STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115004	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor Methodist Nsg C	2001 South Lee Street Americus, GA 31709

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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 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** 37927 Based on observation, interview and record review, the facility failed to refer residents with a newly identified mental disorder or condition to the appropriate state agency for a Preadmission Screening and Resident Review (PASARR) Level II evaluation. This affected one (1) of 2 residents reviewed for PASARR Level II, Resident (R) #22. Review of the facility's policy titled Assessment of Resident Minimum Data Set/Resident Assessment Instrument (MDS/RAI), reviewed and updated October 2016, revealed: Intent - It is the intent of Magnolia Manor facilities that the MDS/RAI be completed per MDS/RAI and regulatory guidelines . Procedural Guidelines . 4. Assessments should be coordinated with the PASARR program. This includes incorporating the recommendations from the PASARR Level II determination and the PASARR evaluation into the assessment, care plan and transitions of care. Any significant change in resident's physical or mental condition should be reported to the state mental health authority or state intellectual disability authority so that a resident review can be conducted . 1.Review of the clinical record for R#22, revealed he was admitted to the facility on [DATE] with diagnoses including cerebral infarction, heart disease, hypertension, mood disorder, anxiety disorder, major depressive disorder, bipolar disorder, chronic obstructive pulmonary disease, acute kidney failure and muscle weakness. Further review of the clinical record revealed a Continuity of Care Document (CCD), which detailed the effective dates of conditions diagnosed after R #22's initial admission on 9/22/16. Among these were unspecified mood [affective] disorder, with an effective date of 4/6/18; major depressive disorder, with an effective date of 12/14/16; anxiety disorder, with an effective date of 8/20/2020; and bipolar disorder, with an effective date of 8/4/21. Three (3) of the conditions, which qualified as a possible serious mental disorder, intellectual disability, or a related condition as listed on the PASARR Level I, required a Level II review. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review, on 3/13/25 at 4:30 p.m., the Administrator acknowledged R#22's post admission diagnoses of depressive disorder, bipolar disorder and anxiety disorder, and reported that she intended to research if any additional referrals were made. In an interview, on 3/14/25 at 8:30 a.m., the Administrator provided documentation of R#22's original PASARR Level I screen but did not locate any referrals for a Level II screening related to the subsequent diagnoses. 42070 44785

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on observations, interviews, and a review of records, facility staff failed to ensure the appropriate medical evaluation of a resident that sustained a head injury during a fall. This resident was at an increased risk for the development of intracranial hematomas (accumulations of blood inside the skull, either within the brain or between the brain and the skull) due to head injury, advanced age, and the use of antiplatelet agents. This deficient practice affected one of two residents reviewed for falls from a total of 37 residents sampled [Resident (R)#119]. Actual harm was identified on 3/5/25 when R#119 experienced a fall with injury which led to a decline in abilities and the facility failed to provide timely follow up for the decline. Findings include: According to Merck Manual (accessed 3/13/25 https://www.merckmanuals.com/home/injuries-and-poisoning/head-injuries/intracranial-hematomas), For people who are taking aspirin or anticoagulants (which increase the risk of bleeding), particularly older adults, the risk of developing a hematoma after even a minor head injury is increased . Some hematomas, particularly subdural hematomas, may develop slowly and cause gradual confusion and memory loss, especially in older adults. These symptoms are similar to those of dementia. People may not remember the head injury. Diagnosis of intracranial hematomas is usually based on results of computed tomography (CT). A review of R#119's medical record revealed an initial admitted [DATE]. R#119's medical history included dementia and repeated falls. An admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/5/25 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 possible points, indicating no cognitive impairment. According to the assessment, R#119 had no disorganized thinking or altered level of consciousness. According to an admission note dated 1/30/25 at 4:17 a.m., R#119 was alert and oriented to person, place, and time. The note further described Resident #119 as having clear, coherent speech with the ability to make his needs known. On 3/11/25 at 12:56 p.m., R#119 was observed lying in his bed on his left side with his eyes closed. A large, raised, bruised area was noted to be encompassing the resident's right eye and surrounding area. The bruising and discoloration extended down the resident's right cheek. R #119's bed was pushed against the wall and three fall mats were observed on the floor. On 3/12/25 at 1:10 p.m., a follow up interview was attempted with R #119. He was sitting in his wheelchair and was positioned at a dining table. When asked about the injury to his right eye, Resident #119 initially presented with garbled speech and struggled to formulate a response but eventually stated, I fell . R#119 added that he was tired. When asked about the circumstances of the fall that led to the injury, R#119 again stated he was tired and declined to explain the circumstances of the fall. A preliminary review of R#119's medication orders revealed an order, dated 1/29/25, for Plavix 75 milligrams (mg) to be administered once daily. A second order, dated 1/29/25, was noted for Aspirin 325 mg to be administered once daily. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Subsequent review of R#119's nursing progress notes revealed a note dated 3/4/25 at 7:43 p.m. The note indicated that the resident was observed lying on his right side on the floor of his room. The note added, noted a large hematoma to the right side of fore head. [sic] The note also indicated that the Nurse Practitioner was notified of the fall and the injury and a recommendation was given to use ice if we need to. A medical provider note by the Nurse Practitioner, dated 3/5/25 at 11:52 a.m., identified R#119 as having a fall from bed on 3/4/25 which resulted in a hematoma to the right side of his forehead. A narrative in the note indicated that R#119's responsible party was notified of the fall and the hematoma. According to the note, the responsible party was advised that R#119 needed a CT scan of his head performed to rule out bleeding related to R#119 receiving Plavix and Aspirin. The responsible party declined to have R#119 transferred to the hospital. The Nurse Practitioner explained to the responsible party that R#119 was at risk for major injuries, but R#119 was ultimately not transferred to the hospital for a CT scan. The note did indicate that R#119's Plavix and Aspirin were placed on hold for 7 days. A review of R#119's medication administration record for March 2025 revealed that facility staff continued to administer the Aspirin and the Plavix for two additional days (3/5/25 and 3/6/25) after the development of the hematoma. The order to hold both medications was eventually entered by the Nurse Practitioner late in the day on 3/6/25. A note by the Social Services department on 3/5/25 at 3:12 p.m. described a wellness visit being conducted with R#119. Resident #119 was described as presenting with confusion, unable to articulate full sentences, and was rambling with slurred/unclear speech. The note also identified R#119 as having excessive saliva spewing from both sides of his mouth during the encounter. The Social Services employee attempted to conduct a BIMS which resulted in a score of 2 out of 15 possible points, indicating severely impaired cognition. According to the note, R#119 had previously scored 15 out of 15 possible points, indicating there was no cognitive impairment at that time. The Social Worker notified the MDS Nurse of her findings. A note by the MDS Nurse, dated 3/5/25 at 3:39 p.m., read, Resident was observed to be drooling, drooling would increase when resident would start concentrating on attempting to stand. When staff would wipe his mouth, he would curse at them, speaking clearly, then start speaking unclearly again. When asked how he was doing, he glared at writer, then looked away without answering. A nursing progress note, dated 3/6/25 at 4:28 a.m., described R#119 as being observed on the floor. The note included a narrative which read, Resident continued to curse, yelling out, and speak clearly and then rambling unclearly after. A nursing progress note dated 3/7/25 described R#119 as being alert but not oriented. The note described R#119 as being very combative today and described behaviors such as yelling, cursing, and attempting to strike staff. A medical provider was notified, and new orders were obtained for Ativan (an anxiolytic medication) to be administered via intramuscular injection. A nursing progress note, dated 3/9/25 at 10:30 p.m., described R#119 as being observed on the floor mat beside his bed. R#119 continued with combative behaviors and agitation. A medical provider was notified, and new orders were obtained for Haldol (an antipsychotic medication) to be administered via intramuscular injection immediately. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Continued review of R#119's progress notes through 3/13/25 revealed a continuing and progressive decline in his medical condition from the time of admission and since sustaining a fall with head injury. Review of neurological flow sheets from 3/4/25 through 3/6/25 revealed that, on 3/4/25, R#119's speech was documented as clear. On 3/5/25 beginning at 10:00 a.m. through 3/8/25 at 7:00 a.m., R#119's speech was documented as rambling. On 3/13/25 at 11:18 a.m., an interview was conducted with the Administrator, the Director of Nursing (DON), and the Assistant Director of Nursing (ADON), to discuss the concern regarding R#119's progressive decline since admission and since sustaining a fall with head injury. The DON stated, We will get some results. When asked why R#119 had not undergone a CT scan as recommended by the Nurse Practitioner, the Administrator and DON explained that R#119's family member declined to have the resident transferred, but that facility staff continued to monitor the resident in house through neurological assessments. When asked what the facility's typical response would be when a resident sustained a fall with a head injury while receiving anticoagulant and/or antiplatelet agents, the DON stated the resident would likely be transferred to the hospital for evaluation. On 3/13/25 at 11:27 a.m., R#119 was observed sitting in his wheelchair in the Unit 4 Day Room attending an activity by the facility's Chaplain. When the Chaplain began singing and playing a guitar, R#119 attempted to leave the activity but was redirected by a staff member. R#119 pointed to his head and complained of a headache. A subsequent observation, on 3/13/25 at 11:37 a.m., revealed R#119 was drowsy and leaning forward in his wheelchair. R#119 was awakened by a staff member and encouraged to sit up straight in his wheelchair. On 3/13/25 at 11:50 a.m., an interview was conducted with the Unit 4 Nurse Manager (NM). The NM confirmed she was familiar with R#119's care and needs. The NM identified R#119 as being increasingly more confused since admission to the unit with intermittently unclear, garbled speech. The NM confirmed that R#119's overall condition was a little worse than it was at admission. When asked whether R#119 had undergone a CT scan since the fall with head injury on 3/4/25, the NM explained that the resident's responsible party declined to have the resident transferred to the hospital for the scan. When asked what the facility's typical response would be in the event that a responsible party was not acting in the best interest of the resident, the NM explained that nursing staff would have the capability to transfer the resident to the hospital. When asked why R#119 had not been transferred despite the strong recommendation from the Nurse Practitioner and the resident's progressive decline, the NM stated the facility decided to monitor R#119 in house. On 3/13/25 at 12:00 p.m., an interview was conducted with the Social Worker. The Social Worker confirmed she was familiar with R#119's medical condition from admission to current. When asked to describe R#119's condition on admission, the Social Worker described R#119 as being able to formulate complete sentences and thoughts. The Social Worker added that, at times, R#119 would have unclear speech patterns, but that they were much more infrequent than at the current time. The Social Worker added that she identified a clear, significant change in R#119's condition after her wellness visit with the resident on 3/5/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 3/13/25 at 2:06 p.m., a follow up interview was conducted with the DON and ADON. The DON stated, We stand by our decision not to send him to the hospital. We are confident in our staff. We have reviewed neurochecks and notes from his provider and we definitely stand by our decision. The DON was then asked to review the copies of neurocheck forms, which were produced earlier in the day. Both the DON and ADON reviewed the forms and stated they could not explain the documented discrepancies and changes with R#119's speech patterns. On 3/13/25 at 3:36 p.m., a telephone interview was conducted with R#119's family member. The family member confirmed that R#119's cognition was intact and that his speech was clear and coherent at the time he was admitted to the facility. When asked whether she was notified of R#119's fall on 3/4/25 which resulted in a head injury, the family member confirmed she had been notified and that she did decline R#119's transfer to the hospital for evaluation. When asked whether she was aware of R#119's medical decline, the family member explained that a nurse had called her earlier in the morning on 3/13/25 and that she told the caller to send R#119 for a CT scan. On 3/14/25 at approximately 9:30 a.m., the DON confirmed that R#119 had been scheduled for a CT scan and would be transported to the appointment by facility staff. 44785

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37927 Based on observations, interviews, record review, and facility policy, staff failed to complete the assessments intended to identify deficits in ability to smoke safely for Resident (R) #22. This affected one (1) of three (3) residents sampled for smoking. The findings include: Review of facility policy entitled, Resident Smoking Guidelines, revealed: Intent - Magnolia Manor realizes the threat that smoking presents to the health and safety of the residents in our facilities . All residents who wish to smoke will be allowed to do so only in designated areas of the facility . Procedural Guidelines . 2.Resident Smoking Assessment List: A. The SSD and/or Care Plan Team Representative will assess each smoker initially, annually, with significant change and quarterly with OBRA MDS schedule to determine the amount of assistance needed and appropriately complete and/or revise the Resident Smoking Assessment List. SSD should document in the social services progress note that the assessment was completed and refer to the care plan for interventions. B. Employees responsible for the supervision of residents who smoke are responsible to inform the Care Plan Team of any changes in the level of assistance needed . Review of the clinical record revealed R #22 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, heart disease, hypertension, mood disorder, anxiety disorder, major depressive disorder, bipolar disorder, chronic obstructive pulmonary disease, acute kidney failure and muscle weakness. A list of residents who smoke was provided by the facility and included R#22 as one (1) of three (3) residents that smoke. A review of the clinical record for R#22, revealed an Annual Minimum Data Set (MDS) assessment, dated 1/31/25, which revealed R#22 with a Brief Interview for Mental Status (BIMS) score of 15, an indication of being cognitively intact. No smoking assessment from the associated evaluation period was found in the clinical record. In an interview, on 3/13/25 2:48 p.m., Social Services Assistant (SSA) AA and SSA BB reported they had not completed smoking assessments for R#22, according to the facility Smoking Policy, Social Services was responsible for the task. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 3/13/25 at 3:18 p.m., the MDS Coordinator and MDS VV reported they did not do the smoking assessment and if one was not completed by the responsible facility staff, they would not have one. The MDS Coordinator stated she was aware R#22 smoked and added the care area to the care plan without an assessment. Both acknowledged it was not possible to know if R#22 continued to be safe to smoke without updated assessments. On 03/13/25 at 4:30 p.m., the Administrator reported only being able to locate annual smoking assessments dated 1/12/23 and 1/12/24. No quarterly smoking assessments were completed and no assessment for safe smoking was completed for the annual assessment dated [DATE]. The Administrator provided documentation of in-service training provided to the Social Services department in November 2024 which identified completion of Smoking Assessments as its responsibility. 44785

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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. 33363 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure food safety, sanitary conditions and the prevention of foodborne illness were maintained. This was evidenced by one of one walk-in freezer temperature gauges that displayed multiple temperatures greater than 20 degrees Fahrenheit (F) by three internal thermometers, which lead to food thawing. Additional failures included a large quantity of raw chicken pieces allowed to sit, unrefrigerated, in the frying area of the kitchen for more than four hours before placing the remaining unused portions into the same freezer with elevated temperature for storage. The facility staff failed to ensure meals served from the steam table were served under sanitary conditions by failing to change gloves, perform hand hygiene when staff changed job duties, ensuring hairnet and beard guards were used, and failed ensure steam table pan covers and food were protected from chemical contamination. This deficient practice impacted 131 of 139 residents that received an oral diet. The findings include: A review of the facility policy titled, Food Storage, not dated, revealed, Procedures .17. Freezer Temperatures: a. Temperatures for freezers should be 0 [zero] degrees or below and must be recorded daily. b. Frozen foods must be received frozen. Do not accept frozen foods which have begun to thaw. c. Holding temperatures for frozen foods is 0 [zero] degrees or below. Frozen meat must be defrosted in a refrigerator on a tray on a lower shelf. Defrosting time will depend on the size of the product. d. Every freezer must be equipped with an internal thermometer, even if equipped with an external thermometer. e. Rewrap packages of frozen food which have been opened. This prevents freezer burns and spoilage. f. Do not refreeze food which has been thawed. g. To freeze leftover food, package in small airtight units for quick freezing, label and date. h. Do do not crowd food. Proper air circulation ensures a more uniform temperature and prevents spoilage. A review of the facility policy titled, Sanitation/Infection Control, not dated, revealed, 1. Effective sanitary practices include, but are not limited to, the following: a. The Dietary Manager is responsible for supervising all sanitation and housekeeping procedures within the Dietary Department. b. The Dietary Manager and consultant dietitian develop a cleaning schedule and the Dietary Service. c. The Dietary Manager is responsible for supervising and training all personnel in proper sanitation procedures for storing, preparing and serving foods. [sic] A review of the facility policy titled, Handwashing/Hand Hygiene, with a revised date of August 2019, revealed, Policy Statement - This facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation: 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors . 8. Hand Hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility policy titled, Personal Hygiene, not dated, revealed the key to a safe and sanitary Dietary Department is healthy employees, properly trained in safe food handling, who practice good personal hygiene. Many cases of food poisoning are traced to human contamination of food. Constant training and supervision of Dietary Department personnel should stress good work habits, good health, and a clean, neat personal appearance. Head covering worn: If hair is long and not covered properly with a cap, a hair net must be worn. Hair spray is not an authorized substitute for hair nets. The head covering must be clean. A review of the facility policy titled, Dishwashing, not dated, revealed Procedure for washing pots and pans, revealed pots and pans are washed any time during or after meal preparation. The sinks are filled as needed. 1. Fill first sink with hot detergent water. 2. Fill the second sink with hot rinse water. 3. The third sink sanitizes the items by: a. Use of a chemical sanitizer added to water; or fill the sink with water kept at 180 degrees F and submerging the items for at least one minute. A review of the facility training records titled, 2024 Annual Skills Fair, dated 10/29/24 to 10/31/24 revealed the topics covered included Infection Control, Hand Hygiene: Understanding When to Wash with Soap & Water Vs Using Hand Sanitizer. All dietary staff signed the record of attendance during this training. A review of the facility's Safety Data Sheet, dated 2/13/15 revealed Magic Germicide that was observed used at the three-compartment sink was used for sanitation of the pots and pans. SECTION 2: HAZARD(S) IDENTIFCATION revealed the Globally Harmonized System (GHS), had a GHS Signal Word: DANGER, which indicated a chemical with more severe or significant hazards. GHS Hazard Phrases: H290 - May be corrosive to metals. H302 - Harmful if swallowed. IF SWALLOWED: Immediately call a POISON CENTER or physician. Rinse mouth. Do not induce vomiting. H314 - Causes severe skin burns and eye damage. H318 - Causes serious eye damage. On 3/11/25 at 10:56 a.m., an observation was made of the walk-in freezer that was equipped with three internal thermometers all reading 20 degrees F. There was food to include ice cream cups that were soft liquid, shortcake desserts thawed and had discolored patches and a shriveled appearance, hamburger patties were opened to the air and had a dull, gray-brown appearance, and a leathery appearing texture, French toast that was open and exposed to the air and had turned a brown color. These items were located throughout the freezer. Observation and interview on 3/11/25 at approximately 10:58 a.m. revealed the facility's walk-in freezer temperature log revealed no temperatures were documented from 3/1/25 to 3/3/25. The freezer temperature logs from 3/4/25 to 3/10/25 revealed temperatures ranged from 20 degrees Fahrenheit (F) to 30 degrees F. The Dietary Manager (DM) asked the dietary staff on the current shift if they were knowledgeable of the temperatures being out of range and were documented as such. The reply of three dietary staff stated they did not know who had recorded those temperatures. The DM was asked to read the temperature of three thermometers located in the rear of the freezer and was not able to accurately read the temperatures. The DM further stated the freezer's 20 degree F temperature may be up from the staff holding the freezer door open for an extended amount of time and that it would go back down. The DM stated that she expected the temperature inside the freezer to hold at zero degrees F to -10 degrees F. At 11:20 a.m., when rechecking the temperature of the walk-in freezer, the DM agreed the temperature remained at 20 degrees F but took no action. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/11/25 at 11:20 a.m. during a tray line observation, [NAME] LL was observed moving eight metal cooking pans with foil covers from the warmer to the steam table. She removed the foil and collected pan covers from the clean storage area under the steam table. One at a time she left the serving line, rapidly dipped the covers into the three-compartment sink beginning with the wash compartment (which contained soapy water) that was murky soiled water, dipped the pan covers into rinse water then dipped the covers into the sanitation solution then immediately removed each and placed the covers directly over the prepared pans of food. [NAME] LL failed to allow any drying time of the sanitation solution before she covered each pan. On 3/11/25 at approximately 11:24 a.m., a second observation was made with the Dietary Manager of the walk-in freezer temperature which read at 26 degrees F on each of the three thermometers located in the interior of the freezer. On 3/11/25 at 11:35 a.m., [NAME] LL was observed removing the pan covers from the steam table pans. There was a substantial amount of sanitation solution that had collected under the handles of each of the eight pan covers. [NAME] LL was observed to remove the covers, placed each in a vertical position and allowed the sanitation solution, which had collected on the top side of the pan covers, to drain into each container of food. It was at this point the surveyor stopped the serving line and asked [NAME] LL if she needed to do anything different which he/she replied no and continued to prepare for serving. She was again stopped from serving by the surveyor and again asked if she needed to change anything and she stated no and began to plate the first tray. The surveyor stopped the meal service and recommended the staff stop the tray line due to the cross contamination of the improper pan cover washing and the sanitation chemical that drained into the food. [NAME] LL left the tray line to seek advice from the DM, who was in his office. When [NAME] LL returned, she informed the dietary staff the DM had stated continue serving and don't worry about it. The serving line began without any correction. The total serving time was one hour and 10 minutes. On 3/11/25 at 1:47 p.m., an interview with the Director of Quality Assurance and Infection Control (QA/IC) stated the findings of the failure of the walk-in freezer to maintain proper holding temperature was a significant risk for foodborne illness and for residents to become sick. She also stated she expected all staff throughout the facility to use proper hand hygiene to prevent the spread of infections and germs and they should follow facility policy on hand hygiene. The Director of QA/IC stated there was a heightened risk of the spread of infection and cross contamination if staff failed to perform hand hygiene. She stated the sanitation solution should never contact food. This chemical exposure could be poisonous to the residents and the exposure could cause serious adverse reactions for certain types of medications and potentially be fatal. The Director of QA/IC stated all the findings mentioned to be extremely concerning. On 3/11/25 at 2:24 p.m., an interview with the Administrator was conducted to discuss the findings in the Dietary Department. She stated that she was not aware of any of the concerns related to the failure of the dietary staff to perform hand hygiene, to prevent cross contamination, the failure to properly maintain a properly operating freezer or the exposure of the sanitation chemicals in the food. The Administrator stated she should be made aware of any issues throughout the facility. She stated the facility had performed mock surveys prior to this date and she did not see any evidence of these issues. She stated the DM had only discussed the documentation of the freezer temperatures. The Administrator stated she took these findings very seriously and would address the concerns immediately. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115004	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Manor Methodist Nsg C	2001 South Lee Street Americus, GA 31709

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/13/25 at 11:50 a.m., an observation was made of [NAME] MM who entered the tray line with a pair of gloves on, a hair net in place but failed to don a beard cover. An observation of [NAME] MM left the tray line seven times and returned without a glove change or performing hand hygiene. He was observed to handle four unwrapped slices of bread with the same pair of gloves in place. The bread was served onto four separate residents' meal trays. On 3/13/25 at 2:10 p.m., an observation was made of the walk-in freezer thermometer which read 20 degrees F. Upon inspection of the contents, there were 12 boxes of dairy products to include ice cream and ice cream sandwiches that were soft and had thawed to a liquid substance. There was a large black trash bag that sat inside a cardboard box stacked on two cardboard boxes. The bag was draining a white cloudy and red slimy liquid onto the floor of the freezer. The bag was open to the environment of the freezer. Inside of the bag were approximately 150 pieces of thawed chicken that had a measured internal temperature of 55 degrees F. In the bottom of the bag was the same white cloudy and red liquid that in appearance was slimy. In addition, there were boxes of thawed sausage patties, thawed hamburger patties, a box of 216 count of southern style biscuits that was thawed and had a brownish appearance and was exposed to the freezer elements, a bag that contained waffles was opened and undated. There were three freezer air circulating fans located on the front of the freezer cooling unit that were not turning. There was a buildup of ice collected under the freezing cooling unit that was dripping liquid to the floor. The DM was observed to open the box of chicken and told the utility worker to take the bag out of the freezer and to clean up the floor. The bag of chicken was observed to be placed on a utility cart while the staff cleaned the freezer floor with soap and water. On 3/13/25 at approximately 2:15 p.m., an interview with the DM was conducted and she stated the chicken was left over from the noon meal and was to be served as fried chicken. When asked how long the chicken had been left out, she stated approximately four hours, but was not clear on the exact time. She stated she expected the chicken to be placed back into the freezer if there were pieces that had not been cooked so the chicken would not spoil. When asked if she was concerned over the chicken being allowed to sit in the heated area of the deep fryer area of the kitchen for an undetermined amount of time, she stated if it was placed in the freezer, the chicken should be alright to serve for a future meal. She stated she had no concerns over the chicken being placed back in the freezer after it had been out of range for four or more hours. The DM stated she did not believe the three thermometers in the freezer were working properly and she did not think the temperature was out of range. The DM stated that she had not reported the temperature readings to maintenance for repairs. On 3/13/25 at 3:30 p.m., another observation was made of the freezer with an internal temperature of 20 degrees F. The large black bag of chicken pieces had been returned to the freezer and continued to drain a cloudy white and red liquid onto the floor of the freezer. On 3/13/25 at 4:04 p.m., a third observation was made of the large black bag inside a cardboard box that contained the thawed pieces of chicken and was noted to continue to drain the white cloudy and red liquid onto the floor of the freezer. The internal freezer temperature gauge continued to read 20 degrees F. On 3/13/25 at 4:05 p.m., the DM and Assistant Dietary Manager (ADM) were instructed by the surveyor to stop food service that utilized any contents from that freezer. The evening meal had been prepared with food items such as hamburger patties and were going to be served at the evening meal. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/14/25 at 9:15 a.m., an interview with the Administrator revealed she was not made aware of the concerns related to the findings of the freezer in the Dietary Department. She stated this would take priority to ensure these issues were resolved and the education of the staff would start immediately. She stated there had been some kitchen staffing changes made to address the concerns. She stated her serious concern remained of the improper workings of the freezer unit due to the risk of leading to a foodborne illness outbreak. She concluded that the single most important method of preventing illness was hand hygiene and this will be her top priority along with the improperly functioning freezer. On 3/14/25 at 10:58 a.m., an interview with the Maintenance Director II revealed he had been notified on 3/13/25 that the freezer was not working properly, and the temperature readings of the thermometers were reading out of range. He stated they had notified the Heating, Ventilation and Air Conditioning (HVAC) contractor on 3/13/25. The service technician had made a service call in the evening of 3/13/25 and determined the freezer was out of range and not in compliance with the required temperature to sustain frozen foods properly. A review of an invoice issued by the facility's air conditioning and heating vendor, dated 3/14/25 revealed the walk-in freezer was noted to have a dirty condenser coil, freezing unit was low in charge so they added refrigerant to the system, and the freezing setting was set too warm. The description noted a dirty condenser coil limits airflow and led to cleaning with special chemicals to restore proper function. On 3/14/25 at 11:10 a.m., an interview with the HVAC technician revealed their findings on 3/13/25 during a service call were that the kitchen freezer was not working properly. He stated the condenser coil was closed off with debris and was improperly circulating the coolant which kept the temperature within a set range. He stated additionally the coolant charge was low which would affect the function of the freezer's cooling system.