STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115132	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abercorn Rehabilitation Center	11800 Abercorn Street Savannah, GA 31419

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on observations, record review, interviews, and policy review, the facility failed to ensure four (Resident (R) 93, R23, R95, and R34) of 90 facility residents observed during initial screening had medications available for self-administration and stored at the bedside only when assessed to do so safely and with a physician's order. These failures placed all four residents at risk for medication errors, overdose, or misappropriation of medications. Findings include: Review of the facility's policy titled, Self-Administration of Medications, dated 06/28/24, revealed, The resident has the right to self-administer medications if the interdisciplinary team [IDT] has determined that this practice is clinically appropriate . A resident may only self-administer medications after the IDT has determined which medications may be self-administered . Based on the interdisciplinary team's assessment, a decision is made as to whether the resident is a candidate for self-administration. This will be recorded on the self-administration of medication assessment . The nurse will obtain a physician's order for each resident conducting self-administration of medications. 1. Review of the Medical Diagnosis tab of R93's electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis, need for assistance with personal care, and fractures of left radius and ulna (forearm bones). Review of R93's incomplete admission Minimum Data Set (MDS), with an assessment reference date (ARD) of 01/17/25 and located in the MDS tab of the EMR, revealed she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. She did not exhibit any mood or behavioral symptoms. During an observation in R93's room on 01/21/25 at 10:14 AM, R93 was lying in bed with a tube of Pain Relief Cream and a small clear medication cup half-full of white cream on her bedside table. Review of R93's Orders tab of the EMR revealed the only order for topical cream was an order, which originated on 01/13/25, for zinc paste to the buttock and sacrum as needed and after each incontinent episode. There were no orders for pain relief cream or self-administration of medications. Review of the Evaluations tab of the EMR revealed there was no assessment of R93's ability to safely self-administer medications. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R93's Care Plan, located under the Care Plan tab in the EMR and dated 05/16/24, revealed, [R93 has] pain r/t [related to] arthritis, fracture. The approaches included: [Administer] analgesics as ordered. R93's Care Plan did not address self-administration of medication or keeping medications at her bedside. During an interview on 01/21/25 at 12:26 PM, Registered Nurse (RN)1 stated R93 did not have orders for the creams at her bedside and did not have an order for self-administration of medications. RN1 stated the resident had recently gone out to an appointment and may have brought the medication without the staff's knowledge. During a concurrent interview and observation with Licensed Practical Nurse (LPN) 1 on 01/21/25 at 12:28 PM, in R93's room, LPN1 confirmed the two creams were left unattended at the resident's bedside and stated she did not know what cream was in the small medication cup. At this time, R93 stated she had ordered the Pain Relief Cream and had it delivered, and she was not aware it needed to be kept in the medication cart and a physician's order was required. LPN1 removed both creams from the room and explained the situation to the resident. 2. Review of R23's Medical Diagnosis tab of the EMR revealed she was admitted to the facility on [DATE] with diagnoses including type 2 diabetes and need for assistance with personal care. Review of R23's quarterly MDS, with an ARD of 11/26/24 and located in the MDS tab of the EMR, revealed she scored 15 out of 15 on the BIMS, indicating intact cognition. She did not exhibit any mood or behavioral symptoms. During an observation in R23's room on 01/21/25 at 10:16 AM, R23 was lying in bed with a small plastic medication cup half-full of white powder on the bedside table next to her beverage cup. R23 stated the cup held medicated powder to help with a rash and the nurse typically applied the powder for her and then took the remaining powder out of the room when finished but must have left it in the room by mistake. Review of R23's EMR under the Orders tab revealed there was no physician's order for any topical powder and no order for self-administration of medications. Review of R23's EMR under the Evaluations tab revealed there was no assessment of the resident's ability to safely self-administer medications. Review of R23's Care Plan, dated 04/01/24 and located under the Care Plan tab of the EMR, revealed, [R23] is at risk for impairment to skin integrity r/t [related to] decreased mobility, obesity and incontinent episodes. A goal was, Rash will heal within the next 14 days with medication use. The approaches included Administer antifungal medication as ordered. R23's Care Plan did not address self-administration of medication or keeping medications at her bedside. During an interview with RN1 on 01/21/25 at 12:26 PM, RN1 stated the resident did not have orders for any topical powder and did not have an order for self-administration of medications. RN1 stated since there was no order to look up on the Medication Administration Record, she was unable to determine how R23 obtained the powder. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation with LPN1 on 01/21/25 at 12:30 PM, in R23's room, LPN1 confirmed the cup of powder was at the resident's bedside and stated she did not know what powder it was. LPN1 removed the powder from the room. 3. Review of R95's Medical Diagnosis tab of the EMR revealed she was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, spinal stenosis, and need for assistance with personal care. Review of R95's incomplete admission MDS, with an ARD of 01/24/25 and located in the MDS tab of the EMR, revealed she scored 15 out of 15 on the BIMS, indicating intact cognition. She exhibited minor symptoms of depression and no behavioral symptoms. During an observation in R95's room on 01/21/25 at 10:32 AM, R95 was lying in bed with a bottle of Chloraseptic (phenol pain relief) throat spray, a carton of miconazole (antifungal) powder, a bottle of Systane(lubricating) eye drops, and a bottle of saline nasal spray on her bedside table. Review of R95's EMR under the Orders tab revealed there was no physician's order for self-administration of medications, nor were there orders for Chloraseptic throat spray, Systane eye drops, saline nasal spray, or miconazole powder. Review of R95's EMR under the Evaluations tab revealed there was no assessment of the resident's ability to safely self-administer medications. Review of R95's Care Plan, dated 01/18/25 and located under the Care Plan tab of the EMR, revealed interventions for nursing staff to administer medications as ordered. R95's Care Plan did not address self-administration of medication or keeping medications at her bedside. During a concurrent interview and observation with LPN1 on 01/21/25 at 12:23 PM, in R95's room, the Chloraseptic spray, Systane eye drops, and miconazole powder remained on the resident's bedside table. LPN1 stated she did not typically work with this resident and was unsure whether she had a physician's order for or the ability to self-administer medications. LPN1 stated she would need to check with the manager. At this time, R95 stated she had brought the medications with her upon admission, has had them on her bedside table since her day of admission, and she had never been told before that they were a problem. During a concurrent interview and observation with RN1 on 01/21/25 at 12:25 PM, in R95's room, RN1 stated the resident did not have orders for the medications at her bedside and did not have an order for self-administration of medications. RN1 stated the resident's family may have brought the medications in, as she was unaware R95 had these medications in her room. During an interview on 01/24/25 at 11:30 AM, the Director of Nursing (DON) stated residents were assessed for the ability to safely self-administer medication only when they expressed a desire to do so. The DON further stated if a resident had not been assessed for self-administration, the staff should remove the medications from the resident's room and store in the medication cart until the assessment process could be completed and proper physician orders obtained. 52063 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of R34's quarterly MDS assessment, located in the EMR under the MDS tab with an ARD of 11/16/24, revealed R34 was admitted to the facility on [DATE]. The resident's diagnoses included chronic obstructive pulmonary disease (COPD), heart failure and pulmonary edema. Further review of the MDS revealed a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. Review of R34's Physician's Orders, located in the EMR under the Orders tab revealed the resident did not have orders to self-administer the inhalers. During an observation on 01/21/2025 at 11:34 AM, a Trelegy Ellipta Inhaler and an Atrovent Inhaler [both of which treat symptoms of Chronic Obstructive Pulmonary Disease, Asthma, Bronchitis, and Emphysema], were observed lying on the top cover, at the foot of R34's bed. There were no staff members in the room at the time of observation. During an interview on 01/21/2024 at 11:36 AM, R34 stated her nurse left the inhalers on the bed earlier that morning, but she could not remember exactly how long the medications had been lying on the bed. During this interview, LPN4 entered the room at 11:37 AM, picked up the two inhalers, and immediately exited the room with the medications. During an interview on 01/24/2025 at 1:30 PM, LPN4, she stated she left the inhalers lying on the foot of R34's bed because the resident asked her to get her some ice water. LPN4 said she returned to the room with a Styrofoam cup of ice water, and realized she left the medications on the bed. LPN4 said she should not have left the medications on R34's bed because another resident could have entered R34's room and taken the inhalers from the room. LPN4 said she thought the facility had a policy about ensuring the residents' medications were always securely stored and she had been educated on the policy. She said she was unsure if there were residents who could have wandered into R34's room and taken the inhalers from the bed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 35693 Based on observation, interview, and record review, the facility failed to ensure resident rooms were clean, creating a homelike environment for three (Residents (R) 63, R59, and R46) of eight residents reviewed for homelike environment. This failure had the potential to negatively impact residents' environment and overall well-being. Findings include: 1. Review of R63's Profile, located in the electronic medical Record (EMR) under the Profile tab, revealed R63 was initially admitted on [DATE] and readmitted on [DATE]. Review of R63's Medical Diagnosis, located in the EMR under the Diagnosis tab revealed R63 had a diagnosis of dementia. Review of R63's Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 12/01/24 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 13 out of 15 indicating R63 was cognitively intact. Review of R63's Care Plan located in the EMR under the Care Plan tab revealed interventions to address cognitive impairment, including cueing, reorienting, and supervising as needed. During an observation on 01/21/25 at 2:20 PM, R63's room revealed trash on the floor, including a plastic juice container, an old bandage, an empty soda bottle, used tissues, a plastic drink lid, a dirty towel, a used plastic bag, and a jelly container. This observation further revealed two dirty plastic plates from the kitchen, one resting on top of a small trashcan, and the other on the floor in the middle of the room between two beds. There was also a dirty fork on the floor. During an observation on 01/23/25 at 1:45 PM, two meal plates, a dirty fork, and other trash were still in the room. There was one plate on top of the trash can and the second plate was now next to the door on the floor. During an observation and concurrent interview on 01/23/25 at 2:07 PM, the same two dirty plates and dirty fork were on the floor, the used bandage, an empty plastic juice cup, and the plastic drink lid remained on the floor. In addition, there were two old meal tickets on the floor, a Styrofoam cup with a straw, an empty milk carton, an empty water bottle under the bed, a used straw on the floor, a pillow on the floor behind the bed, a roll of toilet paper on the floor sitting in a puddle of water near the bed, a meal tray from breakfast set on R63's dresser containing a plate, juice cup, coffee cup, utensils and a meal ticket, and a dirty plate left on residents bed. R63 was observed sitting up in her wheelchair in the doorway of her room eating a meal on her bedside table. R63 stated she had two meals for lunch, with the one plate that was left on the bed and the one in front of her. She could not provide any details about how often staff clean her room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/25 at 2:15 PM, Certified Nurse Aid (CNA) 4 stated she had not been the one to deliver R63's meal tray to her today but confirmed that the old meal plates and trash were present. CNA4 proceeded to pick up all the trash and the plates that were still in the room, the fork, juice cup, and lid and removed them from the room. During an interview on 01/23/25 at 2:45 PM, the Housekeeper (HK) stated he had been in R63's room yesterday and noticed the meal trays. He stated he sweeps and mops every room once daily unless there was a spill that required additional cleaning. HK stated R63 did not have any requirements that required him to clean her room more often. 2. Review of R59's Profile, located in the EMR under the Profile tab revealed R59 was initially admitted on [DATE]. Review of R59's Medical Diagnosis, located in the EMR under the Diagnosis tab revealed R59 had a diagnosis of dementia with other behavioral disturbance. Review of R59's MDS located in the EMR under the MDS tab with an ARD of 12/23/24 revealed the resident had a BIMS score of 15 out of 15, indicating R59 was cognitively intact. The MDS indicated R59 used a walker and independently walked and transferred. Review of R59's Care Plan located in the EMR under the Care Plan tab revealed interventions to address falls risk, including maintaining a safe environment and hoarding with interventions to convey expectations and limitations and refer resident to psych services. Observation on 01/21/25 at 4:15 PM revealed the entire wall against the window next to R59's bed was covered in Styrofoam cups, snacks, toiletries, plastic cups, plushies, plants, decorations, candy, and unopened Jello containers. R59's nightstand, chair, and walker were completely covered with personal items, and half the bedside table was covered in personal items and cups and containers from previous meals. The walker was also piled up with clothing and similar items and parked next to the bathroom door near the foot of R59's bed. Items included Styrofoam cups and containers, straws, clothes, blankets, briefs, plushies, decorations, candy, plants, cards, tubes of lotion, towels, plastic bags, calendars, boxes of crayons and pencils, water bottles, tissue boxes, and hangers. Half of R59's bed was also covered in bags of snacks, and under her bed at the foot was a bag containing several briefs. During an interview on 01/21/25 at 4:15 PM, R59 stated the bag on the floor at the foot of her bed contained her used pull-ups. R59 stated the aids dispose of it when they come in to check on her. During an observation on 01/24/25 at 1:59 PM, the same piles of items remained in R59's room. During an interview on 01/23/25 at 1:32 PM, CNA4 stated R59's room stays that way because R59 tells staff those are her things. During an interview and observation on 01/24/25 at 3:25 PM, the Regional Consultant made her own observations and verified the clutter in R59's room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/24/25 at 3:30 PM, the Administrator stated they had been working with R59 and her family to resolve this matter and finally got R59 to agree to clean it up as long as R59 could supervise the process. The Administrator stated the family told the Administrator they did not want to be involved in the clean-up because R59 would be upset with them. The facility was unable to provide a policy related to maintaining resident rooms in a clean, homelike manner. 52063 3. Review of R46's quarterly MDS assessment, located in the EMR under the MDS tab with an ARD of 12/04/24, revealed the facility admitted R46 on 11/02/20 with diagnoses of history of cerebral vascular accident, right-sided hemiparesis, aphasia, and depression. Further review of this MDS revealed a Brief Interview for Mental Status (BIMS) score of five out of 15, which indicated the resident was severely cognitively impaired. During an observation on 01/23/25 at 2:58 PM, the footboard of R46's bed was damaged, having a sizable portion of the wood-colored veneer missing from the right side of R46's bed's footboard, resulting in exposure of a rough surface. In addition, the brown metal rim of the bed's footboard was detached/not secured, leaving an open space between the damaged area of the footboard and the metal rim. During an interview on 01/23/25 at 4:05 PM, CNA7 said she was assigned to care for R46 on 01/21/25, but she had not noticed the damaged footboard. She said if staff noticed something in disrepair in a resident's room, they should record the issue in the maintenance log stored at the nurses' station. During an interview on 01/23/25 at 4:10 PM, the Director of Maintenance said he was not aware R46's bed was damaged, and his concern was the missing veneer exposed a rough surface on the bed, and a resident could scrape his or her skin on the footboard. The Director of Maintenance stated staff should report any non-emergency environmental issues by logging them into the maintenance log kept at the nurses' station. The Director of Maintenance stated he checked the maintenance logs at the nurses' stations about every two hours and at least four times per day. He said he prioritized the repairs and addressed them as quickly as possible continuing until all issues were addressed. The Director of Maintenance stated that management staff made daily Angel Rounds, and they too, should report any damaged equipment, such as the resident's damaged bed, by completing a form and giving it directly to him. He stated he had extra footboards on hand and would be able to complete the repair of R46's bed immediately. Review of the facility's policy titled, Preventive Maintenance Program, Revised 08/2023, revealed, The company has established the following elements for a successful preventive maintenance program: A center-wide system to communicate issues or items that need attention, repair, or replacement with a weekly routine walk-through by the Administrator, a maintenance representative, and a clinical representative is recommended .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52126 Based on interviews, record review, and facility policy review, the facility failed to report an allegation of resident-to-resident sexual abuse within two hours after the allegation for two residents (Resident (R) 36 and R294) of seven sampled residents. The deficient practice could result in residents being abused. Findings include: Review of R36's Clinical Census located under the Census tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE]. Review of R36's Medical Diagnoses located under the Med Diag tab in the EMR revealed the resident had diagnoses including dementia and cognitive communication deficit. Review of R36's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/29/24, located under the MDS tab of the EMR, revealed the resident had a Brief Interview for Mental Status (BIMS) score of four out of 15, which indicated the resident had severe cognitive impairment. Review of R36's Care plan located under the Care plan tab of the EMR, revealed the resident had impaired cognitive function/impaired thought process related to diagnosis of dementia dated 04/14/22. Further review of R36's care plan revealed the resident was resistive to care dated 01/25/23, with an intervention to allow the resident to make decisions about treatment regime to provide a sense of control. Review of R294's Clinical Census located under the Census tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE]. Review of R294's Medical Diagnoses located under the Med Diag tab in the EMR revealed the resident had diagnoses including dementia. The resident was discharged on [DATE] to another facility. Review of R294's quarterly MDS with an ARD of 04/25/24, located under the MDS tab of the EMR revealed a BIMS score of 7, which indicated the resident had severe cognitive impairment. Review of R294's Care plan located under the Care plan tab of the EMR, revealed the resident had impaired cognitive function/impaired thought process related to dementia dated 01/17/24. Further review of R294's care plan revealed the resident was resistive to care dated 05/21/24, with an intervention to allow the resident to make decisions about treatment regime to provide a sense of control. Review of the intake form received from the State Agency (SA) revealed the SA received the report of the allegation of resident-resident sexual abuse on 05/21/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a written statement by Certified Nursing Assistant (CNA)5, provided by the facility, dated 05/21/24 regarding the event on 05/18/24, stated CNA5 notified Registered Nurse (RN) 2. Review of a written statement by RN2, provided by the facility, dated 05/21/24, regarding the event on 05/18/24, stated RN2 was informed by CNA5 that R36 and R294 were engaging in sexual activity. RN2 stated that CNA5 said that it was heard that they had been engaging in sexual activity on Friday and the unit manager had advised to provide privacy and allow them to do what they want to do.' RN2 stated, I didn't want to go against the unit manager's decision so I advised she should follow what she was told by the unit manager and attempt to redirect them. Review of the facility's investigative documentation, provided by the facility, dated 05/26/24, revealed documentation that the alleged event occurred on 05/18/24. The documentation stated that RN2 was suspended on 05/20/24 pending investigation. All staff received re-education regarding abuse, neglect, exploitation, resident rights, and reporting suspected or known abuse immediately. During an interview on 01/23/24 at 9:55 AM, the Director of Nursing (DON) stated that the alleged event occurred on Saturday, and she was notified on Monday or Tuesday but could not remember. The DON stated that RN2 would have been responsible for reporting the alleged event to the state authorities when RN2 was notified. The DON stated that the required timeframe for reporting abuse allegations is within two (2) hours. The DON stated that the unit manager at the time was RN1. A performance improvement plan was initiated as part of the Quality Assurance Program Improvement (QAPI) committee. During an interview on 01/23/24 at 12:07 PM, RN1 stated that she was not aware of any previous sexual encounters between R36 and R294 other than the one on 05/18/24 that she heard about. Review of the facility's policy titled, Abuse & Neglect Prohibition, effective date 10/24/22, stated, The center will investigate any alleged abuse/neglect . in accordance with state and federal law. The center will report such allegations to the state, as per state/federal regulation. The center will report immediately but no later than 2 hours after forming the suspicion if the events that cause the allegation involve abuse or result in serious bodily injury.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52126 Based on interviews, record review, and facility policy, the facility failed to develop and implement a baseline care plan that included instructions needed to provide effective and person-centered care within 48 hours of admission for one (Resident (R) 94) of six sampled residents. Failure to develop and implement a baseline care plan could place residents at risk for unmet care needs. Findings include: Review of R94's Clinical Census located under the Census tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE]. Review of R94's Medical Diagnoses located under the Med Diag tab in the EMR revealed the resident had diagnoses that included amputation of right great toe, non-pressure chronic ulcer of left foot and heel, type 2 diabetes, hypertension, and fracture of left great toe. Review of R94's Administration Record dated January 2025, located under the Orders tab in the EMR, revealed R94 was prescribed levofloxacin and linezolid (antibiotics) for osteomyelitis (an infection), multiple supplements for wound healing, insulin for diabetes, Tramadol for pain, and Norco (an opioid) for pain. R94 also had orders for wound care to the left foot. Review of R94's Care Plan located under the Care Plan tab of the EMR did not show a focus, measurable goals, or interventions for wound care, pain management, or ADLs. Review of R94's Progress Notes located under the Prog Notes tab of the EMR dated 01/21/25 at 01:37, revealed documentation that R94 was admitted to the facility at approximately 1740 on 01/20/25. R94 was escorted via wheelchair to the assigned room. R94 normally ambulated with a cane due to a right BKA (below-the-knee amputation) and amputation of the left great toe. R94 did not complain of any pain or discomfort and had no wounds, abrasions, or sores to any parts of the body. R94 was assisted in changing clothes by a family member. During an interview on 01/21/25 at 11:20 AM, R94 complained of pain in the foot. A prosthetic leg was observed sitting on the floor next to R94's bed. 01/22/25 at 22:06, revealed documentation that the resident required set-up assistance and cues for meals, positioning assistance by staff, and had a shrinker in place to left BKA. During an interview on 01/24/25 at 10:59 AM, Licensed Practical Nurse (LPN) 6 stated the baseline care plan was based on the Admission Data Set evaluation which would be completed upon admission or during the same shift by the admissions nurse or nurse assigned to the room. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/24/25 at 2:28 PM, the Director of Nursing (DON) stated that the expectation was that the Admission Data Set was to be completed within 48 hours of admission. The baseline care plan is generated from the Admission Data Set. The DON reviewed R94's EMR and confirmed that the Admission Data Set had not been completed and, therefore the baseline care plan had not been generated. The DON stated there was no reason that the Admission Data Set had not been completed. Review of the facility's policy titled, Baseline (Interim/Initial/POC) Plan of Care, revised 08/2023, stated .The baseline care plan will be developed within 48 hours of a resident's admission. Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission. The Baseline Plan of Care includes the minimum healthcare information necessary to properly care for a resident including, but not limited to: information received from the referring center, initial goals based on admission orders and/or Resident/Representative interview, physician's orders, dietary orders, therapy orders, social services orders, recommendations if applicable, resident and family interviews, clinical screens and assessments, and Other information received during the admission process.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693 Based on observation, interview, record review, and facility policy review, the facility failed to provide staff assistance with activities of daily living for one (Residents (R) 63) of two residents reviewed for activities of daily living out of a total sample of 31 residents. This failure had the potential to lead to a decline in activities of daily living. Findings include: Review of R63's Profile, located in the electronic medical record (EMR) under the Profile tab revealed R63 was initially admitted on [DATE] and readmitted [DATE]. Review of R63's Medical Diagnosis, located in the EMR under the Diagnosis tab revealed R63 had a diagnosis of dementia. Review of R63's Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 12/01/24 revealed the resident had a Brief Interview of Mental Status (BIMS) score of 13 out of 15 indicating R63 was cognitively intact. The MDS also indicated R63 required partial assistance to complete bathing, dressing, using the toilet, and eating. Review of R63's Care Plan located in the EMR under the Care Plan tab revealed interventions to address cognitive impairment, including cueing, reorienting, and supervising as needed. The care plan also included a focus area related to resisting care, keeping oxygen on, and requiring assistance with activities of daily living. Observation on 01/21/25 at 11:30 AM, R63 was wearing a green sweater with food spilled on it. R63 did not have on pants at this time. She was sitting up in bed and was covering herself with a bath towel. Her hair was uncombed, and her lipstick was smeared across her mouth. Observation on 01/21/25 at 2:20 PM, R63 was wearing the same green sweater, still dirty from food and wearing a brief with no bottoms. Observation on 1/23/25 at 12:30 PM revealed R63 asleep, still wearing the green sweater and no bottoms, and the entire bottom of her feet had caked-on dirt. During an observation and concurrent interview on 01/23/25 at 1:40 PM, R63 was still wearing the same dirty green sweater and wearing no bottoms, just a brief. R63's hair was unkempt, and her face was dirty from what appeared to be food. R63's feet were covered in layers of scaly excess dry skin, toenails with what appeared to be fungal infection and had not been clipped, and heels with hard layers of scaly excess dry skin. R63 stated when she takes a shower/bath, she cleans her own feet and does not need help. R63t stated it had been about 15 days since she had a shower and stated she washes her own hair and feet and doesn't need help. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/25 at 1:45 PM Certified Nurse Aid (CNA) 4, who documented the bath, stated she had to give bed baths to everyone yesterday because the shower aid could not make it in. When asked if she had given a bed bath to R63, CNA 4 stated she did not and it must have been an error. Observation on 01/23/25 at 2:10 PM revealed R63 eating her lunch. R63 had torn up her paper meal ticket and mixed it into her mechanically soft food. R63 was struggling to independently eat, with the plate sitting between her tray/bedside table and her chest, dropping food on herself. Observation on 01/24/25 at 9:26 AM, R63was observed attempting to wash up independently in her bathroom. Observation on 0 1/24/25 at 9:30 AM revealed R63's bathroom call light went off, and staff headed to R63's room. R63 was observed standing between the bathroom door and her bed without a shirt or bottoms on. Review of the task sheet for bathing located in the EMR under the Task tab indicated R63 had a bath/shower on 01/22/25 at 1:46 PM. During an interview on 01/24/25 at 9:10 AM, Licensed Practical Nurse (LPN)4 stated R63 wanted to be independent and refused help from staff often. During an interview on 01/24/25 at 10:45 AM the Social Services Director (SSD) stated R63 was mostly independent and that the recent observations were unlike her. The SSD stated R63 may have experienced a change in condition and would inform the doctor. During an interview on 01/24/25 at 3:10 PM, CNA1 stated R63 sometimes refused baths and preferred to bathe and wash up independently. CNA1 stated R63 ate, dressed, and transferred independently.

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F 0684 Level of Harm - Minimal harm or potential for 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** 40415 Based on observations, interviews, and record review, the facility failed to ensure one (Resident (R)1) in the sample of 31, received wound care per the physician's orders. The facility's deficient practice increased R1's risk of infection which delayed healing and caused discomfort. Findings include: Review of R1's undated Admission Record located in the electronic medical record (EMR) under the Profile tab revealed admitted [DATE] with a diagnosis of encephalopathy. Review of R1's Physician's Orders located in the EMR under Orders tab dated 08/03/24 revealed, .clean nostril lesion, apply xeroform, cover with band aide daily Review of R1's Treatment Administration Record (TAR) located in the EMR under Orders tab dated 08/03/24 revealed, .clean nostril lesion - Start Date- 08/03/2024. Review of R1's TAR, located in the EMR under the Orders tab from 08/03/2024 through 01/24/2025, revealed no staff initials were documented on eleven days: 08/04/2024, 08/12/2024, 09/03/2024, 09/07/2024, 10/05/2024, 10/05/2024, 11/14/2024, 11/28/2024, 12/24/2024, 01/08/2024, 10/08/2024. and 01/23/2024. Review of R1's comprehensive Care Plan located in the EMR under the Care Plan tab revealed, .lesion to nose, keep clean and dry, monitor for signs and symptoms of infection, treatments as ordered. please see TAR Date Initiated: 08/03/2023 . During an observation on 01/24/23 at 9:47 AM R1 was lying in bed in her room. R1's bandage was dated 01/22/2025. During an observation on 01/25/23 at 9:47 AM R1 was lying in bed in her room. R1's bandage was dated 01/22/2025. During an interview on 01/21/24 at 1:46 PM, the Director of Nursing (DON) stated R1 was to get daily wound care on her nose. The DON stated the nurse assigned to the resident was responsible for completing R1's treatment and was to be completed daily. The DON further stated that Registered Nurse (RN)1 was responsible for auditing the treatment records for any holes. The DON stated she had not been informed of any missed treatments. The DON stated her expectations would be for the nurse to complete the wound care daily as ordered, and if identified the care was not completed, the nurse assigned would be called to return to the facility to complete the care. During an interview on 01/21/24 at 2:01 PM, the Wound Care Nurse (WN) stated R1 was to get daily wound care on her nose. The WN stated the nurse assigned to the resident was responsible for completing R1's treatment daily and was to be completed daily. The WN stated that RN1 was responsible for auditing the treatment records for any missed treatments and would relay this information to the DON. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/21/24 at 2:10 PM, RN1 stated R1 was to get daily wound care on her nose. RN1 stated the nurse assigned to the resident was responsible for completing R1's treatment and was to be completed daily. RN1 stated that she was responsible for auditing the treatment records and usually does every three days, but she had not been able to do that because she had been covering two units. RN1 stated, Moving forward, I will be checking the TAR daily and setting expectations for the nurses and I will also be letting the weekend supervisor know that there have been concerns. RN1 further stated that some complications of not performing wound care as ordered could lead to infection, sepsis, and possible death.

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F 0689 Level of Harm - 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** 52126 Based on observations, record review, and interviews, the facility failed to provide adequate supervision to prevent accidents during incontinence care for one (Resident (R) 295) of four sampled residents reviewed for accidents. The failure resulted in a fall with injury, two fractured knees, and a fractured hip, requiring transfer to the hospital for evaluation. Findings include: Review of R295's Clinical Census located under the Census tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE], with diagnoses which included anxiety, muscle weakness, and hemiplegia and hemiparesis following cerebrovascular disease affecting left dominant side. R295 was discharged to the hospital on 10/26/23. Review of R295's Care Plan located under the Care Plan tab of the EMR revealed the resident had an ADL self-care deficit related to debility and impaired mobility that was initiated on 08/16/22 with an intervention that two staff were required to assist with bed mobility. Review of R295's Progress notes located under the Prog Notes tab of the EMR dated 10/19/23, revealed at the following documentation, 11:45 PM on 10/18/23, while a staff member was changing the resident, the resident was rolled onto their left side with left side assist bar in place. The resident was unable to maintain position and rolled onto the floor. The resident was observed with a bruise to the left cheek and the resident complained of pain to the left hip. The resident was sent to the emergency room for further evaluation. Review of R295's Progress Notes, located in the EMR under the Prog Notes tab dated 10/19/23 at 08:16 AM, revealed documentation that R295 returned from the hospital with imaging studies that show no signs of fracture to head, neck, and left femur. [R295] continued to complain of pain to the left thigh, Tylenol was administered and may use ice if pain or swelling continued. Further review of R295's progress notes revealed on 10/19/23 at 12:40 PM, R295 continued complaints of pain to the left lower extremity and abdominal distention. R295 was referred back to the emergency room for further evaluation by the provider. Review of a written statement by Certified Nursing Assistant (CNA)6, provided by the facility, dated 10/23/23, revealed the CNA was trained on how to access the Kardex and did not have any issues with accessing the Kardex. CNA6 stated the Kardex provided information on mobility in bed, one- or two-person assist, diet, and anything needed to know about resident. CNA6 stated the Kardex was not reviewed prior to providing care to R295 because R295 was not an assigned resident and was trying to take care of resident's needs. CNA6 stated the resident was turned away from the CNA. CNA6 also stated that training was received on proper bed positioning and to roll the resident toward CNA when providing care. CNA6 stated that while pulling the brief under R295, R295 said, I can't hold on. CNA6 stated, The resident's legs began falling over the side of the bed and could not catch [R295]. CNA6 stated the incident could have been prevented by reading the Kardex and asking for assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/19/23, R295 stated she rolled off the right side of the bed while the CNA was changing her brief. R295 stated she fell to the floor on her left side. Review of the facility provided investigative documentation dated 10/26/23, revealed CNA6 was suspended on 10/19/23 pending investigation. [R295] was sent the emergency room again on 10/19/23 for further evaluation and was found to have a fractured right femur and both knees fractured. In conclusion, [CNA6] did not request assistance from a second staff member and the resident rolled out of bed onto the floor. [CNA6's] employment was terminated. A performance improvement plan was implemented in the facility's Quality Assurance and Performance Improvement (QAPI) committee. All staff received re-education on referring to the Kardex for the plan of care. During an interview on 01/23/25 at 9:55 A.M., the Director of Nursing (DON) stated that she was not aware of the incident since it was before she was hired as the DON. The DON stated that nursing staff are expected to refer to and follow the Kardex when caring for residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693 Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to provide respiratory care in accordance with professional standards for two (Residents (R) 53 and R63) of three residents reviewed for respiratory care out of a total sample of 22 residents. This failure had the potential to lead to respiratory complications and infections. Findings include: Review of the facility's policy titled, Caring and Handling of Respiratory Equipment, revised 08/23, revealed, . 5. Equipment should be changed based on the following schedule: a. Change within every seven days or when obviously contaminated: Cannula and humidifier, Simple mask, Partial rebreathing mask, Non-rebreathing mask, Tracheostomy collar, Face tent, T-piece, Handheld nebulizers, Large bore tubing, Ventilator breathing circuits with conventional humidifiers .10. Empty intermittently used nebulizers after use and rinse with warm water and allow to air dry. After drying, place in a plastic bag, which is then hung from the flowmeter. 1. Review of R53s Profile in the electronic medical record (EMR) under the Profile tab, revealed R53 was admitted on [DATE]. Review of R53's Medical Diagnosis in the EMR under the Diagnosis tab, revealed resident was admitted with diagnosis of chronic obstructive pulmonary disease. Review of R53's admission Minimum Data Set (MDS), located in the EMR under the MDS tab with an assessment reference date (ARD) of 01/07/25, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R53 was cognitively intact. Review of R53's active Orders located in the EMR under the Orders tab revealed an order dated 01/01/25 for ipratropium-albuterol solution 0.5-2.5 mg[milligrams]/2 mL[milliliter] with directions 3 ML inhale orally every 4 hours. Order also included an order dated 01/24/25 for oxygen via nasal cannula 2 liters. Review of R53's Care Plan located in the EMR under the Care Plan tab revealed a focus for impaired gas exchange/ineffective airway clearance initiated 01/01/25 with interventions to monitor for signs and symptoms of distress but no specific interventions related to nebulizer therapy. During observations on 01/21/25 at 3:50 PM, 01/22/25 at 9:40 AM, and 01/23/25 at 12:15 PM revealed R53's nebulizer mask sitting next to the nebulizer machine on a nightstand uncovered. During an interview on 01/23/25 at 12:15 PM, R53 stated she had not had her nebulizer treatment in the morning, and she reported shortness of breath. During an interview on 01/23/25 at 12:20 PM, the Infection Preventionist (IP) stated she would check on the nebulizer treatment and administer it. During this time, the IP confirmed the mask was stored uncovered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/24/25 at 9:00 AM, revealed R53 asleep in bed receiving oxygen therapy via nasal cannula. The oxygen tubing and water tank were not dated. 2. Review of R63's Profile, located in the EMR under the Profile tab revealed R23 was initially admitted on [DATE] and readmitted [DATE]. Review of R63's Medical Diagnosis, located in the EMR under the Diagnosis tab revealed R63 had diagnoses of dementia and chronic diastolic heart failure on initial admission and diagnoses of acute and chronic respiratory failure with hypercapnia, cyanosis, and chronic obstructive pulmonary disease with acute exacerbation on readmission on 01/17/25. Review of R63's MDS located in the EMR under the MDS tab with an ARD of 12/01/24 revealed the resident had a BIMS score of 13 out of 15, indicating R63 was cognitively intact. Review of R63's Orders located in the EMR under the Orders tab revealed an order for oxygen via nasal cannula 3 L[liters] with a start date of 11/30/24 and end date of 01/10/25. Orders also included an order to change oxygen tubing and clean concentrator filter every Sunday with a start date of 12/01/24 and end date of 01/10/25. There were no further active orders for oxygen therapy or oxygen tubing. Review of R63's Medication Administration Record (MAR) located in the EMR under the Orders tab revealed R63 had only received oxygen therapy 01/01/25 through 01/08/25. The MAR also revealed the oxygen cannula and tubing had been replaced on 01/05/25. There was no documentation of oxygen therapy after 01/08/25. Review of R63's O2 [oxygen] Sats [saturation] Summary located in the EMR under the Vitals and Weights tab revealed oxygen saturation documented from 09/17/24 through 01/08/24 at 3:53 PM when she was discharged to the hospital. There were no oxygen saturation measurements documented after her return on 01/17/25. Review of R63's hospital Skilled Nursing Home Orders signed by the hospital physician on 01/17/25 revealed an order for oxygen therapy 4 liters via nasal cannula. During an observation on 01/21/25 at 11:30 AM, revealed R63 on oxygen therapy via nasal cannula and oxygen tubing undated. During an observation on 01/23/25 at 12:38 PM, revealed R63 without her oxygen on. The oxygen tubing was observed undated and laying on the bed under R63's leg. During an interview on 01/24/25 at 9:10 AM, Licensed Practical Nurse (LPN)5 stated there should be an order for oxygen in the chart if a resident was on oxygen and the tubing should be dated. During an interview on 01/24/25 at 3:36 PM, the Director of Nursing (DON) stated she expected there to be an order for oxygen and expected tubing to be changed on Sundays on the overnight shift and it should be dated. The DON confirmed that cannulas and masks should be stored in a bag. The DON explained that when the hospital sends the facility orders, the facility doctor reviews the orders to determine which orders are continued and which are discontinued. The DON stated she would contact the physician regarding R63's oxygen orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/24/25 at 3:42 PM the Regional Consultant reviewed R63's orders and oxygen saturation records and confirmed there was no active order for oxygen or oxygen saturation measurements. During an interview on 01/24/25 at 3:50 PM, Registered Nurse (RN)3 stated they must have just forgotten to enter the order for oxygen saturation when R63 returned from the hospital because R63 was having oxygen saturation measured every shift before she left to the hospital.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33865 Based on observations, record review, and interviews, the facility failed to ensure residents were provided with food that was palatable and at a safe and appetizing temperature for three of three residents (Resident (R) 2, R15, and R65) of 31 sample residents. This failure had the potential to affect resident food satisfaction leading to potentially decreased oral intake and weight loss. Findings include: Review of the facility's policy titled, Food Service Policy, revised 08/23, revealed The center provides and each resident receives food that is .palatable, attractive, and at the proper temperature . Review of R2's quarterly Minimum Data Set (MDS) located under the MDS tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 12/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 was cognitively intact. During an interview on 01/21/25 at 10:07 AM, R2 stated the food was cold all the time, especially at breakfast. She stated they did not always have time to warm it up. Review of R15's quarterly MDS located under the MDS tab of the EMR with an ARD of 01/04/25 revealed a BIMS score of 15 out of 15, which indicated R15 was cognitively intact. During an interview on 01/21/25 at 2:40 PM, R15 stated the food was hot when they ate in the dining room, but not when served in the room. R15 stated they had to eat in their room for the dinner meal. Review of R65's quarterly MDS located under the MDS tab of the EMR with an ARD of 12/12/24 revealed a BIMS score of 15 out of 15, which indicated R65 was cognitively intact. During an interview on 01/21/25 at 11:14 AM, R65 stated the food was cold at all meals and they let it sit in the hall too long. During an interview on 01/23/2025 at 8:56 AM, R35 said she had not received her breakfast yet. Observation on 01/23/2025 at 8:58 AM, revealed staff was feeding a resident in his room. There were four covered breakfast trays at the top of an open rolling cart, but no other staff were in the hallway passing trays. At 9:03 AM, the staff person that was observed feeding the resident, exited the room with the resident's tray, shelved it on the bottom of the open cart, used hand sanitizer, and carried one of the four remaining breakfast trays into another resident's room. No other staff members were in the hallway to complete tray service for the three remaining breakfast trays on the cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115132	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abercorn Rehabilitation Center	11800 Abercorn Street Savannah, GA 31419

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/25 at 12:52 PM, the Dietary Manager (DM) stated she was aware of the residents' complaints of cold food. She stated she tried to get the residents to the cafe to ensure hot food and an easier alternative selection. She stated she thought the lack of residents in the dining room was related to short staffing. She stated she did not know why the residents were not eating in the dining room at dinner meals. She stated she had inquired about a heated pellet system. During an observation and interview on 01/23/25 at 1:03 PM, a test tray was constructed at 12:36 PM, arrived at the unit at 12:45 PM, the tray pass started at 12:47 PM, and the last tray was delivered at 1:11 PM. The test tray was evaluated at 1:11 PM and consisted of turkey at 126 degrees Fahrenheit (F), dressing at 134 degrees F, vegetable (mixed) at 127 degrees F, and applesauce at 70 degrees F. The DM stated the temperature for the applesauce should have been less than 40 degrees F, and the hot food needed to be above 135 degrees F by the time it arrived at the resident. The iced lemonade with melted ice was 48 degrees F. During an interview on 01/23/25 at 3:49 PM, the Administrator stated she was aware of the complaints about cold food when she came in August but had not heard of any recent complaints. She stated the process was all hands on deck during meals so that trays were passed out.