STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015454	A. Building B. Wing	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview at Redstone Village	12000 Turnmeyer Drive Huntsville, AL 35803

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and a review of the facility policy Medication Administration, the facility failed to ensure Employee Identifier (EI) #4, Licensed Practical Nurse (LPN), one of three licensed staff observed with a medication cart, did not leave a medication cart unlocked and unattended on 2/15/22, one of four days of the survey. This affected one of two medication carts in the facility and had the potential to affect all 23 residents on level one whose medications were in the medication cart left unlocked and unattended. Findings Include: A review of a facility policy titled Medication Administration with an effective date of February 2021 revealed, . Policy Explanation and Compliance Guidelines: . 4. Medication cart will be locked or under direct observation of authorized associates. RI #11 was readmitted to the facility on [DATE]. On 2/15/22 at 6:43 PM, EI #4, LPN, was observed to position the medication cart in front of Resident Identifier (RI) #11's room to obtain RI #11's blood pressure, oxygen saturation and temperature, while leaving the medication cart unlocked. EI #4 entered RI #11's bathroom, out of site of the medication cart, and washed her hands while leaving the medication cart unlocked and unattended. On 2/15/22 at 7:18 PM EI #4 was asked how long she had worked at the facility. She replied, two going on three years. EI #4 was asked, when should she lock the medication cart. EI #4 replied, every time she was leaving the medication cart if it was not within view. EI #4 was asked, what was the risk of not locking the medication cart. EI #4 replied, somebody touching the cart, getting medications, and looking at what the residents' medications were. EI #4 was asked if she locked the medication cart when she was in RI #11's room. She replied, no. EI #4 was asked if she should have locked the medication cart, to which she replied, she should have. On 2/17/22 at 10:47 AM, an interview was conducted with EI #1, Registered Nurse/Director of Nursing. EI #1 was asked, what was the process for locking the medication cart. EI #1 replied, it should be locked when not in sight of the medication cart nurse. EI #1 was asked, when should the medication cart be left unlocked while the nurse was in a resident room giving medications. EI #1 replied, only if the cart could remain in sight of the nurse. EI #1 was asked what was the risk of leaving a medication cart unlocked while not is the sight of the nurse. EI #1 replied, the risk of someone getting (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	in the cart.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and a review of facility policies titled MEAL SERVICE and Cleaning and Disinfection of Resident-Care Equipment, the facility failed to ensure staff changed gloves and performed hand hygiene during meal delivery and pick up. On 2/14/22 during the supper meal delivery in the downstairs dining room, Employee Identifier (EI) #5 Certified Nursing Assistant (CNA) was observed to deliver a supper tray to Resident Identifier (RI) #2 and RI #11 without changing gloves or performing hand hygiene before each resident's tray delivery and set up. On 2/15/22 during the breakfast meal tray pick up, EI #6, Staffing Coordinator, picked up breakfast trays from RI #251 and RI #31 without performing hand hygiene after each resident's tray was removed from their rooms. Further the facility failed to ensure EI #4, Licensed Practical Nurse (LPN), did not place used resident care equipment in her pocket. This had the potential to affect RI #11, RI #31, and the other 21 residents who resided on level one of the facility. Findings Include: A review of a facility policy titled MEAL SERVICE with an effective date of January 2010 revealed . GENERAL INFECTION CONTROL GUIDELINES . 3. Observe (standard) universal precautions or other infection control standards as approved by appropriate facility committee. 4. Perform hand hygiene between resident meal preparation . RI #2 was readmitted to the facility on [DATE]. RI #11 was readmitted to the facility on [DATE]. On 2/14/22 at 5:09 PM, EI #5, CNA, was observed to set a plate from a tray in front of RI #2, cut the meat with gloves on and take the empty tray to the counter with the same gloves on. EI #5 then picked up another tray while wearing the same gloves and delivered the tray to RI #11. EI #5 opened the yogurt, put the plate on the table for RI #11, and took the tray to the counter. EI #5 then removed the gloves and put on a clean pair of gloves. On 2/14/22 at 5:19 PM, an interview was conducted with EI #5. EI #5 was asked, when did she change her gloves between RI #2 and RI #11. EI #5 replied, she did not change gloves. EI #5 was asked, what was the risk of not changing gloves between residents. EI #5 replied, sanitation and contamination. EI #5 was asked, if she should have changed her gloves between residents. EI #5 replied, yes. RI #251 was admitted to the facility on [DATE]. RI #31 was readmitted to the facility on [DATE]. On 2/15/22 at 8:34 AM, EI #6, Staffing Coordinator, was observed to exit RI #251's room with a dirty tray. EI #6 walked down the hallway, placed the dirty tray on the food cart, and then positioned the food cart in front of RI #31's room without washing her hands. EI #6 then went into RI #31's room, without sanitizing or washing her hands, and asked the resident about lunch preferences. EI #6 then picked up RI #31's breakfast tray off the bedside table, exited RI #31's room and placed the tray on the food cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/15/22 at 8:39 AM, EI #6 was asked, how long had she worked at the facility. EI #6 replied, five years. EI #6 was asked, what room did she get the dirty tray out of before going into RI #31's room. EI #6 replied, RI #251's room. EI #6 was asked, when did she sanitize or wash her hands before going into RI #31's room. EI #6 replied, she thought she hit the sanitizer in the room, but she forgot. EI #6 was asked, what was the risk of not washing or sanitizing her hands before going into RI #31's room. EI #6 replied, germs. EI #6 was asked, should she have sanitized or washed her hands before going into RI #31's room. EI #6 replied, yes, always. EI #6 was asked, what was the policy on washing hands before going into a resident room. EI #6 replied, to sanitize or wash your hands before going into a room. On 2/17/22 at 8:13 AM, an interview was conducted with EI #2 RN, Infection Preventionist. EI #2 was asked, how long had she worked there. EI #2 replied, about a year and a half. EI #2 was asked, how often was staff trained on washing or sanitizing their hands. EI #2 replied, on hire, annually and as needed, group or individual, verbal or one on one. EI #2 was asked, what was the policy on washing hands when picking up a dirty tray from a resident's room and then putting it on the cart and entering another resident's room. EI #2 replied, they should sanitize before entering another residents room. EI #2 was asked, when should staff pick up a dirty tray and put it on the food cart and enter another resident's room without sanitizing their hands. EI #2 replied, never. EI #2 was asked, what was the risk of not washing their hands after picking up a dirty tray and entering another resident's room. EI #2 replied, cross contamination. EI #2 was asked, when should staff serving trays in the dining room with gloves on change them. EI #2 replied, between each resident. EI #2 was asked, what was the risk of not changing gloves in between residents when in the dining room serving trays. EI #2 replied, cross contamination. A review of the policy titled Cleaning and Disinfection of Resident-Care Equipment with an effective date of March 2020 revealed: Policy: Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. RI #250 was admitted to the facility on [DATE]. 02/15/22 06:50 PM EI #4 was observed to assess vital signs for RI #250 and then place the used pulse oximeter and the thermometer in her pocket. On 2/15/22 at 7:18 PM, an Interview was conducted with EI #4, LPN. EI #4 was asked, how long had she worked there. EI #4 replied, two going on three years. EI #4 was asked, where had she placed the pulse oximeter and the thermometer. EI #4 replied, in her pocket. EI #4 was asked, was the thermometer and the pulse oximeter dirty. EI #4 replied, yes. EI #4 was asked, should she put the dirty thermometer and the pulse oximeter in her pocket. EI #4 replied, no. EI #4 was asked, what was the risk of putting a dirty pulse oximeter and thermometer in her pocket. EI #4 replied, bacteria or infection. On 2/17/22 at 10:47 AM, an interview was conducted with EI #1 RN. Director of Nursing (DON). EI #1 was asked, when should equipment be placed in nurse's pocket. EI #1 replied, equipment should not be in the pocket. EI #1 was asked, why not. EI #1 replied, infection control. EI #1 was asked, when should staff change gloves while serving meals in the dining room. EI #1 replied, after each resident. EI #1 was asked, when should staff sanitize hands while picking up dirty trays from resident rooms. EI #1 replied, in between each resident before going to the next room. EI #1 was asked, what harm was there in not sanitizing between residents while picking up trays on units. EI #1 replied, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	possibly infection control.