STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015189	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Pell City	510 Wolf Creek Road, North Pell City, AL 35125

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 - 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. Based on observations, interviews and review of a facility policy titled Storage and Expiration Dating of Medications, Biologicals, the facility failed to ensure all resident medications were stored in the original containers on 03/03/2022, when loose pills and capsules were observed in drawers of all three resident medication carts. This affected three of three resident medication carts observed in the facility. Findings Include: Review of facility policy titled Storage and Expiration Dating of Medications, Biologicals, last revised 01/01/2022, revealed: . PROCEDURE . 2. Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, . 10. Facility should ensure that the medications and biologicals for each resident are stored in the containers in which they were originally received. On 03/03/2022 at 7:55 AM, an observation of medication cart #2 was made with Employee Identifier (EI) #4, Licensed Practical Nurse (LPN). One loose white pill and one loose small white pill was found on the bottom of the second drawer. On 03/03/2022 at 7:55 AM, EI #4 was asked if she knew what the pills were. EI #4 replied, she did not know what medications they were. On 03/03/2022 at 8:00 AM, an interview with EI #4, LPN, was conducted. EI #4 was asked, what was the policy on medications being loose in the medication drawers. EI #4 replied, the loose pills should be disposed of. EI #4 was asked, should medication be loose in the drawers of the medication cart. EI #4 replied, no. EI #4 was asked, what was the risk of medications being loose in the drawers. EI #4 replied, medication errors. On 03/03/2022 at 11:19 AM, an observation was made of medication cart #1 with EI #5, LPN. In the second drawer one white loose pill and one loose blue and white capsule was observed in the bottom of the drawer. On 03/03/2022 at 11:22 AM, an interview with EI #5, LPN, was conducted. EI #5 was asked, should loose pills have been in the bottom of the drawer. EI #5 replied, no ma'am. EI #5 was asked, what was the risk of loose pills being on the bottom of the drawers. EI #5 replied, accidentally picking them (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: 015189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2022
NAME OF PROVIDER OR SUPPLIER Diversicare of Pell City		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Wolf Creek Road, North Pell City, AL 35125	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	up and giving them to a resident or the risk of them popping out of the cart onto the floor and a resident picking it up and taking the medication. On 03/03/2022 at 4:14 PM, a follow-up interview with EI #5 was conducted. EI #5 was asked did she know what medications were on the bottom of the drawer, the one white loose pill and the one loose blue and white capsule in the bottom of the second drawer. EI #5 replied, no. On 03/03/2022 at 11:30 AM, an observation was made of Medication cart #3 with EI #6, LPN. The second drawer slot had one loose oblong mauve colored pill and one round yellow loose pill. On 03/03/2022 at 11:30 AM, an immediate interview was conducted with EI #6, LPN. EI #6 was asked, should loose pills have been in the bottom of the medication cart drawers. EI #6 replied, no there should not have been. EI #6 was asked, what were the loose mauve colored oblong pill and the round yellow loose pill observed in cart #3. EI #6 replied, the mauve colored oblong pill might have been a Depakote (seizure medication) and she did not know what the yellow round one was. EI #6 was asked, what was the risk of the loose pills being on the bottom of the drawers. EI #6 replied, they could have been given to someone by accident. EI #6 was asked, what was the policy on loose pills being in the medication drawers. EI #6 replied, they should have been cleaned out and destroyed. On 03/03/2022 at 11:03 AM, an interview with EI #2, the Director of Nursing (DON)/Registered Nurse (RN) was conducted. EI #2 was asked, what was the policy on medication carts and loose pills. EI #2 replied, pick them up and then destroy the pills. EI #2 was asked, who should have looked for loose pills in the medication cart. EI #2 replied, any nurse could. EI #2 was asked, what was the risk of loose pills being in the bottom of the medication cart drawers. EI #2 replied, a nurse could pick it up and use it. When asked how many medication carts there were in the facility, EI #2 replied, three.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interviews, and review of a facility policy titled, Dispose of Garbage and Refuse the facility failed to ensure trash bags were placed in the refuse dumpster with a closed lid and a discarded mattress was not on the ground in the dumpster area. This was observed on 03/01/2022 and 03/02/2022, two of three days of the survey, and had the potential to affect all 64 residents in the facility. Findings Include: A facility policy titled Dispose of Garbage and Refuse dated 8/2017 documented: 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 . to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris. 2. The Dining Services Director will ensure that: . Appropriate lids are provided for all containers. On 03/01/2022 at 8:50 AM, an observation was made of two closed dumpsters and a big open dumpster containing five clear plastic bags with Personal Protective Equipment (PPE) in bags on top of the big open dumpster that was higher than the container. On 03/02/2022 at 9:22 AM, an observation was made of two closed dumpsters and a big open dumpster containing five clear trash bags with PPE visible in the bags. The garbage was observed coming over the sides of the container and the container was not covered. There was also a mattress observed on the ground next to the dumpster. On 03/02/2022 at 9:22 AM, Employee Identifier (EI) #7 Dietary Manager was asked if the clear bags belonged in that dumpster. EI #7 replied, no. On 03/02/2022 at 12:24 PM EI #7 was asked what was in the big outside dumpster. EI #7 replied, bed parts, and construction stuff. EI #7 was asked what was the risk of those garbage bags being in that dumpster. EI #7 replied, pests and safety. EI #7 was asked if the dumpster was covered. EI #7 replied, no, she had never seen it covered. EI #7 was asked where the garbage belonged. EI #7 replied, in the regular dumpster. EI #7 was asked, what was the policy for garbage in the dumpsters. EI #7 replied, garbage should be in the cans and covered and the garbage was to be picked up around the dumpsters.

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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, resident record review and review of a facility policy titled Handwashing/Hand Hygiene, the facility failed to ensure Employee Identifier (EI) #8, a Certified Nursing Assistant (CNA), washed or sanitized her hands during lunch meal delivery and set up on 03/01/2022. EI #8 delivered and set up trays for Resident Identifier (RI) #29 and RI #13 without performing hand hygiene between residents.

This had the potential to affect RI #13, one of two residents observed to have lunch meal trays passed to them by EI #8 on 03/01/2022.

Findings Include:

A facility policy titled Handwashing/Hand Hygiene, with an effective date of March 2020, documented:

. POLICY

This center considers hand hygiene the primary means to prevent the spread of infections.

POLICY INTERPRETATION AND IMPLEMENTATION . 5. Use an alcohol-based hand rub or, alternatively, soap . and water for the following situations: . b. Before and after direct contact with residents; . m. Before and after eating or handling food; .

RI #29 was readmitted to the facility on [DATE].

RI #13 was readmitted to the facility on [DATE].

On 03/01/2022 at 12:18 PM, an observation was made of EI #8, CNA, delivering a lunch tray to RI #29. EI #8 used RI #29's remote bed control to position RI #29 for lunch and set up RI #29's lunch tray, opening containers, removing lids from drinks and using the spoon from RI #29's hand to put condiments on food for RI #29. EI #8 then walked out to the hall, without sanitizing or washing her hands, and removed another lunch tray from the food cart and delivered the tray to RI #13. EI #8 used RI #13's remote bed control, set up RI #13's tray, removing lids from containers and passing silverware to RI #13. EI #8 then began to feed RI #13, but then stopped and exited RI #13's room without washing or sanitizing her hands.

On 03/01/2022 at 12:27 PM EI #8 was asked when she sanitized or washed her hands when she exited RI #29's room. EI #8 replied, she did not. EI #8 was asked, what was the risk of not sanitizing her hands. EI #8 replied, infection. EI #8 was asked, what did the facility's policy say about hand washing. EI #8 replied, she was supposed to wash her hands or sanitize them when coming out of a room.

On 03/03/2022 at 10:35 AM, EI #3, Infection Preventionist, was asked what was the policy for staff to wash or sanitize their hands after a meal tray was set up for a resident, before delivering another tray for another resident. EI #3 replied, a staff member should wash/sanitize their hands in between each resident. EI #3 was asked, when should a staff member not wash their hands after setting up a tray and picking up another tray. EI #3 replied, they should always wash or sanitize their hands. EI #3 was asked, what was the risk of a staff member not washing their hands after setting up a

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tray and picking up another residents tray. EI #3 replied, transmission of any contaminant from one resident to another. On 03/03/2022 at 11:03 AM an interview was conducted with EI #2, Director of Nursing (DON). EI #2 was asked, when should a staff member sanitize her hands after setting up a resident's tray and before picking up another resident's tray from the meal cart. EI #2 replied, she should sanitize her hands in between each resident and if the hands are visibly soiled she needed to wash them. EI #2 was asked, when did the policy say staff should sanitized their hands after setting up a resident's tray. EI #2 replied, she should have sanitized before and after touching a resident or touching a resident's tray. EI #2 was asked, what was the risk of not sanitizing or washing hands after setting up a resident's tray and before picking up another resident's tray. EI #2 replied, infection control and contamination.