STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115587	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buchanan Healthcare Center	144 Depot Street Buchanan, GA 30113

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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 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** 45813 Based on observations, staff interview, and record review, the facility failed to provide a safe, clean, comfortable, homelike environment in 20 of 20 resident rooms on the East and [NAME] halls. Specifically, door frames were chipped and scuffed, one with rusted metal sticking out, and the doors had holes and peeling paint with chipped, rough wood exposed. Loose vinyl baseboards were also observed in several rooms. Findings include: 1. Observation on 4/2/2024 at 9:36 am of resident room doors in Rooms 17, 18, 19, and 20 revealed the room doors were painted brown and had chipped, scuffed paint. The doors also had chipped rough wood on the doors. Further observations revealed each doorframe to have scuffed and peeling paint. During an interview 4/4/2024 at 2:12 pm with Administrator revealed the facility did not have a policy related to maintenance concerns or safe, clean, comfortable, homelike environment. 47947 2. Observation on 4/2/2024 at 10:15 am of resident rooms revealed that the door frame of the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] had damaged, rough wood on the bottom. Observation on 4/3/2024 at 12:45 pm revealed that the shared bathroom door frame between room [ROOM NUMBER] and room [ROOM NUMBER] was repaired and repainted by the Maintenance Director. 49394 3. Observation on 4/2/2024 at 9:22 am in room [ROOM NUMBER] revealed that the bottom of the door frame was damaged and had a rusted piece of metal sticking out leading to the shared bathroom. The area was rusted and the paint was chipped away. It was also noted that the adjoining door to the bathroom had a hole in it and the wood was chipped in several areas. (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	Observation and Interview on 4/2/2024 at 2:55 pm with the Administrator and Maintenance Director, they were notified of the findings and were taken to room [ROOM NUMBER] to show them what was noted earlier. Both acknowledged the metal piece and broken area to door frame and the hole and chipped wood to the adjoining door. The Maintenance Director stated that this type of damage occurs with wheelchairs constantly hitting this area of the door frame. She also revealed that repairs had been done on the other door frame about a month ago. She was asked why she was not aware of this area since it was in the same bathroom, just the opposite door frame. She stated that the area was not there when repairs were done to the other door frame a month ago. There were obvious signs of repairs done to the door frame that she referred to. The Maintenance Director stated that she would take care of the repairs right away. The Maintenance Director was asked about how work orders are placed and how often were resident's rooms inspected. She stated that work orders were put into the computer via the maintenance system and that she checked them daily. She was asked if there was a way to show the work orders that had been placed. She stated that she was not quite sure how to print them out. Observation 4/3/2024 at 8:13 am of the room [ROOM NUMBER] toilet room door frame revealed that the area of concern had been repaired. The area was closed and painted over. However, the adjoining door had not been repaired and the hole in the door along with the chipped wood remained. Observations on 4/4/2024 9:52 am with the Administrator and the Maintenance Director during rounds on the East and [NAME] halls revealed all residents' doors to the hallway (20 rooms) inside and out were noted to be chipped, scuffed, rough to the touch, and missing paint or stain. Door frames were noted to be chipped, scuffed, rough to the touch, and have missing paint. On both hallways, in multiple areas, loose vinyl baseboards were noted. The Administrator and the Maintenance Director revealed they have a plan in place to paint all the residents' rooms and bathrooms. They also plan on sanding and painting all the handrails. The Administrator indicated the concern related to the sharp metal observed on the bathroom door should have been reported in the computer maintenance system or to the Maintenance Director. She further indicated they do not have a policy or actual plan in place for the maintenance concerns.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47947 Based on record review and staff interviews, the facility failed to ensure level II (two) Preadmission Screening and Resident Reviews (PASRR) were completed for two of 18 (R) (R31 and R19) sampled residents. The deficient practice had the potential for R31 and R19 not to receive needed services. Findings include: 1. Review of the electronic medical record (EMR) for R31 revealed diagnoses including but not limited to bipolar disorder, anxiety disorder, personality disorder, vascular dementia, and cognitive communication deficit. Review of the most recent Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score coded as 11, which indicates moderate cognitive impairment. Review of the PASRR Level I (one) Assessment for R31 dated 9/6/2021 revealed that level one documentation was negative for Mental Illness. There was no evidence that a Level II PASRR assessment was completed and in her medical record for reference. Interview on 4/4/2024 at 10:10 am with the Social Services Director (SSD) revealed that when residents are admitted from a hospital with a PASRR Level I (one), the facility does not re-evaluate those residents. The SSD was not sure if residents with a primary diagnosis of dementia would possibly qualify for a PASRR Level II. The SSD confirmed that R31 does not have PASRR Level II. This resident was admitted from the hospital. 37650 2. Review of the EMR for R19 revealed diagnoses including but not limited to diabetes mellitus type 2, seizure disorder, metabolic encephalopathy, depression, bipolar, paranoid schizophrenia, vascular dementia, and hypertension. Interview on 4/4/2024 at 11:13 am with the SSD revealed R19's diagnosis of bipolar disorder, paranoid schizophrenia, and vascular dementia was discovered following a behavioral health consult. She indicated she had not completed a new application for a PASRR Level II with the updated mental health diagnoses for R19. Interview on 4/4/2024 at 11:29 am with the Administrator revealed her expectation for PASRRs was for the SSD to ensure correct coding was completed on the PASRR form. She further indicated the SSD should have submitted the information in the Georgia Medicaid Management Information System (GAMISS) timely. The Administrator revealed the facility did not have a PASRR policy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45813 Based on record review and staff interviews, the facility failed to develop a care plan for one of 18 sampled residents (R) (R43) related to wound care and failed to follow a care plan for one of 18 sampled residents (R) (R18) related to oxygen (O2) therapy. The deficient practice had the potential to cause R43 and R18 to not receive treatment and/or care according to their needs. Findings include: Review of R43's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, indicated R43 was admitted to the facility with diagnoses but not limited to unspecified protein-calorie malnutrition, open wound right foot, open wound left wound. Review of R43's most recent Minimum Data Set (MDS), located in the EMR with an Assessment Reference Date (ARD) of 1/27/2024 revealed R43's Brief Interview of Mental Status (BIMS) score was 4 out of 15, indicating that R43 was severely cognitively impaired, and resident had a pressure ulcer/injury and received care. Review of the care plan dated 4/2/2024 for R43 revealed a care plan indicating resident was at risk for skin breakdown and injury. Further review of the record revealed a care plan was not developed related to the pressure ulcers R43 had on bilateral (both) heels. Treatment as ordered. Interview on 4/3/2024 at 3:19 pm with the MDS/Care Plan Coordinator revealed she was responsible for developing care plans. She verified the care plan for R43 and stated she should have also developed a care plan for an actual pressure wound to the bilateral heels. She stated R43 was admitted to the facility with the wounds. Review of the active physician orders in the EMR for R18 include oxygen (O2) at 2 liters per minute (LPM) via nasal cannula (NC) PRN (as needed) for SOB (shortness of breath) or O2 saturation less than 90 percent (%). Check each shift to determine need as needed. The order start date was 3/22/2024. Review of the care plan dated 4/2/2024 revealed R18 was at risk for shortness of breath and poor oxygenation due to COPD (chronic obstructive pulmonary disease). Interventions included: administer 02 at 2 LPM per nasal cannula PRN for oxygen saturation less than 94% per MD orders. Review of the EMR revealed there was no documentation related to R18's O2 saturation being checked every shift to determine the need for PRN O2 therapy. Review of the recorded O2 saturation checks in the EMR revealed since the initiation of the O2 order, O2 saturations were only documented on 3/22/2024 at 12:11 am and 3/27/2024 at 4:32 am. Further review revealed there were no nursing progress notes in the EMR since the O2 order was initiated on 3/22/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/3/2024 at 9:16 am with Licensed Practical Nurse (LPN) Nurse Supervisor EE revealed she verified the O2 saturations were not being checked twice daily as ordered by the physician. She looked at the care plan and verified the care plan was not being followed as it relates to the current O2 order. Interview on 4/3/2024 at 10:11 am with MDS/Care Plan Coordinator revealed that the Director of Nursing (DON) had made her aware of resident's care plans not being followed today and she had updated the care plans. The MDS/ Care Plan Coordinator stated that the physician order was not being followed and the care plan was not being followed. She further stated the nurses do have access to the care plan. Interview on 4/3/2024 at 10:19 am with the Registered Nurse (RN) MDS Coordinator revealed R42's wound care plan was updated 10/9/2023. The RN MDS Coordinator verified that if the staff were not abiding by the physician's orders for wound care, the plan of care was not being followed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45813 Based on observations, staff interviews, record review, and review of the facility policy titled, Wound Treatment Management, the facility failed to follow the doctor's order for one of 18 sampled residents (R) (R 43) reviewed for pressure ulcers. Specifically, the facility failed to consistently apply boots to the heels of R43 to relieve pressure to a stage four and deep tissue pressure ulcer. Findings include: Review of the facility policy titled Wound Treatment Management provided by the facility and revised December 5, 2022, revealed under Policy: Policy Explanation and Compliance Guidelines: Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. Review of R43's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, indicated R43 was admitted with the following diagnoses but not limited to unspecified protein-calorie malnutrition, open wound right foot, open wound left wound. Review of R43's Minimum Data Set (MDS), located in the EMR with an Assessment Reference Date (ARD) of 1/27/2024, revealed R43's Brief Interview of Mental Status (BIMS) score was a 4 out of 15, indicating that R43 was severely cognitively impaired. Review of an assessment by the wound physician for the Initial Wound Evaluation dated 1/29/2024 revealed R43 had pressure wounds on his left and right heels. Stage 4 Pressure Ulcer to Left Heel: Etiology [cause] Pressure MDS 3.0 Stage 4 Duration > [over] 15 days Objective Healing/Maintain Healing Wound Size (L x W x D): 3.3 x 5.3 x 0.3 cm [centimeter] Surface Area: 17.49 cm^2 [centimeters squared] Exudate [fluid made up of cells, proteins, and solid materials]: Moderate Serous [bloody] thick adherent devitalized [softened] necrotic [dead] tissue: 25 % [percent] Granulation [forming granules] tissue: 15 % Other viable tissues: 60 %. Recommendations Off-Load [relieve pressure] Wound. UNSTAGEABLE (DUE TO NECROSIS) OF THE RIGHT HEEL FULL THICKNESS Etiology Pressure MDS 3.0 Stage Unstageable Necrosis Duration > 15 days Objective Healing/Maintain Healing Wound Size (L x W x D): 4.5 x 4.8 x Not Measurable cm Depth is unmeasurable due to presence of nonviable tissue and necrosis. Surface Area: 21.60 cm^2 Exudate: None Thick adherent devitalized necrotic tissue: 90 % Other viable tissues: 10 %. Recommendations Off-Load Wound. Review of current physician orders, located in the EMR under the Orders tab and dated 2/28/2024 revealed, Patient is to wear the bilateral heel boots while in bed. Observation on 4/2/2024 at 2:36 pm, R43 was observed in his room, lying in bed. R43 was groomed and dressed appropriately, and it was noted that R43 was not wearing his heel boots (boots designed to offer relief from pressure ulcers). Observations 4/3/2024 at 8:17 am and at 2:38 pm revealed R43 lying in bed. Resident was observed with socks on both feet. R43 was not wearing heel boots to off-load heels from the bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/3/2024 at 1:17 pm with Licensed Practical Nurse (LPN) 1, she stated, The resident heels should be floated to prevent further skin damage. I expect her heels to float in bed or while sitting in the geri chair. LPN1 further stated, The resident's right heel is healed, and the left heel is at stage three. LPN1 continued to share that wearing the boots ordered by the doctor would prevent further damage to the pressure ulcer. Interview on 4/3/2024 at 2:14 pm with the Director of Nursing (DON), the DON stated, I expect that doctor's orders are followed. The purpose of applying boots to R43's heels is to prevent further wound damage. Interview on 4/3/2024 at 3:01 pm with LPN Nurse Supervisor EE, she acknowledged R43 should be wearing heel boots while in bed to offload the pressure from his heels. She verified R43 did not have the heel boots on and stated she was not sure who was responsible for ensuring R43 had them on as ordered by the physician. LPN EE further stated that the wound doctor comes to the facility weekly to assess, measure, classify, and stage wounds. She further stated the Nurse Managers, and the Charge Nurses are responsible for wound care in the facility. LPN Nurse Supervisor EE verified the order for the Heel protectors on the orders. Interview on 4/3/2023 at 3:09 pm with Certified Nursing Assistant (CNA) AA revealed she was assigned to care for R43. She stated she performed R43's activities of daily living (ADL) care and acknowledged resident had socks on both feet. CNA AA further stated she was not aware R43 needed to have heel boots. Interview on 4/3/2024 at 3:14 pm with LPN BB revealed she was aware R43 had wounds on his heels and was supposed to have heel boots on while in bed. LPB BB stated she was sure R43 had them on at the beginning of shift and the therapist probably removed the heel boots during R43's therapy treatment. Telephone interview on 4/3/2024 at 3:26 pm with Certified Occupation Therapy Assistant (COTA) DD revealed she treated R43 in the therapy room today. COTA DD further stated R43 did not have heel boots on during the therapy session. She further stated R43 had a puffy area to his right foot, like maybe he had a bandage underneath the sock. Interview on 4/3/2024 at 3:32 pm with the DON and Assistant Director of Nursing (ADON) revealed R43 used the heel protectors to both heels for pressure reduction and relief. The ADON stated the heel boots should be intact while in bed, and the charge nurse was responsible for making sure R43 had the heel boots on. The ADON stated that the wound doctor makes recommendations for devices, and they should be followed to promote wound healing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47947 Based on observations, staff interview, and record review, the facility failed to keep the residents free of accident hazards as evidenced by water temperatures below 110 degrees Fahrenheit (F) in 10 of 20 resident rooms on two of two halls, and one doorway with a rusted piece of metal sticking out from the bottom of the door. The deficient practices had the potential to cause injury to residents residing in these rooms. Findings include: Observation on 4/2/2024 beginning at 9:30 am through 10:10 am, during the screening process, unsafe hot water temperatures were obtained using the Maintenance Director's (MD) digital thermometer ranging from 112.3 degrees F to 115.6 degrees F. Interview on 4/2/2024 at 10:30 am with MD revealed that after checking the hot water temperatures this morning, some adjustments were made to the thermostat. She stated that she regularly checks the water temperatures in the following rooms: shower room, kitchen, laundry, mechanical room, soiled utility room, and therapy room. She also stated that she was educated to check water temperature this way when she was hired over three years ago. She confirmed that she does not check water temperatures in resident's rooms. Interview on 4/2/2024 at 10:50 am with the Administrator revealed that the MD receives guidance from the Corporate Maintenance Director. The last visit from the Corporate Maintenance Director was about one year ago. The facility follows a building management platform designed for senior living for entering maintenance issues into a computer program. The management platform included instructions and guidelines. Review of printed instructions from the building management platform revealed: For burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit, although this temperature can still cause burns if exposure reaches five minutes. Many states have even stricter standards that set maximum temperatures lower than 120 degrees Fahrenheit, although 100 degrees Fahrenheit is considered a safe water temperature for bathing. Walking rounds on 4/2/2024 from 3:15 pm to 3:35 pm, the unsafe water temperatures were confirmed by the Administrator and the MD, using the facility's digital thermometer. A total of 10 out of 20 resident's rooms were tested , in two out of two halls, with temperatures over 110 degrees F. 37650 Observation on 4/2/2024 at 12:50 pm, the hot water in the sink located in R298's bedroom, room [ROOM NUMBER], was observed to be very hot to the touch. 49394 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 4/2/2024 at 9:22 am of R249's room/bathroom, it was noticed that the bottom of the door frame leading to the shared bathroom was damaged and had a rusted piece of metal sticking out. The area was rusted, and the paint was chipped away. It was also noted that the adjoining door to the bathroom had a hole in it and the wood was chipped in several areas. On 4/2/2024 at 2:55 pm, the Administrator and MD were notified of the findings and were taken to R249's room to show them what was noted. Both acknowledged the metal piece and broken area to the door frame and the hole and chipped wood to the adjoining door. The MD stated that this type of damage occurs with wheelchairs constantly hitting this area of the door frame. She also revealed that repairs had been done on the other door frame about a month ago. She was asked if she was aware of this area since it was in the same toilet room just the opposite door frame. She stated that the area was not there when repairs were done to the other door frame a month ago. There were obvious signs of repair done to the door frame that she referred to. The MD stated that she would take care of the repairs right away. The MD was asked about how work orders are placed and how often are resident's rooms inspected. She stated that work orders are put into the computer via the maintenance platform system and that she checked them daily. The MD was asked if there was a way to show the work orders that had been placed. She stated that she was not quite sure how to print them out. Observation on 4/3/2024 at 8:13 am of the toilet room door frame revealed that the area of concern had been repaired. The area was closed and painted over. However, the adjoining door had not been repaired and the hole in the door along with the chipped wood remained.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45813 Based on observations, staff interviews, record review, and a review of the facility policy titled, Physicians/Practitioner Orders, the facility failed to provide necessary respiratory care consistent with professional standards of practice for one of six residents (R) (R18) receiving oxygen therapy. Specifically, oxygen (O2) saturations were not checked as ordered by the physician to determine if PRN (as needed) O2 therapy was indicated. In addition, the facility failed to properly store O2 tubing while not in use. The deficient practice had the potential to cause respiratory distress and respiratory infection. Findings include: Review of the facility's undated policy titled Physician/Practitioner Orders revealed under Policy: The attending physician shall authenticate orders for the care and treatment of assigned residents. Review of the electronic medical record (EMR) revealed R18's diagnoses included but not limited to chronic obstructive pulmonary disease (COPD) with acute exacerbation and chronic bronchitis. Review of the active physician orders for R18 include Oxygen at 2 LPM (liters per minute) via nasal cannula (nasal cannula) PRN (as needed) for SOB (shortness of breath) or O2 saturation less than 90 (percent) %. Check each shift to determine need as needed. The order start date was 3/22/2024. Review of R18's care plan dated 4/2/2024 revealed R18 was at risk for shortness of breath and poor oxygenation due to COPD. Interventions included: administer 02 at 2 LPM per nasal cannula PRN for oxygen saturation less than 94% per MD orders. Review of the EMR revealed there was not any documentation related to R18's O2 saturation being checked every shift to determine the need for PRN O2 therapy. Review of the recorded O2 saturations in the EMR revealed that since the initiation of the oxygen order, O2 saturations were only documented on 3/22/2024 at 12:11 am and 3/27/24 at 4:32 am. Further review of the record revealed there were not any nursing progress notes in the record since the O2 order was initiated on 3/22/2024. This was verified by Licensed Practical Nurse (LPN) Nurse Supervisor EE. Observation on 4/2/2023 at 9:32 am and at 2:33 pm revealed R18 lying in bed. The O2 tubing and NC were observed lying on the floor along the left side of the bed. Observation on 4/3/2024 at 9:10 am in R18's room revealed O2 tubing/NC lying on the floor, not properly stored while not in use. The O2 concentrator (machine that dispenses oxygen) was on at the time of this observation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and walking rounds on 4/3/2024 at 9:16 am with LPN Nurse Supervisor EE revealed she verified that the O2 tubing/NC was not properly stored while not in use. She stated that residents sometimes remove the NC. She stated that the NC should be stored in a plastic bag while not in use. LPN Supervisor EE verified that the O2 concentrator humidifier was dry and did not have water, and the NC was connected to the humidifier. She further stated that there should be water in the humidifier if it is attached to the concentrator. LPN EE stated she does not make compliance rounds and the nursing staff were responsible for ensuring that the tubing was properly stored while not in use. She verified that R18's physician order states that the O2 saturations should be checked twice daily to see if he required the use of the PRN O2. She verified that the O2 saturations were not being checked twice daily as ordered by the physician. Interview on 4/3/2024 at 9:26 am with Certified Nursing Assistant (CNA) AA revealed she had reported to the nurses that R18 removes the NC. CNA AA further stated when caring for R18, if she saw that resident had the NC off, she reapplied it, but did not change the tubing. CNA AA stated she was not aware that the NC should be stored in a plastic bag while not in use. She also stated that if the humidifier was empty, she refilled the humidifier, but she did not do it today because the water was not in the room to refill it. Interview on 4/3/2024 at 9:32 am with LPN BB revealed she had not checked in on R18 today. She stated she did not check R18's O2 saturations every day because there was not an order that populates on the electronic medication administration record (MAR) to do it. LPN BB further stated she did check R18's O2 saturation during the medication pass, if he was experiencing any abnormal issues. LPN BB also stated she was aware the respiratory tubing should be in a plastic bag when not in use. Interview on 4/3/2024 at 9:41 am with the Director of Nursing (DON), she verified the order was not being followed if the O2 saturations are not documented every shift as ordered. She stated that the order to check O2 saturations twice daily should have been a separate order, so it was not populating for the staff to check the level twice daily as ordered, because it was listed as PRN. The DON stated all nursing staff were responsible for checking the respiratory tubing while in the room to ensure that it was properly stored while not in use. Interview on 4/3/2024 at 1:03 pm with the Regional Consultant FF revealed the facility does not have a policy related to O2. She further stated that all nurses received training related to O2 administration during their schooling and they follow the standards of practice related to O2 administration and O2 safety.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on observations, staff interviews, and record review, the facility failed to ensure accurate assessment for the use of bed side rails for one of 18 sampled residents (R) (R42). Findings include: Observation on 4/2/2024 at 9:21 am and 2:46 pm revealed R42 was lying in bed with two quarter bedrails in the up position. R42 had bilateral hand contractures. Both hands were clenched closed. Observation on 4/3/2024 at 8:59 am revealed R42 was lying in bed with two quarter bedrails in the up position. R43 had rolled gauze in both hands at the time of this observation. Observation on 4/3/2024 at 4:20 pm revealed R42 was lying in bed with two quarter bedrails in the up position. Both hands were closed and contained rolled white gauze for contracture management. Further observations revealed that both bedrails were up with pillows between the resident and the bedrails on both sides. A review of R42's electronic medical record (EMR) diagnoses to include but not limited to cerebral infarction, contracture of hand, and hemiplegia affecting left dominant side. A review of R42's EMR revealed an active physician order for bilateral quarter upper side rails as enablers to promote participating in bed mobility and leveraging during transfers. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R42's Brief Interview for Mental Status (BIMS) score should not be conducted because resident is rarely/never understood. In addition, the MDS revealed R42 requires total staff assistance of two staff for bed mobility and roll left to right. Further review revealed R42 had impairments of the upper and lower extremities on both sides. Review of the care plan (last review date 3/06/2024) for R42 revealed resident required (max assistance) in ADLs related to current DX [diagnosis] and cognition. The goal established included R43's care needs will be met and maintain current function through next review period. Intervention included to provide max [maximum] assistance for (repositioning, transfers, bathing, grooming) as needed. Review of R42's EMR revealed R42 had been assessed for the use of side rails on 11/24/2023 indicating side rails are indicated for transporting in bed, potential for falling out of bed due to immobilization and unresponsiveness, and safety while providing care that requires turning/moving immobilized resident. Further review of the record revealed a Side Rails assessment completed 2/8/2024 which did not indicate a medical symptom requiring the use of side rail. The reason for side rail usage - Bed mobility (assist with turning Side-to-side). Types of rails to be used - Top half two sides. Review of the record revealed a therapy screening dated 2/28/2024 which revealed R42 is nonverbal and doesn't follow commands. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR revealed an Occupational Therapy Discharge Summary dated 12/28/2023 that revealed upon discharge from skilled services resident was totally dependent for care. Analysis of Goal Progress: Resident maintains need for total assistance. Maximum assistance for all participation and mobility. Goal Patient will safely perform bed mobility tasks with Substantial/Maximal Assistance and 75% [percent] verbal cues and visual cues and 75% tactile cues for use of log rolling technique and for proper sequencing in order to decrease the risk for skin breakdown. Upon discharge from skilled therapy on 12/28/2024 resident remained dependent for bed mobility. Interview on 4/23/2024 at 4:27 pm with Certified Nursing Assistant (CNA) AA revealed R42 requires total care with activities of daily living (ADL). She further stated two persons are required to provide care for the resident. CNA AA stated R42 does not assist with care and was not able to utilize the side rails for positioning or bed mobility during care. She also stated R42 did not move unless she was moved by the staff. CNA AA further stated she was unsure of the reasoning R42 had the side rails on her bed. Interview on 4/3/2024 at 4:32 pm with Licensed Practical Nurse (LPN) BB revealed R42 did not roll or assist with turning. LPN BB further stated R42 cannot use the side rails for bed mobility and the staff did all the moving for her. Interview on 4/3/2024 at 4:41 pm with LPN Nurse Supervisor EE revealed R42 was weak when admitted to the facility. She further stated R42 required two persons to assist with care and was dependent on the staff for all care to include repositioning while in bed. Interview on 4/3/2024 at 4:49 pm with Director of Nursing (DON) revealed she verified the order in the EMR for bilateral, quarter, upper side rails as enablers to promote participating in bed mobility and leverage during transfers. The DON stated she did not know why R42 had the side rails and she did not know what to tell the surveyor regarding that order. The DON further stated according to the order, R42 should be able to use the side rails, but she did not think she could. Interview on 4/3/2024 at 4:52 pm with the Assistant Director of Nursing (ADON) revealed R42 was not able to assist with bed mobility. The ADON stated she thinks the side rail order was an admission populated order in the electronic system which cannot be modified at this time. Interview on 4/4/2024 at 9:22 am with the Administrator revealed R42 had the side rails for safety related to seizure precautions. She stated the physician orders and care plan should reflect that as the indication for the side rail usage. Interview on 4/4/2024 at 9:28 am with the DON revealed the facility does not have a side rail policy that she was aware of. She further stated that they just completed the assessments to determine the use of side rails in the facility for residents and that process probably needs to change.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 45813 Based on staff and family interviews, and review of facility documents titled, Facility Assessment Tool 2024 and the PBJ (payroll-based journal) Staffing Data Report Quarter 1 2024 (October 1, 2023, through December 31, 2023), the facility failed to ensure that the facility had adequate nursing staff. The deficient practice had the potential to affect the care provided to the 49 residents that resided in the facility. Findings include: Review of The Facility Assessment Tool 2024 revealed the average daily census in the facility was 49 to 55 residents. The staffing plan included six to nine licensed nurses providing direct care, 10-16 nurses' aides, and two to four certified medication aides. Review of the PBJ Staffing Data Report Quarter 1 2024 (October 1, 2023, through December 31, 2023) revealed based on the data submitted, the facility triggered for a One-Star Staffing Rating (Failure to submit PBJ data by the deadline, more than 4 days in the quarter without RN (Registered Nurse) Staffing hours, failure to respond to, submit documentation for, or failure to pass a CMS audit designed to discover discrepancies in PBJ data). Interview on 4/3/2024 at 2:40 pm with the Administrator and the Minimum Data Set (MDS) Coordinator revealed they were both aware of the one-star staffing rating the facility received for the first quarter of 2024. The Administrator further stated that it was due to the facility having a high turnover rate and the previous Director of Nursing (DON) leaving. The Administrator also stated the Assistant Director of Nursing (ADON) had left as well, so the facility did not have RN coverage for the required 8 hours. The Administrator stated losing the two RNs contributed to the low staff rating. The DON stated that the facility worked diligently to hire nurses, particularly RNs. The Administrator stated because the facility was located in a rural area, staffing had been a challenge. The MDS Coordinator stated that staffing was based off the PPD (patient per day). She further stated that the facility utilizes staffing agencies for Certified Nursing Assistants and Certified Medication Aides. Interview on 4/3/2024 at 3:00 pm with the Regional Staffing Consultant revealed the facility had only three RNs on staff during the first quarter of 2023, which she attributed to the high staff turnover rate. She stated that the facility was currently in compliance with RN coverage and staffing. She acknowledged the one-star staffing rating and said that everyone was working hard to get staff into the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37650 Based on observations and resident and staff interviews, the facility failed to serve meals that were palatable and attractive for one of 48 residents (R) (R248) who receive a regular diet from the kitchen. The facility census was 49 residents. Findings include: Meal test tray observation on 4/3/2024 at 12:38 p.m., the Activities Director (AD) was asked to perform a taste test on the lunch menu items. She stated the mashed potatoes were warm enough to eat but were bland without the gravy. She stated the collard greens tasted bland and were not seasoned. The AD reported the chicken did not look done, and she did not want to sample it. She stated because the chicken was pink inside, it indicated to her residents would not eat it. The greens had no real flavor, and the chicken was not appetizing to look at. The AD was not sure if it tasted good because it was not done; the collard greens had no flavor; and the mashed potatoes tasted like they came from the box with no seasoning added. Observation and Interview on 4/3/2024 at 1:15 pm revealed R248 was not able to continue eating one piece of her chicken because it was pink in the middle, so she decided not to eat the second piece of chicken. R248 revealed she did not eat the oven fried chicken because after one bite she noticed the chicken was still pink in the middle. Further review of R248's second piece of oven fried chicken revealed the chicken was still pink inside. R248 reported her lunch was not good, and she did not eat the chicken because it was still pink inside, and the collard greens were not seasoned. Further observation of the oven fried chicken revealed multiple pink and red indicating the chicken was not fully cooked. Interview on 4/3/2024 at 1:30 pm with the Administrator and Certified Dietary Manager (CDM), they were shown the findings of the oven fried chicken on the test tray and from R248's lunch tray. The Administrator confirmed she would not eat the oven fried chicken because it did not look like it was done. The CDM reported the oven fried chicken was done because it comes pre-fried, and they put it in the oven and warm it up to a temperature of 165 degrees (F). The CDM confirmed she warmed the collard greens in the microwave, put them in a metal pan, and placed them on the steam table. The CDM revealed she does not use seasoning in the foods that come pre-cooked. Salt and pepper are placed on the table for resident use.

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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. 37650 Based on observations, staff interviews, record review, and review of the facility policy titled, Safe Food Handling, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, kitchen shelves were not clean and sanitary; kitchen staff failed to discard food in the reach-in refrigerators and freezer by the use by date to include leftovers; kitchen staff failed to label/date opened food items in the reach-in refrigerator/freezer and dry storage area; kitchen staff failed to discard rotting vegetables in the dry storage area; dishwasher water was not reaching required temperatures; and kitchen staff failed to use a recipe when preparing pureed foods. The deficient practices had the potential to affect 48 of 49 residents receiving an oral diet. Findings include: Review of the facility policy titled Safe Food Handling with an effective date of 9/8/2021 revealed under Policy: To ensure food is safe. 8. Make sure all refrigerated items are labeled, dated, and covered with a use by date. Review of facility undated procedure posted in the kitchen titled Dating and Labeling Procedures revealed All items must have a receive date. All food items made in house is [sic] to be dated for 3 days. All food prepackaged such as cheese is to be labeled for 7 days. All food must have a beginning date and ending date and name of food on label with employee initials. Food in dry Storage will get labeled with open date. Observations and interview during a tour of the kitchen on 4/2/2024 from 9:30 am to 10:05 am revealed in refrigerator number three, 4 large, unlabeled/undated bags filled with a yellow liquid on the bottom shelf of the refrigerator, in two white buckets. The Certified Dietary Manager (CDM) revealed the 4 large bags were liquid eggs, unlabeled and undated. Continued observations revealed in refrigerator number two, one large plastic container of open cherries with no open date, one pack of leftover cooked bacon dated 1/2/2024 with a discard date of 1/4/2024. The CDM confirmed the cherries did not have an open date but there was a received date of 11/28 (no year provided), she revealed the cherries were used recently for a dessert. She stated the bacon was recently taken out of the freezer and placed in the refrigerator. Further observations and interview revealed freezer number one contained three family sized packs of vegan rice and vegetable dinner and three ready to bake peach pies with no receive date, one bag of hot dog buns out of the original packaging, unlabeled/undated. The CDM confirmed the receive dates were not on the food items, and she was not aware how long they had been in the freezer. Continued observations and interview revealed a large plastic jug of molasses on the top of a wooden shelf with black ants crawling around the top of the jug, along the shelf, and on the molasses. The CDM confirmed black ants were crawling on the shelf and other dry goods. Further observations revealed a large box of baking potatoes with several potatoes sprouting (growing additional bad areas on the potato), one medium box with six cabbages exposed to the elements of the atmosphere causing them to turn dark colors on different areas, and the fresh vegetables were sitting on the wooden shelf with the dry goods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 4/3/2024 at 9:37 am of the dishwasher temperatures revealed a water temperature of 118 degrees Fahrenheit (F) during the first wash. The second temperature check revealed a water temperature of 111 degrees F. The third water temperature check revealed a water temperature of 111 degrees F. Interview on 4/3/2024 at 9:45 am with [NAME] KK, she revealed that if the water temperature does not reach 120 degrees F, they wait and run a dish cycle again. Interview on 4/3/2024 at 9:46 am with the CDM, she reported there were issues with the plumbing and a plumber was coming out. The CDM confirmed that the dishwasher water temperature had not reached 120 degrees F. She stated if the water temperature of 120 degrees F or higher was not reached, they would have to wash, rinse, sanitize, and dry the dishes. Observation and interview on 4/3/2024 at 11:04 am revealed [NAME] KK reported she measured out seven scoops of 3 ounces (oz) of peach cobbler prior to the observation. [NAME] KK added two 1/2 pints of whole vitamin D milk to the peach cobbler to start the blending process. At 11:08 am the cook KK added one more 1/2 pint of whole vitamin D milk to the pureed peach cobbler mixture to achieve a pudding consistency. [NAME] KK revealed the dessert should be a hot food item, but they cannot serve it hot because it will melt the plastic containers. [NAME] KK revealed the peach cobbler was ordered pre-made. [NAME] KK stated she measured seven 2 oz scoops of seasoned breadcrumbs to the puree as a substitute for the cornbread on the regular meal menu. [NAME] KK added two 1/2 pints of vitamin D milk to begin the blending process. She added one more 1/2 pint of vitamin D milk to gain the desired pudding consistency. [NAME] KK placed the bread crumb puree in a non-oiled metal pan and placed it on the steam table. [NAME] KK revealed she goes by her own recipe that her family member used. She stated does not use the recipe that the facility provided. [NAME] KK indicated there was a recipe book to follow for pureeing foods. A request to see the recipe book was made but the recipe book was not received. Interview on 4/3/2024 at 3:09 pm with the Administrator and the CDM revealed the facility did not have a policy on food puree, food storage, dishwasher water temperatures, or dating/labeling food items. The CDM revealed the dietary staff have procedures they follow.

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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. 37650 Based on observations and staff interviews, the facility failed to ensure the dumpster area was properly maintained and free from debris. The deficient practice had the potential to attract pests and transfer microorganisms. Findings include: Observation on 4/4/2024 at 8:37 am revealed the dumpster, located outside the back entrance of the kitchen, contained trash bags filled to the top which prevented the lids from closing, food particles on the ground around the dumpster, and a stray cat wondering around the dumpster in search of food. Interview on 4/4/2024 at 8:45 am with the Certified Dietary Manager (CDM) revealed the Maintenance Director (MD) maintained the dumpster area. The CDM revealed the dumpster was blocked by a vehicle on 4/3/2024, when it was due to be emptied. It was confirmed by the CDM that the dumpster was full of trash bags and the lids would not close.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 37650 Based on observations, staff interviews, and record review, the facility failed to maintain effective pest control in the kitchen and in one of two food pantries. The deficient practice had the potential to affect all 48 residents receiving oral feedings. The facility census was 49 residents. Findings include: Observation and interview on 4/2/2024 at 10:05 am revealed a large plastic jug of molasses was observed on the top of a wooden shelf with black ants crawling around the top of the jug, along the shelf, and on the molasses. The Certified Dietary Manager (CDM) confirmed black ants were crawling on the shelf and other dry goods. Review of the Pest Control Contract revealed one visit in December 2023 on 12/28/2023. No recommendations. (Noted contract for biweekly regular service on statement.) January 2024 revealed two visits, on 1/25/2024 and 1/11/2024. No recommendations. February 2024 revealed one visit on 2/12/2024. No recommendations. (Noted contract for biweekly regular service on statement.) March 2024 revealed one visit on 3/26/2024. No recommendations. (Noted contract for biweekly regular service on statement.) The pest control contract states that pest treatment to the building will be conducted monthly June 17, 2017. Statement states biweekly service. No updated contract was noted. Interview on 4/2/2024 at 10:08 am with the CDM revealed she would have the Administrator contact the Pest Control company.