed an admission date of 05/02/13 with diagnoses including multiple sclerosis, diabetes mellitus type II and congestive heart failure. RI #112 was transferred and admitted to the hospital on [DATE] and returned to the facility on [DATE]. Interview with Employee Identifier (EI) #1, Administrator and EI #2, the Director of Nursing on 04/29/21 at 11:27 AM, both confirmed the facility never sent the ombudsman a notice of transfers.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow the posted menu for the lunch meal on 04/26/21. This failure has the potential to affect 133 of 134 residents living at the facility, there was one resident requiring tube feedings. Findings include: During the lunch meal observation on the East Short Hallway and the Solona Unit, on 04/26/21 at 12:20 PM, nine residents were served chicken alfredo and green peas. Observation on 04/26/21 at 1:20 PM revealed Resident Identifier (RI) #80 was served a plain hot dog on a bun and mashed potatoes. On 04/26/21 at 1:20 PM, RI #48 was served a plain hot dog on a bun and mashed potatoes. On 04/26/21 at 01:20 PM an interview with Employee Identifier (EI) #10, Assistant Director of Nursing (ADON) confirmed RI #80 and RI #48 were served hot dogs for lunch. On 04/26/21 at 1:40 PM, EI #17, a dietary staff member acknowledged that chicken alfredo was served for lunch today and the change was not updated and posted on the menu. On 04/26/21 at 2:00 PM, RI #8 stated he/she was served a hotdog with mashed potatoes for lunch today. A review of the posted lunch menu for 04/26/21 revealed: Ham and Pinto Beans Pan Fried Potatoes Homestyle Cornbread Alternate: Sloppy [NAME] on a Roll Fiesta Corn Chocolate Ice Cream A review of the facility's policy titled, Menus, dated 09/2017 revealed, . 6. Menus will be served as written, .

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, record review and interview, the facility failed to provide breakfast or a nourishing snack to residents who dialyze on the first/early shift three times a week. This failure affected two of nine residents identified by the facility as receiving dialysis. Findings include: During an interview with Resident (RI) #62 on 04/27/21 at 2:00 PM, during a Resident Council Meeting, stated I don't get no breakfast before dialysis and I am a diabetic. RI #62 said that he/she undergoes dialysis three times a week on the first shift (6:30 AM to 10:30 AM). During an interview with RI #120 on 04/27/21 at 11:05 AM, he/she stated he/she was not provided anything to eat prior to going to dialysis. During an interview with RI #120 on 04/28/21 at 5:46 AM, in his/her room just prior to his/her being placed on the transport gurney, RI#120 stated he/she had not received anything to eat this morning. During an interview with EI #25, Registered Nurse (RN), on 04/28/21 at 6:56 AM, at the medication cart in the TCU hallway, when questioned about RI #120 not receiving breakfast this morning, stated the kitchen has a list of residents on dialysis and the kitchen staff is supposed to bring those residents something to eat prior to that resident leaving for dialysis. During an interview on 04/28/21 at 6:40 AM, with the EI #10, Assistant Director of Nursing (ADON), at the nurses' station of TCU, said he/she thought the kitchen staff brought a snack or breakfast for the residents going to their early (prior to the facility's usual breakfast time) dialysis appointments. EI #10 reviewed RI #120's Electronic Medical Record (EMR) for an order regarding an early breakfast for RI#120 on dialysis days, but was unable to locate that order. EI#10 stated he/she would follow up with the kitchen staff regarding the early breakfast process. EI#10 also reviewed the EMR for RI#290 (an additional Resident that goes to an early dialysis appointment) and was unable to locate any information regarding an early breakfast on dialysis days. During an interview with the EI #16, Dietary Account Manager (DAM), on 04/29/21 at 10:30 AM, in the dining room, stated there was a list of dialysis residents posted in the kitchen with their dialysis chair times and when they depart the facility to go to dialysis. EI #16 explained the process in the kitchen was if a resident left for dialysis prior to 5:30 AM the night shift cook prepared a snack that was placed in the nursing unit's pantry for the floor nursing staff to give to the Resident prior to leaving for dialysis.

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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. Based on observation, interview and record review, the facility failed to ensure the proper handling of clean dishes and silverware. This failure has the potential to affect 133 of 134 residents living at the facility, there was one resident requiring tube feedings. Findings include: 1. On 04/26/21 at 9:38 AM an observation of Employee Identifier #18, Dietary Aide (DA) revealed EI #18 was cleaning off dishes, pots, pans, and glasses from breakfast preparing them for the dishwasher wearing gloves. EI #18 was observed spraying/rinsing off dirty dishes and placing them on trays and into the dishwasher and then moving to the clean side of the dishwasher and handling the clean trays of dishes wearing the same gloves. EI #18 never removed the gloves or performed hand hygiene. On 04/26/21 at 09:40 AM an interview with EI #18 was conducted. When questioned what actions she had just performed she stated, I went from handling dirty dishes to handling clean dishes and did not change gloves and perform hand hygiene. A review of the facility's policy titled, Warewashing (sic), dated 09/2017, indicated, Policy Statement All dishware, serviceware (sic), and utensils will be cleaned and sanitized after each use. Procedures 1. The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure garbage was properly disposed of and contained. This failure has the potential to affect all 134 residents who resided at the facility. Findings include: On 04/26/21 at 9:43 AM an observation of the area behind the building with Employee Identifier #17, a dietary staff member, revealed four dumpsters used for collecting garbage at the facility. One of four dumpsters was left open; multiple bags of garbage and boxes were noted inside. During an interview on 04/26/21 at 9:43 AM an interview with EI #17, EI #17 stated, the door should be closed. She confirmed one of four trash dumpsters had a door open and the dumpster contained a mixture of cardboard boxes and miscellaneous trash. A review of the facility's policy titled, Dispose of Garbage and Refuse, dated 08/2017, indicated, Policy Statement: All garbage and refuse will be collected and disposed of in a safe and efficient manner. Procedures: 1. The Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris.