STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115298	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairburn Health Care Center	178 West Campbellton Street Fairburn, GA 30213

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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** 45811 Based on observations, interviews, record review, and review of the facility policy titled Medication Storage, the facility failed to assess four of 65 sampled residents (R) (R56, R44, R41, and R21) for the ability to self-administer medications before leaving medications at the bedside. Findings included: A review of the policy titled, Medication Storage dated 2/12/2022 revealed that the facility will ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. 1. A review of the electronic medical record (EMR) for R56 revealed that the resident presented with diagnoses of lupus erythematosus, asthma, Muscle weakness (generalized), cognitive-communication deficit, adult failure to thrive, and major depressive disorder. A review of the current physicians orders included Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 mcg (microgram) (Fluticasone Umeclidinium-Vilanterol), Albuterol Sulfate Inhalation Aerosol Solution 108 (90 Base) mcg (Albuterol Sulfate), Incentive Spirometry, Claritin Tablet 10 MG (milligram) (Loratadine), Prednisone Tablet 5 MG. There was no assessment for self-administration of medications documented in the EMR. During an observation on 7/30/2024 at 10:00 am, the following medications were observed at R56's bedside: Zinc Oxide Ointment and Trelegy Ellipta Inhaler Aerosol. During an observation of R56's room on 7/30/2024 at 1:15 pm, a tube of Bacitracin Zinc was seen on the counter in the middle of the room. During an interview on 7/30/2024 at 1:30 pm, the DON and the Infection Control Nurse confirmed Zinc Oxide Ointment and Trelegy Ellipta Inhaler Aerosol were at R56's bedside. The DON stated there should not be medications at the bedside. During this observation, additional medications were found at the bedside: Dulcolax, Fluticasone Nasal Spray, and rubbing alcohol. DON stated she did not know who the medications belonged to. During an interview on 7/30/2024 at 2:15 pm, Licensed Practical Nurse (LPN) QQ confirmed that R56 was ordered the medications as needed (PRN) but stated that she was not sure who left the medication at the bedside. (continued on next page)

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	2. A review of the EMR for R44 revealed that the resident had orders for Hydrocortisone External Lotion 2.5 % Hydrocortisone (Topical), Remeron Tablet 15 MG (Mirtazapine), Ferrous Sulfate Tablet 325 mg, Ergocalciferol Capsule 50000 Unit; that the resident presented with diagnoses of Alzheimer's Disease, adjustment disorder with mixed anxiety and depressed mood, pruritus, and atopic dermatitis. During an observation on 7/30/2024 at 2:00 pm, R44 was sitting on the side. The following medication was observed on the bedside table: Triamcinolone 0.1% cream. The resident stated that she uses this cream mostly at night for itching. During an interview on 7/30/2024 at 2:15 pm, LPN QQ confirmed that the medication was at the bedside in the resident's room and stated that the triamcinolone acetonide was ordered for R44 earlier in the year and discontinued on 6/17/2024. She pointed out the discontinued date located on the medication. She does not know who left the medication in R44's room. 3. A review of R41's EMR revealed diagnoses that included major depressive disorder, single episode, unspecified upper limb, unspecified glaucoma, insomnia, unspecified, muscle weakness, type 2 diabetes mellitus without complications, and hoarding disorder. A review of R41's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident presented with a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact. A review of R41 orders revealed she has orders for Flonase suspension 50 mcg (fluticasone propionate) two sprays in both nostrils one time a day for postnasal drip/sinus/allergy and refresh ophthalmic solution 1.4-0.6 % (polyvinyl alcohol-povidone) instill one drop in both eyes twice (BID) a day for dry eyes, however, there is no order for self-administration in the chart Observation on 7/30/2024 at 11:19 am revealed fluticasone propionate nasal spray, a 24-hour nasal spray; tear eye drops; and medication in a small plastic cup on R41's bedside table. During an interview on 7/30/2024 at 11:35 am, LPN II revealed she gave R41 her morning medication but did not wait until she swallowed the medication. LPN II confirmed the medication in the plastic cup on R41's bedside table was her morning medication given to her at 8:40 am. LPN II also confirmed that R41 should not have nasal spray or tear eye drops at her bedside. During an interview on 8/1/2024 at 9:15 am, LPN II revealed she has been working at the facility since 2006 and that her hours are from 7:00 am to 3:00 pm. LPN II stated staff complete rounds daily to ensure there is no medication at the bedside. LPN II stated that R41 does not have an order for self-administration. During an interview on 8/2/2024 at 10:16 am, R41 revealed that the reason the nasal and eye medication was in the room was because she could get it when she needed it. 4. A review of R21 EMR revealed diagnoses that included hypertension, gastritis, chronic right heart failure, and obstructive sleep apnea. A review of R21 MDS dated [DATE] revealed, Section C-Cognitive Patterns: Brief Interview for Mental Status (BIMS) of 15; Section GG-indicated resident having no impairment. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R21's orders revealed she had an order for diclofenac sodium external Gel 1 %, however, there is no order in the chart for self-administration. During an observation on 7/31/2024 at 12:16 pm, medication (diclofenac sodium) was observed on R21's bedside table. During an interview on 8/1/2024 at 9:15 am, LPN II stated that R21 does not have an order for self-administration and confirmed that the medication (confirmed diclofenac sodium) was on R21's bedside table. During an interview on 8/1/2024 at 3:26 pm, the DON revealed she has been working at the facility since June 2023. She confirmed that prescribed medications should not be left with any resident and that no residents in the facility had self-administration orders. The DON stated all nurses are expected to visually see all residents take their medication before leaving the room.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 44757 Based on observations, record reviews, staff interviews, and a review of the facility policy titled Menus, the facility failed to honor residents' rights to make choices related to meals and snacks. This had the potential to affect 108 of 112 residents who can consume meals. Findings included: A review of the facility policy titled Menus revealed that the residents' council would be included periodically in menu planning . and if a food group is missing from a resident's daily diet (e.g. dairy products) the resident will be provided with an alternate means of meeting the resident's nutritional needs (e.g. calcium supplementation or fortified non-dairy alternative). A review of the last six months of resident council meeting minutes revealed that residents voiced that they had not been receiving snacks and that residents were not notified if snacks were being put out or distributed; food was cold and not delivered promptly; and residents could not eat in the dining room because staff did not assist them into the dining area. During an observation on 7/31/2024 at 5:30 pm, no residents were in the dining room awaiting dinner. During an interview on 8/1/2024 at 1:03 pm, R66 stated all residents eat dinner in their room because they do not have the staff to assist them to the dining room. Trays come down the hall around 4:30-5:30 pm with no snacks afterward. The resident stated that the staff will go around and ask the residents about dinner preferences, but it is pointless because it is not what they will have for dinner. She further stated that the staff was not passing out snacks or letting the residents know snacks were available. The resident stated there used to be a store in the facility available for the residents to buy their own snacks but they closed it down. During an interview on 8/3/2024 at 1:45 pm, the Dietary manager (DM) stated there is a menu that has been developed but due to the menu constantly changing, he has to substitute the meal that is on the menu. He further stated to not pay attention to the menu he handed out because it is not correct. During an interview on 8/5/2024 at 12:20 pm, the Registered Dietitian (RD) HH revealed she understood that if a resident voiced a request, nursing would communicate that to the dietary department. She revealed the menu is on the wall and the alternatives she can't remember seeing on the wall. Furthermore, RD HH revealed she noticed that with the alternatives, there may be some gaps. She revealed she does not recall seeing menu cards on the resident's tray. Tray cards are the keyway to communicating alternatives. The tray card is the direct dietary communication and at the time of the tray card it will show preferences and allergies for the resident.

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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** 36377 Based on interview, record review, and review of the facility policy titled Bed Hold Policy, the facility failed to provide bed hold information, in writing, at the time of transfer to the hospital, or within 24 hours, for one resident (R), R154 of three sampled residents. Findings included: A review of the facility policy titled Bed Hold Policy (2/12/22) stated at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. Bed Holds Notice Upon Transfer 1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifies. (a). The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. A review revealed that R157 has the following diagnoses but not limited to chronic diastolic (congestive) heart failure, renal disease, and Type 1Diabetes Mellitus. The Admission Minimum Data Set (MDS) dated [DATE] listed a Brief Interview Mental Status Score of 14 which indicates little to none cognitive impairment. A review of R157 's hospital record, census, and MDS record (discharge and entry tracking record) revealed that R157 was hospitalized on [DATE], 3/5/2024, 4/12/2024, 5/6/2024, and 6/20/2024. Although the facility provided written information about the bed hold policy on admission, a review of the clinical and financial records revealed no evidence that the resident and responsible party were provided with written information on bed hold at the time of transfer or within 24 hours for the hospitalization s. During an interview on 8/3/2024 at 2:42 pm, the Business Office Manager (BOM) confirmed not having any electronic medical record (EMR) or hard copy bed hold forms documents to show that bed hold information was provided for the hospitalization s. She stated that the business office manager and licensed nursing staff are responsible for ensuring the resident/family are provided with the form at the time of transfer to the hospital. The next step is to upload the hard copy into the resident's EMR record. During an interview on 8/3/2024 at 2:43 pm LPN reported licensed nurses' staff are responsible for giving the resident bed hold form at the time of transfer hospital. During an interview on 8/3/2024 at 3:40 pm, the Administrator reported that she expects the bed hold form to be given to the resident by the staff. She was unaware that the forms were not being given. The Administrator stated that she would provide a copy of the bed hold policy to the surveyor.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 45811 Based on observations, interviews, and record reviews the facility failed to identify and submit a Preadmission Screening/Resident Review (PASARR) Level 2 review for one of three residents (R) (R60). Findings included: A review of the PASRR Level I Assessment revealed that the Resident has a Primary Diagnosis of serious mental illness, developmental disability, or related condition. There is presenting evidence to indicate a suspected diagnosis for an undiagnosed condition as indicated by substantial functional limitations in three or more of the following areas of major life activities; self-care, understanding and use of language, learning, mobility, self-direction and capacity for independent living. Review of the Nurse Practitioner Psychiatric Consultant on 7/16/2024 included: Assessment and Plan: 1) Schizophrenia ICD-10 code F20.9- Stable on current regime. Continue with the plan of care as GDR is contraindicated due to the risk of worsening depression, psychosis, and/or anxiety. 2) Staff to continue to monitor mood and behavior and document accordingly. 3) Will continue to care with a follow-up in 12 weeks or sooner if needed. Time Spent: 16 minutes A review of the medical record revealed the physician's orders (e.g., psychoactive medications) - Ativan Tablet 0.5 mg give 1 tablet by mouth one time a day for Anxiety Lyrica Capsule 150 MG (Pregabalin) give 150 mg by mouth three times a day for tremors, Target Behavior: Anxiety, Agitation, Delusions, Hallucinations). Document # of behaviors each shift. Frequency= number of times behavior occurred and Intensity= how easily behavior is redirected. 0= did not occur, 1= easily redirected, 2= difficult to redirect, Care now to evaluate and treat. Diagnosis: schizophrenia, Cyanocobalamin Tablet 1000 MCG Give 1000 mcg by mouth one time a day related to Adult Failure to Thrive, Benztropine Mesylate Tablet 2 mg give 2 mg by mouth at bedtime related to Schizophrenia, Remeron Tablet 15 MG (Mirtazapine) give 15 mg by mouth at bedtime related to Adult Failure to Thrive, Zyprexa Tablet 15 mg give 15 mg by mouth at bedtime related to Schizophrenia. Medical Diagnosis - Hemiplegia and hemiparesis, Other Hereditary and Idiopathic Neuropathies, Lack of Coordination, Schizophrenia, Generalized Anxiety Disorder, Adult Failure to Thrive, Cerebral Infarction The care plan includes Self-care deficits related to the diagnosis of failure to thrive, neurological deficits, pain, and Mood; The resident has a mood problem diagnosis of Schizophrenia, Resident uses daily anti psychotropic medication for his diagnosis of Schizophrenia (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/2/2024 at 12:55 pm NP RR; this Resident has not exhibited any adverse behaviors. During an interview on 8/3/2024 at 10:00 am with the Wound Care Nurse; he does not have any behaviors. During an interview on 8/3/2024 at 12:15 p.m. with LPN JJ, no behaviors were noted. He is independent and makes his needs known. During an interview on 8/3/2024 at 1:15 pm, the Social Service Director; PASARR Level 1 and 2 came with the Resident from the hospital. There is only a Level 1 for this Resident. He does see psych services. During an interview with the administrator on 8/3/2024 at 3:42 p.m., it was revealed that the Resident did not have a Level 2 completed by the hospital in 2021. The Social Service Director will complete Level 2 now. During an interview on 8/5/2024 at 2:50 pm with the Social Service Director; the process for PASARR is the hospital will initiate Levels 1 and 2. If the hospital does not initiate Level 2 the Social Service Director at the facility should initiate Level 2. She is not sure why Level 2 was not initiated for this Resident; she states he was admitted before her time.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on record review staff interviews, and a review of the facility policy titled, Discharge Summary, the facility failed to reconcile all pre-discharge medications with the resident's post-discharge medication for one of three residents (R) (R158). Findings included: A review of the facility policy, Discharge Summary stated It is the policy of this facility to ensure that a discharge summary is provided upon a resident's discharge which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies. Reconciliation of medications means a process of comparing pre-discharge medications to post discharge medications by creating list of both prescription and over the counter medication that includes the drug name, dosage, frequency, route, and indication for use the purpose of preventing unintended changes. A review of R158's record revealed a discharge date of [DATE]. The resident had the following diagnoses at the time of discharge not limited to vascular dementia, Parkinson's disease, and type 2 diabetes mellitus. The facility's Annual Minimum Data Set (MDS) dated [DATE] assessed a Brief Interview Mental Status Score of 14 which indicates little to noncognitive impairments. A review of the Physician Order Form revealed a discharge order dated 2/29/2024 that stated discharge to home with health services for disease process and medication management. DME: Durable Medical equipment: high back wheelchair 18in cushion, hospital bed, oxygen. No directions were specified for the order. A review of the Discharge Summary form failed to list the medications and documentation of signatures of the staff providing the information to the residents. The form listed the resident as a full code. A review of the physician order in the medical record lists the resident as a Do Not Resuscitate (DNR). The recap of the functional level for ADL care was not transcribed on the form. During an interview on 4/27/2024 at 2:19 pm, the Family of R158's family, Family member A (complainant) reported that the facility nurse failed to give the resident all her medications. The resident only received some of her medications. Family Member A reported that at the time of discharge there were no specific information provided about the resident capabilities and functional level at the time of discharge. Interview on 8/3/2024 at 3:11 pm, Social Service Worker (SS) reported that this was an oversight and a mistake to list the resident as full code and not a DNR. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/5/2024 at 3:13 pm, the Director of Nursing (DON) reported that the discharge summary should consist of the care instructions (diet, disease process, wound orders, and functional level. She stated that the therapy department staff (Occupational Therapy/Physical Therapy OT/PT) should have completed their part for the functional level. The medications should be documented that it was given. The discharge summary should have stated that the resident is a DNR, and the resident medications should have been signed off by the nurse along with the resident/resident's family member's signature. During an interview on 8/5/2024 at 3:40 pm, the DON reported that she was able to speak with LPN II by phone. LPN II admitted to her that she failed to make a copy of the medication form with the resident's signature and the family's signature to place in the resident's medical record. The nurse stated that she gave the original copy to the family. The DON stated that without proof of the copy, she could not confirm that the resident or family received the medications from the nurse. She stated that a copy of the medication form is what staff should place in the resident chart at the time of discharge to verify medications were given.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138 Based on observations and resident and staff interviews, the facility failed to provide a safe environment free from accident hazards for three of 64 residents (R) (R41, R9, and R24). Findings included: 1. A review of R41 Electronic Medical Records (EMR) revealed diagnoses that included major depressive disorder, single episode, unspecified upper limb, unspecified glaucoma, insomnia, unspecified, muscle weakness, type 2 diabetes mellitus without complications, and hoarding disorder. A review of R41 Quarterly Minimum Data Set (MDS) dated [DATE] revealed, Section C-Cognitive Patterns: Brief Interview for Mental Status (BIMS) of 15; Section GG-indicated resident using a wheelchair. An observation on 7/30/2024 at 11:19 am revealed nail polish remover on the R41 bedside table. An Interview on 8/1/2024 at 9:15 am with Licensed Practical Nurse (LPN) II LPN II revealed she has been working at the facility since 2006, her hours are from 7:00 am to 3:00 pm. LPN II acknowledges some of the rooms have clutter. LPN stated staff are consistently decluttering, residents are told they cannot have certain things in their room. LPN II confirmed the hazardous items on the R41 bedside table. 2. A review of R9 MDS dated [DATE] revealed, Section C-Cognitive Patterns- BIMS of 13; Section GG-indicated resident using a wheelchair. A review of R9 EMR revealed diagnoses that included heart failure, anemia in chronic kidney disease, hypertension, type two diabetes mellitus without complications, chronic kidney disease, gastro-esophageal reflux disease without esophagitis, and mood disorder due to known physiological conditions with depressive features. An observation on 7/30/2024 at 12:49 pm with R9 revealed a bottle of Isopropyl alcohol on her bedside table. R9 was observed to be alert and oriented. An Interview on 7/31/2024 at 12:42 pm with R9 revealed she bought the Isopropyl alcohol from the store herself, she stated someone took her to the store. R9 stated she uses it on her legs. R9 stated her grandson took her to the store. In an Interview on 7/31/2024 at 12:44 pm LPN II confirmed the rubbing alcohol in R9's room. LPN stated the residents and families have been informed that certain things are not allowed in their room, LPN stated she would reach out to the resident's grandson regarding this matter. The Isopropyl alcohol was removed from the R9's room. LPN confirmed daily rounds are made by the facility to ensure the residents safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. A review of R24 EMR revealed diagnoses that included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the right dominant side, essential (primary) hypertension, paranoid schizophrenia, major depressive disorder, single episode, type two diabetes mellitus without complications. Review of R24 MDS dated [DATE] revealed, Section C-Cognitive Patterns: Brief Interview for Mental Status (BIMS) of 14; Section GG-indicated resident having lower and upper impairment on one side. Observation revealed R24 had four bottles of Hibiclens Antiseptic on her bedside table and there was also clutter on the side of the bed. An interview on 7/31/2024 at 12:02 pm revealed R24 sleeping, there were 4 bottles on was noted to be sleeping. R24 awakened to surveyor and Certified Nursing Assistant (CNA) CNA KK knock on the door. R24 stated another resident at the facility gave her 4 bottles of Hibiclens Antiseptic. R24 permitted CNA KK to take the 4 bottles of Hibiclens Antiseptic. CNA KK educated R24 about not having certain chemicals in her possession. R24 does not have any concerns. An interview on 7/31/2024 at 12:03 pm with CNA KK revealed she has been working at the facility since April of 2024. CNA KK stated she tried decluttering the resident's room by throwing away some things, but the resident does not want anyone touching her personal belongings, resident carries a bag of her personal belongings with her, and the staff tries to make her bed every other day but sometimes the resident refuses, the resident has not had any falls that she knows of. CNA KK confirmed the four bottles of Hibiclens Antiseptic on the resident's bedside table. An Interview on 8/1/2024 at 09:15 am with LPN II revealed she has been working at the facility since 2006. LPN II acknowledges some of the rooms have clutter. LPN II stated staff are consistently decluttering, and residents are told they can't have certain things in their rooms. LPN II stated no residents have spoken about not getting bedtime snacks. An interview on 8/1/2024 at 3:26 pm with the Director of Nursing (DON) DON revealed she has been working at the facility since June of last year. DON stated it is not appropriate for a resident to have a nail polish remover, Hibiclens Antiseptic, and rubbing alcohol, in his or her room. DON stated all residents are educated about what they should and should not have in their rooms. DON stated is aware of clutter in some of the residents as some of the residents do not want to let go of their personal belongings as they like to hold on to their stuff.

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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, interviews, record review, and the policy titled, Oxygen Administration, the facility failed to provide effective oxygen therapy for four of 10 residents (R) (R47, R62, R21, and R100. Findings included: Review of the policy titled, Oxygen Administration, date implemented 2/12/2022, Under the Policy section, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Under the section Policy Explanation and Compliance Guidelines: Oxygen is administered under orders of a physician, except in the case of an emergency. Infection control measures include following manufacturer recommendations for the frequency of cleaning equipment filters and keeping delivery devices covered in plastic bags when not in use. 1. A review of the medical record for R47 includes Medical Diagnosis - Diffuse traumatic brain injury with loss of consciousness of unspecified duration, Persistent vegetative state, Chronic Respiratory Failure with Hypoxia, Tracheostomy, Gastrostomy. Orders - Suction trach every shift and as needed every shift, Trach Care- the area with normal saline, pat dry apply gauze, and apply neck strap. - Assess for drainage, bleeding, discomfort, and redness, Emergency trach with Obturator and keep at bedside, Change Tracheostomy tube every 30 days (s) for monitoring, Change disposable Inner cannula (#6 Shiley) every night shift for trach care, and Albuterol Sulfate Nebulization Solution (2.5 mg/3ml) 0.083% 3 ml via trach every 4 hours as needed for wheezing SOB. Care Plan - Resident is receiving all fluids and/or nutrients via a tube secondary to a swelling problem related to having a tracheotomy due to an MVA. Care Plan - Resident is at risk for bacterial/viral infection related to tracheostomy status, incontinence of bowel and bladder. The resident is at risk for respiratory infection, UTI, R47 has a Tracheostomy related to her diagnosis of Traumatic Brain Injury. She is in a Persistent Vegetative State secondary to cervical vertebrae Injury due to an MVA. Beside, there will be an O2 cylinder, suction machine, and obturator. During an observation on 7/30/2024 at 10:00 am in R47 room an Ambu bag, yanker suction was seen on the floor. During observation on 7/31/2024 at 9:30 am in R47 room an Ambu bag, yanker suction was seen on the floor and respiratory tubing was lying on the air conditioner and not in a bag. During an interview on 8/1/2024 at 9:00 am with LPN QQ; she confirmed there was an Ambu bag on the floor and unbagged oxygen tubing was on the air conditioner unit. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of medical records for R62 includes Medical Diagnosis - Chronic Respiratory Failure with Hypoxia, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Morbid Obesity. Physician's orders - Saline Nasal Solution (Saline) 1 unit in both nostrils every 6 hours as needed for dry nasal cavity, Prednisone Oral Tablet 20 mg give 2 tablets by mouth one time a day for gout, Hospice to evaluate and treat as indicated, Incentive Spirometry every shift for Shortness of Breath and as needed for Shortness of Breath. Care plan - Hospice Services: Resident has a condition or chronic disease that may result in a life expectancy of less than 6 months. He was admitted to hospice with a Diagnosis of CHF, The Resident is at risk for COPD and is dependent on supplemental oxygen, The resident has a potential risk for altered respiratory status related to diagnosis of COPD, CHF, Sleep Apnea, morbid obesity, and history of acute respiratory failure with hypoxia. The resident utilizes oxygen via NC at 2L/min continuously. During an observation on 7/30/2024 at 10:30 am with R62 it was revealed he has 0xygen on at 3 liters nasal cannula and there was no respiratory distress noted. During an observation on 7/31/2024 at 12:15 pm it was revealed R62 has oxygen on at 3 liters nasal cannula. He has no respiratory distress noted. During an interview on 8/1/2024 at 9:20 am with LPN QQ; she confirmed the Resident was on oxygen but there was no order. During an interview on 8/3/2024 at 10:00 am with CNA BB; it was revealed he is in total care, he does get short of breath sometimes, but he usually keeps his oxygen on. During an interview on 8/3/2024 at 10:15 am with LPN AA it was revealed that the nurses check the oxygen levels every shift and they maintain oxygen therapy for the Residents. During an interview on 8/3/2024 at 12:09 pm with LPN JJ, it was revealed the R62 is in total care, he wears his oxygen all the time; nurses should check the oxygen every shift; if a new nurse comes on shift and needs to know what the oxygen level should be they will need to check the Medication Administration Record (MAR). The MAR was reviewed, and the Oxygen is not on the MAR. During an interview on 8/5/2024 at 2:30 pm with the DON it was revealed the nurses are responsible for maintaining oxygen therapy. 3. A review of R21 Electronic Medical Records (EMR) revealed diagnoses that included hypertension, gastritis, chronic right heart failure, and obstructive sleep apnea. A review of R21's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, Section C-Cognitive Patterns: Brief Interview for Mental Status (BIMS) of 15; Section GG-indicated resident having no impairment. A review of R21's orders revealed she has an order for nasal 02 at two liters per minute(2LPM), as needed (PRN) every six hours as needed for shortness of breath (SOB). Observation on 7/30/2024 at 12:50 pm revealed R21 oxygen level to be set at one point five liters per minute(1.5LPM), the filter was dirty, and the tubing was not bagged. R21 turned off oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/01/2024 at 11:09 am revealed R21 to be alert and oriented, her oxygen tubing was bagged, and her level was set at three liters per minute(3LPM). An interview on 7/30/2024 at 12:50 pm with R21 revealed R21 to be alert and oriented. R21 oxygen was on but she was not using it. An interview on 7/31/2024 at 12:16 pm with R21 revealed she uses her oxygen as needed. The tubing was not bagged, the filter was dirty, and the level was set at 1.5 LM. An Interview on 8/1/2024 at 9:15 am with LPN II revealed she has been working at the facility since 2006, her hours are from 7:00 am to 3:00 pm. LPN II stated staff complete rounds daily to ensure there is no medication at the bedside. LPN II stated that R21 has PRN orders for oxygen to receive 2LPM. LPN II confirmed oxygen tubing should be bagged, and the filter should be cleaned. 4. A review of R100's clinical record revealed that she was admitted on [DATE]. Pertinent diagnoses are but not limited to other toxic encephalopathy, type 2 diabetes mellitus with other specified complications, acute respiratory failure with hypercapnia, other asthma, morbid obesity, and major depressive disorder. A review of R100's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. Section N revealed resident received an anti-coagulant and section O documented the resident received continuous oxygen. A review of R100's care plan revealed there was no care area, goals, or interventions for the administration of oxygen. A review of the Physician's orders revealed no order for oxygen therapy. A review of the Medication Administration Record (MAR) dated 7/1/2024-7/31/2024 revealed oxygen therapy was omitted from the MAR. Observations on 7/30/2024 at 12:34 pm, 7/31/2024 at 12:15 pm, and 8/1/2024 at 10:30 am revealed R100 was receiving oxygen via nasal cannula at two liters per minute (2 LPM). An interview on 8/1/2024 at 10:30 am with LPN AA revealed she was familiar with R100 and that she had passed her morning medications. LPN AA searched for the resident's order for oxygen therapy and confirmed there was no order. She revealed that there should be an order for oxygen use and confirmed the resident was currently receiving oxygen. An interview on 8/1/2024 at 3:30 pm with the Director of Nursing revealed that she expects all nursing staff to check the resident's oxygen order on every shift to the concentrator to ensure the correct prescribed liter per minute rate is set. She confirmed that was not occurring since R100 had no physician's order for oxygen therapy. 49138 49675

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on staff interviews, record review, and review of the facility policy titled, Hemodialysis, the facility failed to ensure communication was documented between the facility staff and dialysis staff to ensure pertinent information was being communicated for one of three residents (R) (R54) reviewed for dialysis. Findings included: A review of facility policy titled Hemodialysis (dated 2/1/2022) stated that the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goal and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. The facility will assure that each resident receives care and services for the provision of hemodialysis consistent t with professional standards of practice. this will include Ongoing assessment and oversight of the resident before, during, and after dialysis treatments, including monitoring of the resident's condition during treatment, monitoring for complications, implementation of appropriate interventions, using appropriate infection control practices, and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. (8). The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding and other complications. A review of R54's medical record revealed the following diagnoses but not limited to hypertensive chronic kidney disease or end stand renal disease (onset 9/1/2023), legal blindness, and cerebellar stroke syndrome. A review of R54's Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was receiving dialysis. A review of R54's physician orders revealed a physician order dated 9/21/2023 for dialysis on Monday, Wednesday, and Friday. A review revealed missing dialysis forms for the months of May 2024,7/17/2024, 7/19/2024, and 7/24/2024. A review of the Dialysis Communication Form for Section 1 (pre-treatment to be completed by facility staff) for a period of 6/1/2024 through 7/31/2024) was incomplete for 7/1/2024 completed but no nurse signature, 7/8/2024 completed but no nurse signature, 7/22/2024 with no nurse signature, Continued review of the Dialysis Communication Form for Section 2 (to be completed by dialysis center) for a period of 6/1/2024 through 7/31/2024 revealed no documentation for dates of 7/1/2024, 7/5/2024, 7/8/2024, 7/10/2024, 7/12/2024, 7/15/2024. 7/22/2024 (partially completed with no signature, 7/26/2024, 7/29/2024. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Dialysis Communication Form for Section 3. (to be completed upon return from dialysis by the facility staff) revealed no documentation. In addition, the form dated 6/1/2024 through 7/31/2024 revealed no documentation for the time returned, temperature, blood pressure, and other vitals. The form revealed incomplete vital sign information and no staff signature for 7/1/2024, 7/5/2024, 7/8/2024, 7/10/2024, 7/12/2024, 7/15/2024, 7/26/2024, 7/29/2024. The form revealed no information was documented related to the resident's vital signs, assessment of thrill and brut (the feeling or sound of blood flow through the fistula) and/or mental status. In addition, the data was partially completed with missing data, including a missing dialysis staff signature. During an interview on 8/2/2024 at 2:00 pm, Licensed Practical Nurse (LPN) II confirmed that R54 's dialysis communication forms that was in his hard copy folder at the nurse station and the electronic system were missing documentation from the receiving nurse. She reported that the nurse should complete vitals, weights, and other information on the form once the resident returns from dialysis. The completed forms are given to the Medical Record to upload into the facility electronic system (EMR). The last hard copy form at the nurse station was dated 2/26/2024 During an interview on 8/2/2024 at 2:25 pm, the Director of Nursing (DON) printed the dialysis forms from the EMR for R54. She stated that once the resident returns from dialysis, the hard copy form is given to the medical record to upload into the system. At that the time, the forms would have been completed by the receiving nurse who received the resident from dialysis. During an interview on 8/2/2024 at 3:00 pm with Medical Record /Business Office Manager Staff LL at the time of observation of R54's dialysis form, Medical Record Staff confirmed the dialysis communication forms that the surveyor received from the DON was not thoroughly completed with the nurse information. She reported that she does not review the dialysis communications forms to ensure the forms are correct. She stated that once the licensed nursing staff submits the forms to her, all forms are uploaded into the facility's electronic systems. During an interview on 8/5/2024 at 3:10 pm, the DON reviewed the dialysis communication forms with the surveyor. She confirmed that the forms were not being completed by the facility nursing staff once the resident returns from dialysis. DON reported that she was not aware that the form was not being completed until brought to her attention during the survey. She reported that she expects that the forms are completed based on policy. She stated that any care that staff provides to a resident is important. She stated that care for services for any dialysis resident depends on the order. R54 order stated that communication forms are to be completed. If the order states to evaluate and assess the resident once he returns, then this is what is supposed to happen. The charge nurses are to check the resident's bruit and thrill to ensure the shunt is working, vitals, and weight. Any sudden changes in fluids can cause the resident to become orthostatic.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 45811 Based on observation, record review, staff interview, and review of the policy titled, Medication Administration the facility failed to ensure a medication error rate of less than five percent (5%) during medication administration for three of six Residents (R) (R44, R46, and R61). There were 35 opportunities observed resulting in three medication errors. The medication error rate was 8.57%. The facility census was 112. Findings included: Review of the policy titled, Medication Administration date implemented 2/12/2022, under the section, Policy Explanation, and Compliance Guidelines: Review MAR to identify medication to be administered and Compare medication source with MAR to verify resident name, medication name, form, dose, route and time. Record review for R44 revealed diagnoses of but not limited to Alzheimer's Disease, Retention of urine, and Essential Hypertension. Orders - cranberry 450 mg 1tab po daily for urinary tract health, order started 8/2/2024, Ferrous Sulfate Tablet 325 (65 Fe) mg. Care Plan - The resident is at risk of bladder incontinence related to abnormalities in gait, diagnosis of urinary retention, dementia, and Alzheimer's disease. During Medication Administration Observation on 7/31/2024 at 9:03 am R44 was given Cranberry 450mg - 1; the order is Cranberry 425mg. Record review for R46 revealed diagnoses of but not limited to Type 2 Diabetes Mellitus, Urinary incontinence, and a History of Cerebral Infarction. Orders - cranberry 450 mg 1 tab po daily for urinary tract health, the order started 8/2/2024. Care Plan - Resident has a risk for infection related to incontinence of bowel and bladder and a history of UTI. During Medication Administration Observation on 7/31/2024 at 11:36 am R46 was given Cranberry 450mg 1; Order was Cranberry 425mg. Record review for R61 revealed diagnoses of but not limited to Cerebral Infarction and Prediabetes. Orders - VIT Ds 125mcg 1 tab po daily for a supplement, order changed on 8/2/2024. Care Plan - The resident has DM II dx and should be monitored for hyperglycemia: increased thirst, appetite, pallor, and slurred speech. During Medication Administration Observation on 7/31/2024 at 12:02 pm R61 Vitamin D3 5000 IU 125mcg - 1 was given but the Order is Vitamin D3 25mcg. During an interview on 8/1/24 at 9:10 am, with Licensed Practical Nurse (LPN) QQ, the following medications were reviewed and confirmed as given with the nurse; R44 - given Cranberry 450mg but the order was for Cranberry 425mg, R46 - given Cranberry 450mg but the order was for Cranberry 425mg, R61 - given Vitamin D3 125mg but the order was for Vitamin D3 25mcg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/2024 at 3:15 pm DON revealed she expects the staff to follow the orders of the physician. DON's role and responsibility is to make sure everything flows well between the departments and nursing. The DON monitors staff to make sure they are doing what needs to be done for the Residents through audits, being on the floor, and observation.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44757 Based on observations, record reviews, staff interviews, and a review of the facility policy titled, Menus the facility failed to ensure residents were served meals that were palatable, appetizing, and attractive. The deficient practice had the potential to affect 97 of 112 residents who consume an oral diet. Findings included: A review of the facility policy titled, Menus issued April 2024 revealed, Menus shall meet the nutritional needs of residents, be prepared in advance, and be followed Guidelines 6. Deviations from menus that have already been posted will be noted (including the reason for the substitution and/or deviation) in the kitchen and/or recorded in the record book used solely for recording such changes. The Dietitian should be made aware of these changes and have signed off on them on the Substitute log. 7. Menus will provide a variety of foods from the basic daily food groups and will indicate standard portions at each meal. An observation on 8/1/2024 at 6:30 pm revealed a meal that included meatless hotdog bun with a slice of cheese and 8 ounces of chicken noodle soup along with a side portion of lettuce. Interview on 8/1/2024 at 6:37 pm with Administrator and Regional Nurse Consultant verified the dinner meal was unacceptable and proceeded to the kitchen for the Dietary Manager CC to address and prepare a meal. Interview on 8/1/2024 at 6:41 pm with Dietary Manager (DM) CC revealed he was providing the menu of submarine bread with grilled cheese; however, he used a hot dog bun due to the kitchen running out of bread. He stated that the small portions of chicken noodle soup were the correct ounces according to his Registered Dietician. He stated the salads did not have meat because he did not have any deli meats in the cooler. An interview on 8/3/2024 at 1:45 pm with DM CC revealed the items purchased are limited since they have to use the upright freezer as well as the deep freezer. He stated there is a menu that has been developed by the registered dietitian but due to the menu constantly changing, he must constantly substitute the meals that are on the menu. He further stated the meal that is served is not on the menu that he handed me but what is served is always on the menu that is posted outside for the residents. Interview with the Registered Dietitian (RD) LL on 8/1/2024 at 12:55 pm revealed when asked about the menus, such as the alternate food or always available menu, she stated she has not checked to see if they were posted but they should be posted. Furthermore, RD LL revealed the alternate menu consists of comparable choices to the posted menu. She revealed the residents should know what the alternate meal choice is when they choose their meal for the day because the coordinator should tell them at the time when they are picking what they would like to eat for their meal. She further stated choices should be available for the residents even if they decide at the last minute, that they no longer want what they chose to eat earlier in the day. The RD LL revealed the menus were on a 30-day cycle, therefore they repeat monthly.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 49138 Based on observations, staff interviews, and a review of the facility policy titled, Menus the facility failed to ensure meals and snacks are served at times per resident's needs, preferences, and requests. Nourishing alternative snacks were not provided for 97 of 112 residents to eat at non-traditional times or outside of scheduled mealtimes. The facility census was 112. Findings included: 1. A review of the facility policy titled, Menus dated April 2024 revealed Guidelines: 2. Menus and available snacks shall be adjusted to meet individual caloric and nutrient-intake needs of the resident. Reviewing the Resident Council minutes revealed the resident's expressed concerns about not receiving snacks. A Resident Council meeting was held on 7/31/2024 from 2:00 pm to 3:00 pm with 21 residents in attendance. The residents stated they do not receive snacks at night. The following residents were in attendance: R66 Brief Interview for Mental Status (BIMS)15, R95 BIMS13, R80 BIMS15, R41 BIMS15, R21 BIMS 15, R67 BIMS 14, R69 BIMS 15, R68 BIMS 12, R56 BIMS 15, R79-BIMS 15, R51 BIMS 9, R87 BIMS 3, R43 BIMS 15, R73 BIMS 15 ,R96 BIMS 15, R7 BIMS 00, R42 BIMS 11, R103 BIMS 12,and R1 BIMS 8 An observation on 8/1/2024 at 11:35 am of snacks in the pantry revealed chocolate sandwich cookies, graham crackers, and six chocolate wafer bars. An interview on 8/1/2024 at 11:23 am with the Dietary Manager (DM) revealed that he leaves 20 snacks at the nurse's station for residents and diabetic residents are provided sandwiches. The DM stated that he only provides a limited number of snacks because the food comes up missing at night. The DM confirmed that he did not have meat or peanut butter and jelly to prepare sandwiches for residents. An interview on 8/1/2024 at 11:40 am with the Administrator revealed that she was aware of food coming up missing but was unaware of the limited number of snacks provided to residents. An interview on 8/3/2024 at 12:20 pm with Licensed Practical Nurse (LPN) JJ revealed snacks are not offered; some residents get a snack bag. LPN JJ stated that they had never seen snacks offered to the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on observations, staff interviews, and a review of the facility policy titled Date marking for food safety, the facility failed to ensure that food was properly labeled, stored, and prepared in a sanitary condition to prevent foodborne illness, failed to monitor and log daily temperature of refrigerator and freezer temperatures to ensure food was preserved per recommended guidelines, failed to monitor and log daily steam table temperatures, failed to monitor and log daily dishwasher temperatures, failed to test and log daily test sanitation solution in three-compartment sink. In addition, the facility failed to ensure the cleaning of appliances (stoves, ovens, fryers), countertops, food preparation areas, floor tiles, and ceilings. The deficient practice had the potential to affect 97 of 112 residents receiving an oral diet. Findings included: Review of the facility policy titled, Date marking for food safety, not dated, stated 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 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 9:30 am with the Dietary Manager (DM). The following concerns were noted during the tour: 1. Observation of the walk-in cooler revealed a container of a brown liquid substance later identified as tea was not labeled or dated, a bag of shredded lettuce that was not dated, a jar of relish with the best used-by date of [DATE], a tub of dark brown items later identified by DM as cooked sausage patties not labeled or dated, and two opened bags of hot dog buns not dated. 2. Observation of one stand-up freezer revealed four containers of Yoplait yogurt with an expiration date of [DATE]. 3. No record of daily temperature logs for two stand-up freezers and a walk-in cooler 4. No record of daily temperature logs for the dishwasher since [DATE]. 5. No record of daily steam table temperatures 6. No records or logs of the testing of the sanitizing solution for the three-compartment sink since [DATE]. (continued on next page)

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	115298	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairburn Health Care Center	178 West Campbellton Street Fairburn, GA 30213

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. The oven had a buildup of dark, thick, greasy substances that coated the outside walls and oven doors. 8. The fryer contained dark brownish almost black colored oil 9. The fryer was coated with the buildup of a dark brown greasy substance 10. The convection oven was covered with a white and light brown substance 11. Food preparation areas were soiled in food crumbs, dirt, and grime. 12. A wired rack was pushed against a wall that stored pots and pans. The wall was covered in a dark brownish-black substance, and the floor underneath the shelf was covered in food crumbs, dirt, and debris 13. A black substance was found in the ice machine once the surveyor wiped the inside frame 14. Sanitizing sink soiled with a white substance, debris containing food particles surrounding it. The shelving unit above is rusty, missing paint, and covered in a greasy soiled substance 15. Glassware crates stored on the floor covered in a brown substance 16. Kitchen floor covered with food particles, grime, and grout-stained 17. Handwashing sink lacked paper towels and a garbage can; a five-gallon bucket was observed under the sink covered in a brown substance with an insect glue trap on top. 18. The meat and vegetable sink is not labeled. A broken broom and handle under the meat and vegetable sink; under the sink, floor soiled, white pipes with a dark brown substance; the meat and vegetable sink counter on the left side contained a soiled rag, two different cleaning substances, and a container with a brown liquid substance. The surface was soiled with debris and particles. On the right side, the counter contained a hose, a steel sponge, a butcher knife a serrated knife, and a bottle of a cleaning agent. The surface was covered with debris containing food particles and dust. 19. A container of clean utensils was observed to be sitting on top of a counter in a food preparation area with paper receipts on top of them. 20. Three holes in different ceiling tiles along with a sticky fly trap hanging from the ceiling. 21. The hood vent located above the stove was coated in a dark brown substance 22. Dish washing machine covered in debris, and food particles both on top of the machine and underneath. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and rounding on [DATE] at 10:30 am with the Dietary Manager and Administrator confirmed there are no temperature logs for the low-temperature dishwasher machine for [DATE], [DATE], [DATE], or [DATE]. The DM confirmed there are no temperature logs for the walk-in cooler or two stand-up freezers for the last year. The DM confirmed there are no logs of the testing of the sanitizing solution for the 3-compartment sink for [DATE], [DATE], [DATE], or [DATE]. The DM also confirmed that steam table temperatures were not being done. The DM and administrator confirmed environmental concerns of the kitchen including the condition of the appliances (fryer, oven, and convection oven; soiled, covered in grime), dark colored grease in the fryer, floors (covered in debris, grime, food particles), ceiling (tiles with holes), food preparation counters covered in debris, grime, and grease, glassware storage crates resting on the floor and covered in a brown substance. The Administrator confirmed the hood needed cleaning. DM revealed that clean utensils should not be stored in the food preparation area and that paper receipts should not be covering clean utensils. DM revealed there is no cleaning list. The staff just communicate what needs to be cleaned. The DM revealed his staff do not use the two-compartment sink for meat or vegetables and that is why it is not labeled. He revealed his staff cannot read and if they needed to wash vegetables they would use a large bowl. The Administrator advised that the facility needs to deep clean the kitchen by pressure washing but it would need to be closed. She stated that she intends to close the kitchen and have the cook's grill outside so deep cleaning can be done and ceiling tiles can be replaced. The Administrator revealed everything in the kitchen needed to be scrubbed. DM and the Administrator confirmed there were four expired yogurts in the stand-up freezer a container of tea not labeled or dated, a bag of lettuce not dated, 2 opened bags of hot dog buns not dated, and a jar of relish expired in the walk-in cooler. The Administrator revealed that she expects the DM to manage the kitchen appropriately and that all food items were labeled and dated according to policy. An interview on [DATE] at 10:10 am with the day shift cook revealed he has been a cook for four months. He revealed he has never logged steam table temperatures because he never knew he was supposed to do it. He reported he wipes down appliances every day. An interview on [DATE] at 11:55 am with Dietary Aid EE revealed she has worked at the facility for two years. She revealed that she has received in-services on various topics such as food handling and handwashing but does not remember when the last time she had an in-service. She stated that if a resident complained of their food being cold, she would replace the food with another tray. She revealed that there used to be a cleaning list posted but there has not been one for a while. An interview on [DATE] at 4:25 pm with the only maintenance worker for the facility who has been employed for [AGE] years revealed he cleans the ice machine every 3 months, which is the manufacturer's recommendation. He stated the administrator keeps the logs and he last did them in May. Otherwise, no other cleaning/maintenance is completed. The surveyor was given a document titled ice machine cleaning and sanitation log dated [DATE]. The document had a time of 8:30 pm and a checkmark under the header cleaned and a checkmark under the header sanitized. Neither the maintenance worker nor the Administrator have the manufacturer's cleaning recommendations. An interview on [DATE] at 4:30 pm with the Administrator revealed if the ice machine is dirty, she expects that it be emptied, drained, and cleaned. She revealed having a dirty ice machine is a risk to residents and could make them ill. The surveyor asked for the manufacturer's cleaning recommendations and all policies on the sanitation of the ice machine.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138 Based on observations, staff interviews, and a review of the facility policy titled, Disinfection of Bedpans and Urinals the facility failed to ensure a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by not labeling and properly storing bath basins, bed pans, and urinals in eight of 49 rooms (309, 313, 315,402, 404, 405, 407, and 408). Findings included: A review of the policy titled Disinfection of Bedpans and Urinals dated 2/12/2022, revealed policy: bedpans and urinals are handled in a manner to prevent the spread of infection through personal equipment. Under Policy Explanation and Compliance Guidelines: 1. Bedpans and urinals are for single resident use only. [NAME] with resident's name and discard upon discharge. 2. Store bedpans and urinals in the resident's bedside cabinet or drawer after placing them in a plastic bag or as per facility policy. Observations on 7/30/2024 at 11:19 am and 8/1/2024 at 11:15 am revealed eight basins and two bedpans in the bathroom located in room [ROOM NUMBER] on the 300 hall were not labeled or bagged. Observations on 7/30/2024 at 11:19 am and 8/1/2024 at 11:15 am revealed five basins and one bedpan in the bathroom located in room [ROOM NUMBER] on the 300 hall were not labeled or bagged. Observations on 7/30/2024 at 12:26 pm and 8/1/2024 at 11:15 am revealed one basin located in room [ROOM NUMBER] B on the 300 hall not labeled or bagged. Observations on 7/30/2024 at 2:00 pm, 7/31/2024 at 8:30 am, and 8/1/2024 at 11:50 am revealed bed pans, bath basins, and urinals not bagged or labeled in the following bathrooms: An observation in the bathroom shared between room [ROOM NUMBER] and room [ROOM NUMBER] revealed three bath basins not bagged or labeled. An observation in the bathroom shared between room [ROOM NUMBER] and room [ROOM NUMBER] revealed two bath basins, and three urinals, were not bagged or labeled. An observation in the bathroom of room [ROOM NUMBER] revealed four urinals on the floor, four urinals on the shelf above the toilet, and three bath basins on the shelf above the toilet all not bagged or labeled. During an interview and rounding on 8/1/2024 at 12:18 pm, CNA BB revealed after observing all rooms, CNA BB revealed all bath basins and urinals should be bagged and labeled. She stated all basins and urinals should be cleaned after each use and changed out every night. During an interview and rounding on 8/1/2024 at 12:23 pm, LPN AA confirmed all urinals and bath basins should be bagged and labeled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/2024 at 3:30 pm, the Director of Nursing (DON) confirmed all urinals and bed pans should be bagged and labeled to eliminate the risk of cross-contamination. 49675