STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015155	A. Building B. Wing	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Health Services, Inc	907 11th Street, NE Jasper, AL 35504

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34019 Based on observations, interviews and a review of facility policies titled, Handwashing and Glove Use, Cleaning Dishes-Manual Dishwashing, Diet Spreadsheet, and Food Temperatures, The facility failed to ensure: 1. the PPM (parts per million) in the sanitizer bucket reached 200; 2. the temperature of a pan of rice and hot dog were taken at the tray line and; 3. staff did not turn off the handwashing sink faucet with bare hand. This had the potential to affect 60 of 103 residents who may have received rice, and one resident who may have received a hotdog from the kitchen. Findings Include: 1) A review of a facility policy titled, Cleaning Dishes-Manual Dishwashing, with no date, revealed: . Procedure .5. Check sanitation sink often using a test strip to assure the level of sanitizing solution is appropriate. On 9/18/2019 at 3:02 p.m., the surveyor observed dietary staff (Employee Identifier) EI #3, nutrition worker, washing a cart off with a dirty looking cloth from the sanitizer bucket. EI #3 took a strip from a strip holder and dipped it in the bucket and brought it out. The water in the sanitizer bucket measured less than 150 ppm on the test strip. The color on the strip did not compare with any color on the test strip box. EI #4 told EI #3 to pour the water out of the bucket and fill the water in the bucket to the line. On 9/18/2019 at 3:36 p.m., an interview was conducted with EI#3. EI #3 was asked (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when dipping the test strip into the sanitizer bucket what was the ppm. EI #3 replied, it looked like 150 and 200. EI #3 was asked what should the ppm be. EI #3 replied, it should be 200. EI #3 was asked what did they use the sanitizer bucket for. EI #3 replied, the one in the dish room they use it to wipe the food carts out. EI #3 was asked what should the ppm in the sanitizer bucket be. EI #3 replied, 200. EI #3 was asked why was it important that the ppm in the sanitizer bucket be 200. EI #3 replied, to sanitize. EI #3 was asked when the ppm was less that 200 what problems can they have. EI #3 replied, things would not be sanitized. EI #3 was asked why did she changed the water in the sanitizer bucket. EI #3 replied, she wanted the strip to match up to the correct ppm. On 9/18/2019 at 3:48 p.m., an interview was conducted with EI #4, nutrition worker. EI #4 was asked what was the ppm when EI #3 tested the sanitized water. EI #4 replied, it looked like 150 and 200. EI #4 was asked what should it be. EI #4 replied, 200. EI #4 was asked why did EI #3 change the water in the bucket. EI #4 replied, it was not reading the correct ppm. EI #4 was asked why was it important that it read the correct ppm. EI #4 replied, to kill off the germs and airborne virus. EI #4 was asked did the ppm read up to 200. EI #4 replied, no. EI #4 was asked who was responsible for testing the ppm in the red bucket. EI #4 replied, whoever was in that position. 2) A review of a facility policy titled, Food Temperatures, with a date of 2017, revealed Policy: The temperature of all food items will be taken and properly recorded prior to service of each meal. A review of a document titled, Diet Spreadsheet, with a date of Day 25 Wednesday was conducted. There was no documentation of the second pan of rice or a hotdog temperature. 09/18/19 at 12:21 p.m., the surveyor observed EI #4 not taking the temperature of a hot dog that was served to a resident. The surveyor observed the cook, EI #6 pull a pan of rice from the steamer and did not take the temperature of the rice before putting it on the tray line. On 9/18/2019 at 3:53 p.m., an interview was conducted with EI #4. EI #4 was asked who took the temperature of the hot dog. EI #4 replied, she did. EI #4 was asked where did she record the temperature of the hotdog and hamburger. EI #4 replied, she did not record the temperature. EI #4 was asked what did the facility policy say regarding taking temperatures of foods at the tray line and recording them. EI #4 replied, record the temperature before they start serving. The temperature has to be 135 and they have to take the temperature again close to the end. EI #4 replied, the cook record them on the menu. On 9/19/2019 at 9:23 a.m., EI #6, the Cook, was asked what was the temperature of the hotdog. EI #6 replied, she never heard of a temperature for the hotdog. At that time EI #6 was asked what was the temperature of the second pan of rice. EI #6 replied, she did not take the temperature of the rice. EI #6 was asked what was the facility policy on taking temperatures of food at the tray line EI #6 replied, take the temperature before serving and again before starting the very last cart. EI #6 was asked what foods temperatures should be taken at the tray line. EI #6 replied, everything that they were serving. EI #6 was asked why should food temperatures be taken at the tray line. EI #6 replied, to make sure they were at a safe temperatures for the residents to eat. EI #6 was asked what was the temperature of the first pan of rice. EI #6 replied, 186. EI #6 was asked when should she record food temperatures on the Diet Spreadsheet/Menu Spreadsheet. EI #6 replied, right before you started serving and right before they start the very last hall. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) A review of a facility document titled, Handwashing Flow Chart with no date, revealed, . Dry hands using paper towel (s) . 6 a. Use clean, disposable paper towels to turn off faucet valves . On 9/18/2019 at 11:15 a.m., the surveyor observed EI #5 turn the water faucet off with bare hands. On 9/19/19 at 9:07 a.m., the surveyor conducted an interview with EI #5. EI #5 was asked what was the facility policy on how to wash their hands. EI #5 replied, they were supposed to go to the sink, turn on the faucet, let it run for 20 seconds, get soap on there finger tips, wash their hands all the way down to the bottom and then rinse them. EI #5 stated they were supposed to use the paper towel to turn off the water. EI #5 was asked why did she turn the water faucet off with bare hands and then take a paper towel to dry hands. EI #5 replied, she missed a step and she was nervous on yesterday. EI #5 was asked why should she wash hands properly. EI #5 replied, to prevent cross contamination, prevent airborne illnesses and for sanitation. EI #5 was asked what was the potential harm to the residents when hands were not washed properly. EI #5 replied they can get extremely sick.

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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** 41625 Based on observation, interview, record review and review of a facility policy titled Glucometer Cleaning, the facility failed to ensure that Employee Identifier (EI) #2 did not place the glucometer in her shirt pocket between use on multiple residents. This affected 1 of 2 licensed staff performing point-of-care glucometer testing and 2 of 2 residents who received blood sugar monitoring, Resident Identifier (RI) # 58 and #341. Findings Include: A facility policy titled GLUCOMETER CLEANING last revised on April 15, 2013. Policy . It is the policy of (name of facility) to clean the glucometer after each use. Procedure 1. After completing blood sugar testing, remove glucometer from resident's room. 2. Obtain germicidal sanitizing sheet from super Sani-cloth container (purple top), and wipe down glucometer. 3. Return glucometer to cart and allow to air dry for at least 2 minutes. RI #58 was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis to include Diabetes Mellitus, Type 2. RI #341 was admitted to the facility on [DATE] with a diagnosis to include Diabetes Mellitus, Type 2. An observation was made on 9/17/19 beginning at 3:38 PM, of Employee Identifier (EI) #2, Licensed Practical Nurse (LPN), performing blood glucose monitoring for RI #58. EI #2 obtained a blood sample using a glucometer, lancet, and a glucometer test strip. After obtaining blood glucose results, EI #2 wiped the glucometer with an alcohol pad, placed the glucometer into her left uniform shirt pocket, and exited RI #58 's room. EI #2 returned to the medication cart and did not remove the glucometer from her pocket. EI #2 reported to the surveyor she was finished at the medication cart until around 5:00 PM. EI #2 was observed walking away from medication cart towards the nurse's desk. A second observation was made on 9/17/19 beginning at 4:58 PM, of EI #2 performing blood glucose monitoring for RI #341. EI #2 returned to the medication cart gathered supplies, placed 4 alcohol pads in her left uniform shirt pocket, retrieved a wipe from the Sani-Cloth purple topped box and cleaned the glucometer, and allowed it to air dry. EI #2 entered RI # 341's room and placed the glucometer directly on the bedside table. EI #2 placed a barrier and moved the glucometer to the barrier on the bedside table. EI #2 retrieved the glucometer test strip container from her left shirt pocket, removed a single test strip from the container, and placed the container back into the same pocket. EI #2 obtained blood sample using the glucometer, lancet, and a glucometer test strip. After obtaining blood glucose results, EI #2 wiped the glucometer with an alcohol pad, placed the glucometer into her left uniform shirt pocket, and exited RI #341's room. EI #2 returned to the med cart, removed the glucometer from her left uniform shirt pocket, and cleaned glucometer with a wipe from the Sani-Cloth purple topped box. EI #2 left the glucometer on top of the medication cart to air dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with EI #2 on 9/18/19 at 4:16 PM. EI #2 was asked, on 9/17/19 while being observed performing blood glucose monitoring, did she place the glucometer in her left uniform shirt pocket. EI #2 replied, yes. EI #2 was asked, should she put a glucometer in her uniform pocket. EI #2 replied, no. An interview was conducted with EI #1, Infection Control and Clinical Care Coordinator on 9/18/19 at 5:15 PM. EI #1 was asked, what should staff do with a glucometer after performing blood glucose check in a resident's room. EI #1 replied, staff should, wash down the glucometer with a wipe from the purple-top box and allow it to air dry for three to five minutes. EI #1 was asked, how should staff transport a glucometer. EI #1 replied staff should transport the glucometer on a barrier tray or in a cup to serve as a barrier. EI #1 was asked, when should staff put multiple resident use equipment, like a glucometer, or supplies in staff shirt's pocket. EI #1 replied, Never. EI #1 was asked, what was the harm in putting a glucometer in a pocket. EI #1 replied, cross contamination could occur with anything in the staff's pocket.