STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115265	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Satilla	1600 Riverside Ave Waycross, GA 31501

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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 - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138 Based on observations, staff interviews, record reviews, and review of the facility's policy titled, Medication Administration, Facility B failed to ensure over-the-counter medication were not stored at the bedside for one of 55 residents (R) (R151). This deficient practice had the potential to allow unauthorized access of unsecured medications to residents and visitors. Findings include: A review of Facility B's policy titled, Medication Administration, revised date 4/2022, revealed, Policy: Self-Administration of medication: Residents can self-administer medication if they can do so safely and are authorized to do so by their attending physician and interdisciplinary team. The medications will be kept in a lock safe box in the resident's room. The resident will open and self-administer his/her medications. The nurse will record the resident's self-administration of the medication on the medication record. Any self-administration error that occurs must be reported to the interdisciplinary team and the resident will be re-evaluated for continued self-administration. Resident Self -Administration of Medication dated 4/1/2024 documented it is the policy of this facility to support each residents right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. Review of electronic medical records (EMR) revealed R151 was admitted with diagnoses of but not limited to shortness of breath, respiratory failure, heart failure, type 2 diabetes mellitus with diabetic neuropathy, atrial fibrillation, cerebral infarction, pneumonia and obstructive sleep apnea. Review of R151 EMR revealed there was no physician order for cough drops. Review of R151 EMR revealed there was no care plan for self-administration of medication. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed a Basic Interview for Mental Status (BIMS) score of 99 indicating severe cognitive impairment. (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 - Few	Review of nurses' notes dated 1/7/2025 documented R151 had [name brand] cough drops on his over the bed table. He stated that his wife brought them. When asked if other candy works just as good for throat irritation, he stated no. Explained that these could not be kept in the room but would speak with his wife and see if could find alternative or if needed get an order for these. He stated understanding. Spoke with his daughter, I could not reach wife. She stated he has always used these even at home and explained they could not be kept in room related to be considered a medication. She stated understanding. An Observation on 1/7/2025 at 11:02 am revealed a plastic zip closure storage bag of cough drops on R151 bedside table. An interview on 1/7/2025 at 2:11 pm with Licensed Practical Nurse (LPN) CC confirmed that R151 could not have cough drops at his bedside without a physician's order. LPN CC revealed a family member must have brought the cough drop into the facility. LPN CC stated she spoke with R151 and advised him that he could not have cough drops at his bedside. An interview on 1/9/2025 at 1:45pm with the Director of Nursing (DON) revealed R151's family member bought the over-the-counter medication into the facility, and it was discussed upon admission that no medication could be brought into the facility. DON expects staff to monitor for medication brought in from outside the facility, in the resident's room when rounding. Staff will be reeducated about self-administration of medication. An interview on 1/9/2025 at 1:55 pm with Administrator revealed her expectations was for staff to follow policies and procedure. Staff will be reeducated as she was made aware of cough drops being found at the resident's bedside.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on interviews, record review, and review of the facility's policy titled, Transfer and Discharge, Facility A failed to provide notice of transfer/discharge to residents or their representatives for one of four sampled residents (R) (R2) reviewed for hospitalization . Findings included: Review of Facility A's policy titled, Transfer and Discharge revised on 7/1/2024, revealed 12. Emergency Transfers/Discharges-initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified) G. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated. R2 was admitted to the facility with diagnoses of but not limited to sepsis, dementia severe with psychotic disturbance, and epilepsy. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R2's Brief Interview for Mental Status (BIMS) score was unable to be determined. Review of medical records revealed R2 was transferred to the hospital from the facility on 10/22/2024 and readmitted to the facility on [DATE]. R2 was also transferred to the hospital from the facility on 1/4/2025 and readmitted to the facility the same day. Further review revealed no evidence of the provision of transfer/discharge notice was provided to R2's representative. During a telephone interview on 1/9/2025 at 9:17 am with the resident's representative, who was from the Office of the State Guardian, revealed she did not receive a notice of transfer/discharge in writing from the facility when the resident went to the hospital on 10/22/2024 or on 1/4/2025. The representative stated the facility failed to notify her that R2 was sent to the hospital on 1/4/2025 and was only made aware of the hospital stay when she visited the resident at the facility on 1/8/2025. Interview on 1/9/2025 at 8:39 am with Licensed Practical Nurse (LPN) AA revealed when a resident is transferred to the hospital staff complete a transfer document in the electronic health record, notifies the family/representative via telephone, and calls the hospital to give a report such as the medications the resident is taking and vitals. She confirmed that nothing is given in writing to the family/representative or resident regarding reason for transfer/discharge. Interview on 1/9/2025 at 8:47 am with LPN BB revealed that when a resident is transferred out of the facility to the hospital, the facility notifies the resident's representative or family via telephone. She revealed staff complete a transfer form in [named electronic system] and that the facility calls the hospital to give a report. LPN BB revealed the resident's code status, and a list of medications are sent with emergency services. She confirmed nothing is given in writing to the resident or the representative regarding reason for transfer/discharge. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/9/2025 at 8:55 am with the Business Office Manager (BOM) revealed that due to R2's poor cognition, he was not given anything in writing regarding a reason for transfer/ discharge on 10/22/2024 or on 1/4/2025. The BOM revealed that R2's representative was notified via telephone the resident was being transferred to the hospital on 10/22/2024 and 1/5/2025 and to him, that was adequate notification. He confirmed that there was nothing given in writing to the resident's representative regarding the reason for transfer/discharge on 10/22/2024 or 1/4/2025. Interview on 1/9/2025 at 1:00 pm with the Administrator revealed that R2's representative was called on 10/22/2024 and 1/4/2025 but nothing in writing regarding a notice or reason for transfer/discharge was given to the representative/guardian.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on record reviews, interviews, and review of the facility's policy titled, Bed Hold Prior to Transfer, Facility A failed to provide a notice of bed hold for one of four residents (R) (R2) reviewed for hospitalization . Findings included: Review of facility A's policy titled, Bed Hold Prior to Transfer, revised on 3/1/2023, revealed Policy: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave. Policy Explanation and Compliance Guidelines: Notice before Transfer. 2. The facility will have policies that address holding the resident's bed during periods of absence, such as during hospitalization or therapeutic leave. 3. The facility will provide written information about these policies to residents and/or resident representatives prior to and upon transfer for such absences. Record review revealed R2 was admitted to the facility with diagnoses of but not limited to sepsis, dementia severe with psychotic disturbance, and epilepsy. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R2's Brief Interview for Mental Status (BIMS) score was unable to be determined. Review of medical records revealed R2 was transferred to the hospital from the facility, on 10/22/2024 and readmitted to the facility on [DATE]. R2 was transferred to the hospital from the facility on 1/4/2025 and readmitted to the facility the same day. Further review revealed no evidence of the provision of a notice of bed hold provided to R2's representative on either date. During a telephone interview on 1/9/2025 at 9:17 am with R2's representative, who was from the Office of the State Guardian revealed she did not receive a notice of bed hold in writing from the facility when R2 went to the hospital on 10/22/2024 or on 1/4/2025. The representative revealed the facility failed to notify her that R2 went to the hospital on 1/4/2025 and was only made aware of the hospital stay when she visited the resident at the facility on 1/8/2025. Interview on 1/9/2025 at 8:39 am with Licensed Practical Nurse (LPN) AA revealed when a resident is transferred to the hospital staff complete documentation in the electronic health record, notifies the family/representative, and calls the hospital to give a report such as the medications the resident is taking and vitals. She confirmed that nothing is given in writing to the family/representative or resident regarding the bed hold policy. Interview on 1/9/2025 at 8:47 am with LPN BB revealed that when a resident is transferred to a hospital, the facility notifies the resident's representative or family via telephone. She confirmed nothing is given in writing to the resident or the representative regarding the bed hold policy. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/9/2025 at 8:55 am with the Business Office Manager (BOM) revealed that due to the resident's poor cognition, he was not given anything in writing regarding a bed hold. The BOM revealed the resident's representative was notified via telephone about the bed hold policy on 10/22/2024 and 1/5/2025 and to him, that was adequate notification. He confirmed that there was nothing given in writing to the resident's representative regarding the bed hold policy on 10/22/2024 and 1/4/2025. On 1/9/2025 at approximately 11:45 am, the Administrator from the sister facility (facility B) who was present to assist facility A's Administrator with the survey, revealed he found bed hold agreements; however, they were not completed. They had the residents name and responsible party listed but it was missing the responsible party's signature, address, and phone number. Later, an interview with facility A Administrator at 1:00 pm revealed that the forms were completed via telephone and nothing in writing was sent to the representative/guardian.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50877 Based on observations, staff interviews, record review, and review of the facility's policies titled, Comprehensive Care Plan and Nail Care Policy, Facility A failed to implement the care plan for two of 55 residents (R) (R22 and R12). Specifically, the facility failed to provide a scoop mattress for resident (R22) and failed to provide proper nail care for (R12). The sample size was 55. Findings include: Review of the facility A's policy titled, Comprehensive Care Plan, revised 1/1/2023, revealed that it is the policy of this facility to develop and implement a comprehensive person-centered plan of each resident, consistent with rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. 1. Review of the electronic medical record (EMR) revealed R22 was admitted to the facility with pertinent diagnoses including but was not limited to depression and anxiety. Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not assessed due to short-term and long-term memory issues. Review of the care plan for R22, dated 11/27/2024, revealed a risk for falls. Goals included but not limited to not having any fall related injuries by next review. Interventions included but not limited to using scoop mattress. Observation on 1/9/2024 at 2:42 pm of R22 revealed that her bed had a standard facility mattress, and she was lying at a 30-degree angle elevation. An interview on 1/09/2024 at 2:55 pm with Licensed Practical Nurse (LPN) AA confirmed that R22 was not on a scoop mattress as care planned. An interview on 1/9/2024 at 3:10 pm with the Director of Nursing (DON) confirmed that R22 was not on a scoop mattress as care planned. She revealed that care plans should be implemented as written. Observation and interview on 1/9/2025 at 3:10 pm with the Administrator, accompanied by the DON to R22's bedside, confirmed there was not a scoop mattress in use. 36377 2. Record review of the medical record revealed R12 had diagnoses of but not limited to dementia, gastro esophageal reflux disease, and left-hand contracture. Review of R12's Quarterly MDS assessment dated revealed R12 was assessed a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment; MDS also revealed R12 required total assistance with all Activities of Daily Living (ADL). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ADL care plan for R12, created 11/10/2021 and last revised 5/15/2023, documented R12 needs assist with grooming, bathing, and personal hygiene r/t (related to) mobility impairment and self-care impairment. Interventions included nail care as needed. During an observation on 1/7/2025 at 10:01 am to 12:46 pm of R12, his left hand and fingers were curled into a fist causing the long discolored yellowish fingernails to become embedded into lower palm of the hand. Also, an odor was coming from R121's hand. Interview on 1/7/2025 at 12:46 pm with family member of R12, Family Member A revealed concerns with R12 having long nails that needed trimming and a foul odor in the palm of the left hand. She further stated her opinion that the odor was a result from staff not washingR12's left palm. Interview on 1/7/20255 at 1:08 pm with the DON and Administrator, the DON confirmed an odor coming from R12's left hand and her staff failed to trim the R12's fingernails. Interview on 1/9/2025 at 3:36 pm with the MDS Coordinator revealed that in her professional opinion, the intervention nail care as needed included trimming the fingernails and cleaning underneath the nails. She revealed her expectation was that the care plan is followed.

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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** 36377 Based on observations, record reviews, staff interview, and review of the facility's policy titled, Nail Care, Facility A failed to perform nail care for one totally dependent resident (R) (R12), who had a left-hand contracture. The sample size was 55 residents. Findings include: Review of facility A's undated policy titled, Nail Care, documented, 1. Assessments of resident nails will be conducted on admissions and readmission to determine the resident nail condition, needs and preferences for nail care, if possible. a. Report unusual or abnormal conditions, needs, and preferences for nail care, if possible. a. Report unusual or abnormal conditions of the nails to the physician and the responsible party (e. g. (example given), curling, color changes, separations from the nailbed, redness, bleeding, pain, odor, infection, etc.) 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Principles of nail care. a. Nails should be kept smooth to avoid skin injury. Record review of the medical record revealed R12 had diagnoses of but not limited to left hand contracture and dementia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed a Brief Interview for Mental Status (BIMS) score of three which indicates severe cognitive impairment. Section GG assessed resident as totally dependent for all Activities of Daily Living (ADLs) skills. Review of R12's Physician Order Form (POF) dated January 2025 listed an order dated 1/9/2024 for nail care weekly every Tuesday. During an observation on 1/7/2025 at 10:01 am to 12:46 pm, R12 was observed lying in bed with a left-hand contracture. Continued observation revealed R12's left hand was curled into a fist and a foul odor was noted. R12's fingernails (on the left hand) were long and had a thick yellowish discoloration. The long fingernails were observed to be embedded into the lower palm of R12's hand resulting in one of the fingernails pinching the palm. There was no breakage in skin but had the potential to result in a skin tear or cause discomfort. During an interview on 1/7/2025 at 12:46 pm with Family Member A of R12. Family Member A reported that staff were not trimming the resident fingernails. The family member also complained of R12's hand having a sour odor from not being washed. During an interview on 1/7/2025 at 1:08 pm with the Director of Nursing (DON) and Administrator, the DON confirmed R12's fingernails were long and embedded into R12's palm. The DON also confirmed that R12's left hand had a mild odor. During a later interview on 1/9/2025 at 1:25 pm with the DON, she revealed her expectation that all staff, including her certified nursing assistants and licensed nursing staff, monitor all residents for nail care. DON revealed that nail care included trimming and cleaning underneath the nails. DON further revealed that long nails have the potential to put the resident at risk of injury.

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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** 45811 Based on observations, staff interviews, record reviews, and review of the facility's policy titled, Oxygen Administration, Facility B failed to ensure oxygen administered by nasal cannula was set at the prescribed rate for one of 42 residents (R) (R30) receiving oxygen therapy. The deficient practice has the potential to cause adverse consequences for the R30. Findings included: Review of facility B's policy titled, Oxygen Administration, revised 3/1/2023, revealed under, Policy Explanation and Compliance Guidelines, Oxygen is administered under orders of a physician, except in the case of an emergency. Review of the medical record for R30 revealed pertinent diagnoses included but not limited to dementia, chronic obstructive pulmonary disease (COPD), anxiety disorder, and allergic rhinitis. Review of the Quarterly Minimum Data Set assessment dated [DATE] Section C - Cognitive Patterns assessed a Brief Interview for Mental Status (BIMS) score of 8. This score suggests moderate cognitive impairment. Section J - Health Conditions, indicates R30 has shortness of breath or trouble breathing with exertion and when lying flat. Review of the care plan for R30, updated on 11/19/2024, documented at risk for alteration in respiratory status related to COPD and allergic rhinitis. She has a history of smoking cigarettes, has order for oxygen via nasal cannula; administer oxygen as ordered per physician's order. Review of physician's orders included, may apply oxygen at 2 liters per minute via nasal cannula for complaints of shortness of breath and discomfort, and monitor oxygen saturation every shift. Observation on 1/7/2025 at 11:30 am R30 was lying in the bed, with no respiratory distress noted. She had oxygen on at 4 liters by nasal cannula. Observation on 1/8/2025 at 9:00 am R30 was sleeping in bed, no distress noted. Oxygen on at 4 liters nasal cannula. Interview and observation on 1/8/2025 at 10:52 am with LPN FF revealed the nurses are responsible for checking the oxygen rate every shift. The nurse states she checks the oxygen every time she goes in the room. R30 is sleeping with oxygen on at 4 liters nasal cannula. LPN FF revealed R30 uses the oxygen constantly. LPN FF verified the oxygen was set at 4 liters nasal cannula. LPN FF confirmed the order was for 2 liters nasal cannula. Interview on 1/8/2025 at 10:55 am with LPN GG, confirmed the oxygen order was for 2 liters by nasal cannula. Interview on 1/9/2025 at 3:30 pm with the DON revealed the facility does not have a respiratory department, the nurses are responsible for making sure the oxygen is on the correct liters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/9/2025 at 3:50 pm with LPN GG, revealed the residents nurse for that shift is responsible for making sure the oxygen rates are correct. The Certified Medical Assistants (CMA) can look at the oxygen and let the nurse know if it is incorrect, and the oxygen rate is listed on the Medication Administration Record.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50879 Based on record review and staff interview, and review of the facility's policy titled, Use of Psychotropic Medication, Facility B failed to indicate the need to extend orders for as needed (PRN) antianxiety medication for one of four residents (R) (R18) beyond 14 days and failed to document the reason for the extension to be in effect. Findings include: Review of facility B's policy titled, Use of Psychotropic Medication, with a revised date of 5/1/2024 revealed under 9. PRN (as needed) orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. (that is) 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order. Record review revealed R18 admitted to the facility with diagnosis of Alzheimer's/ Dementia including patterns of psychosis and hallucinations or delusions, and physical and verbal behaviors. Review of physician orders included but not limited to Alprazolam 0.5 mg (milligram) PRN every 12 hours as needed for anxiety related to diagnosis of generalized anxiety disorder. The start date was 11/4/2024 and the duration/end date was 11/4/2025. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed R18 with a BIMS score of 2 indicated severe cognitive impairment, mood symptoms included anxiety, depression, and pain, and received antipsychotic and antidepressant medications. Review of the care plan for R18 included anxiety. Interventions included anti-anxiety medications, provide medications as ordered by physician and evaluate for effectiveness. Anti-anxiety medications. Monitor for side effects and report to physician. Review of the clinical record for R18 did not document the rationale for its continued use Alprazolam 0.5 mg PRN past 14 days. Interview on 1/9/2025 at 9:45 am with DON (Director of Nursing) regarding how often Hospice provider comes into the building. DON confirmed that an antipsychotic medication required a 14-day limit unless a rationale is provided in the medical record. R18 receives Alprazolam Oral Tablet 0.5 mg (milligram) every 12 hours PRN (as needed). The prescription was written for 11/4/2024 to 11/4/2025. Interview on 1/9/2025 at 10:11 am with primary physician regarding the rational for writing the prescription for Alprazolam 0.5 mg involved convenience. Physician was aware of 14-day limit for anti-anxiety/psychotropic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115265	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Satilla	1600 Riverside Ave Waycross, GA 31501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on observations, staff interviews, and review of the facility policy titled, Date marking for food safety, facility A failed to discard food in the walk-in cooler by the use by date and failed to label and date opened food items in the walk-in refrigerator and dry storage area, this deficient practice had the potential to effect 86 of the 89 residents receiving an oral diet. Findings include: Review of facility A's policy titled Date marking for food safety, revised on [DATE], revealed under Policy: The facility adheres to date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. Under, Policy Explanation and Compliance Guidelines for Staffing: 2. The food shall be clearly marked to indicate the date or by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consist of a color-coded label, the day/date of opening and the day/date the item must be consumed or discarded. 6. The head cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. 7. The Dietary Manager, or designee shall spot check refrigerators weekly for compliance and document accordingly. Corrective action shall be taken as needed. The tour of the kitchen on [DATE] started at 8:45 am with the Dietary Manager (DM). The following concerns were identified during the tour: Walk in cooler- 4 large containers of peeled garlic with an expiration date of [DATE]. A large box of sweet potatoes that appeared rotten with mold, a white fuzzy substance, with an in date of [DATE] and no expiration/out date. A large box of carrots that appeared to be old, rotten, and wilted with an in date of [DATE] and no expiration/out date. 2 large boxes of tomatoes that were soft (overripen) and discolored with what appeared to be mold, a black and white substance with an in date of [DATE] and no expiration/out date. A large box of bananas that were overripen, black in color. No in/out date. Dry pantry- bag of pasta that was opened with no use by date. Interview on [DATE] at 9:30 am with the Dietary Manager revealed that she and her staff are responsible for labeling food items with an open and use by date. She stated that all food should be discarded by the item's use by date and expiration date. She confirmed that all items identified during initial walk through were either expired or not labeled correctly. She revealed that she assigned the task to one of her dietary aid's but that they overlooked the items the surveyor discovered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115265	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:30 pm with Administrator revealed that her expectations were that dietary staff abide by policy by labeling and dating all food items. She revealed dietary staff should be looking for, and discard, expired food items daily. She stated if these things were not completed it could potentially affect all residents receiving an oral diet.