STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115258	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ridge Care Center LLC	600 West Memorial Drive Dallas, GA 30132

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and resident and staff interviews, the facility failed to promote dignity for one of 14 residents (R) (R 6) who ate in the main dining room. Specifically, R6 was seated at a table with inappropriate height.Findings Include:1. Observation on 7/7/2025 at 12:43 pm, at the second table, two of six residents had meal trays and were eating. R6 was seated at that table, but R6 was upset about not having food and Certified Nursing Assistant (CNA) AA moved R6 to the third empty table that was also upper lip height. Observation on 7/7/2025 at 12:59 pm, R6 was observed sitting in a lowered seat wheelchair eating independently with her upper lip at table height. Observation on 7/7/2025 at 1:18 pm, R6 was seated at a single table at eye level. R6 introduced herself.Interview on 7/7/2025 at 1:33 pm, CNA AA said R6 eats all her food, but her upper lip is almost at table height. R6 should be seated at a smaller table so she can see her food.During an interview with the Director of Nursing (DON) on 7/10/2025 at 10:01 am, she said, We heard through the grapevine that this was a problem on Monday, so we started to fix it on Tuesday. We gave you the policies already for Dignity.During an interview with the Administrator on 7/10/2025 at 2:50 pm, she said R6 should be seated at an adjustable table height, a small table. It's harder for anyone to eat when they cannot see the plate. This is a dignity issue, as she should either be seated with other residents, or if at a table alone, she should be seated at a smaller table. We have adjustable table heights, and we should have adjusted it for her or put her at the smaller table if she was sitting alone.During an interview with the Regional Director of Operations on 7/10/2025 at 2:53 pm, stated, R6 should sit at a smaller table so she can see her food.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on record review, observations, and resident and staff interviews, the facility failed to provide bath linen in good condition on seven of nine hallways (C hall, 600 hall, 200 hall, 400 hall, 500 hall, 800 hall and 900 hall). Findings include:On 7/7/2025 beginning at 10:55 am, during a brief tour of C hall, one linen cart revealed no towels or washcloths, a second linen cart has a torn washcloth and a few hand towels in disrepair. On 7/7/2025 at 11:22 am, in the secured hall, a staff member came out of room [ROOM NUMBER] with an arm full of linens, some washcloths tattered, and said, they were not dirty, I promise and put them in soiled laundry bin. On 7/7/2025 at 11:26 am, on the 600-hall linen cart had 10 wash cloths, a few were tattered and 13 bath towels.During an interview on 7/7/2025 at 11:37 am, Resident R12 said, they tore up larger towels and made it into washcloths when the new company took over. I had a few yesterday that were torn.During an interview with R11, on 7/8/2025 at 10:14 am, R11 said, the facility cut up towels to washcloth size and showed four tattered washcloths taken from their drawer.During an observation on 7/9/2025 at 10:23 am, a Certified Nursing Assistant (CNA) on 200 hall had two ripped washcloths in her hand coming out of room [ROOM NUMBER].During an interview on 7/9/2025 at 10:37 am with CNA JJ, they said, on the 900 hall, we sometimes don't have linens, or they are torn and shredded. We only got new linens today because State is in the building. I can't change residents until after 11:00 am because all we have are rags, just torn washcloths and no towels. During an interview on 7/10/25 at 1:09 pm, R13 took 2 torn and shredded washcloths from her shelf and displayed them on her bed.During an interview on 7/10/2025 at 1:10 pm, R15 shared the Resident Council Minutes and June 2025 minutes revealed the facility still did not have enough towels and wash cloths.Review of the grievance log revealed a Resident Council Grievance filed on 4/30/2025 from R15 that area of concern: residents complained about linen shortage that happens daily and occurs on all units. Actions/approaches: the Administrator was present at the meeting and informed residents that extra linen has been ordered to address this issue.During a telephone interview on 7/10/2025 at 2:30 pm with the Environmental Service Supervisor (EVS), they said, We have tried to get the linen par up. Families have taken towels to cut up and making washcloths out of them.An interview on 7/10/2025 at 2:38 pm with the Administrator revealed that families had torn and shredded the bath towels. The families and residents were taking linen into their rooms and storing it, then the staff went in and took the linens out of the rooms. The laundry techs said the CNAs grab linens and they worked from back towards the front to divvy it up fairlyOn 7/10/2025 at 2:39 pm, the Surveyor shared with the EVS, the Administrator, and the Regional Director of Operations pictures of torn and shredded washcloths found in R13's room that day. The Administrator and Regional Director of Operations both said, We should never use anything that's cut up.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review, the facility failed to revise their CLIA (Clinical Laboratory Improvement Amendments) certificate within 30 days after new ownership. The facility does not have a current CLIA certificate appropriate for the level of testing it conducts after approximately seven months of ownership. Findings include:Review of the CLIA Certificate of Waiver with Effective Date of 5/6/2024 and Expiration Date of 5/5/2026 is in the name of the previous owner hospital.Review of the CLIA Certificate of Compliance with Effective Date of 8/19/2023 and Expiration Date of 8/18/2025 is in the name of the previous laboratory service owner. In an interview on 7/8/2025 at 12:21 pm with the facility's Administrator, they stated, We are still operating under that (Previous Owner) waiver as part of the transition. The new owner purchased the facility from the hospital in January 2025.On 7/8/2025 the State CLIA Department was consulted, and they confirmed the following, The facility is out of compliance and should request a revised CLIA certificate using the attached CMS-116 application. Facilities are required to notify CLIA STATE agencies within 30 days of ownership changes. The facility was provided with CMS-116 application on 7/9/2025.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and review of the facility policy titled, Food Storage, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility had expired food in storage areas reserved for resident snacks. This practice affected two of three units (Middle Unit and the Nursing Unit) observed in the facility for resident food storage. Findings include:Review of the facility policy titled Food Storage with a date of January 2025 revealed under 5. Storage Guidelines. D. Perishable and Leftover Foods, Label with preparation date and discard date (typically within 3-7 days based on item type). Observation on 7/7/2025 at 11:30 am of the snack cabinet for residents on the Nursing Unit revealed the cabinet contained an unopened loaf of bread that had an expiration date of 4/24/2025. The bread was hard and had areas of green discoloration in several areas.An interview, on 7/7/2025 at 11:33 am with Certified Nursing Assistant (CNA) II revealed the bread should have been discarded back in April of 2025.Observation on 7/7/2025 at 11:45 am of the residents' refrigerator used for snacks on the Middle Unit revealed the refrigerator contained three wrapped turkey sandwiches with a use by date of 7/4/2025 and three cups of covered apples with a use by date of 7/4/2025.An interview on 7/7/2025 at 11:50 am with CNA HH revealed the sandwiches and apples should have been discarded on 7/4/2025. The CNA threw the sandwiches and apples in the trash.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and review of the facility policy titled, Hand Hygiene, the facility failed to ensure proper hand hygiene during the lunch meal in the Nursing Unit Main Dining Room for three of 14 residents (R) (R4, R5, and R6). The deficient practice had the potential to cause foodborne illnesses for residents eating in the Nursing Unit Main Dining room.Findings include:Review of the facility policy titled Hand Hygiene with an effective date of January 2025 revealed under Policy: This facility considers hand hygiene the primary means to prevent the spread of infections. Under Guidelines: . 5) Use an alcohol-based hand rub for the following situations: . o) Before and after assisting a resident with meals.On 7/7/2025 at 12:49 pm, Certified Nursing Assistant (CNA) AA entered the Nursing Unit Dining Room, sat down without performing hand hygiene and started to assist R4 to eat. CNA AA touched the spaghetti on R4s fork with her bare hands and then brought that fork up to R4s mouth for them to eat the now contaminated food. Using the same hand, CNA AA twirled her own hair and itched her own head, then continued to assist R4 to eat. At 12:51 pm, CNA AA took their cell phone out of their pocket and checked it, then went back to assisting R4 with their lunch meal. At 12:52 pm, CNA AA touched her face, did not use any method of handwashing, and continued assisting R4 to eat. At 12:53 pm, CNA AA got up and changed the tv station to cartoons, then sat down to assist R4 with meal with no handwashing. At 12:54 pm, CNA AA put salt and pepper on R4s spaghetti, then continued to assist R4 with his meal. At 12:55 pm, CNA AA touched her head again and scratched her head several times, then used the same dirty hand to feed R4 with no hand hygiene. At 12:58 pm, a CNA handed CNA AA a pair of gloves to wear while assisting R4 to eat, but instead of putting on the gloves, CNA AA walked away from the R4 to pass out another tray, with no hand hygiene, and CNA AA then proceeded to cut up R5's spaghetti.On 7/7/2025 at 1:02 pm, without hand hygiene, CNA AA moved to assist R5 to eat. At 1:09 pm, CNA AA left R5 and put their hands on their hips, walked to another table, and came back to R4 to assist them briefly, then went to assist R6 to eat with no hand hygiene in between. At 1:10 pm, CNA AA touched their own face with her right hand that she had been using to feed the residents. At 1:11 pm, CNA AA went back to R4 to assist with their drink. There was no observed hand hygiene between assisting R4, R5, or R6.On 7/7/2025 at 1:27 pm, CNA AA returned to the Nursing Unit dining room, and within seconds left the dining room to get another meal cart. At 1:29 pm, CNA AA returned to the dining room with the last meal cart. No hand hygiene was observed before passing out meal trays or between passing out meal trays.During an interview on 7/7/2025 at 1:33 pm with CNA AA, they revealed most of the feeders (dependent diners) eat in this dining room. CNA AA said, If I have an itch I scratch it, but that is not good infection control. I should use hand sanitizer in the dining room. With R5, I didn't use hand sanitizer, I did have gloves, but I didn't wear them.During an interview on 7/10/2025 at 9:49 am with the Manager of the Nursing Unit Licensed Practical Nurse (LPN) KK, LPN KK said, staff should wash hands, grab trays, set them up, open everything and offer bites and drinks in between. I would do handwashing when you stop and then wash hands before I start to feed someone again. I would wash again after I touched my face or hair. I would never touch food on a fork. Don't touch food with bare hands. Between residents, you need to wash your hands. If you did not have clean hands, you could contaminate food and make the residents sick.During an interview on 7/10/2025 at 10:01 am with the Director of Nursing (DON) regarding handwashing or hand hygiene, they said, The staff should use hand sanitizer before serving or feeding. During an interview on 7/10/2025 at 2:50 pm, the Administrator and the Regional Director of Operations both said there should have been handwashing between passing trays, and before you fed anyone, or it would be an infection control issue.