STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115326	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Magnolia Manor	3003 Veterans Parkway S Moultrie, GA 31788

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, resident and staff interviews, and record review, the facility failed to provide care in a manner that maintained or enhanced resident's rights, dignity and respect. Specifically, the facility failed to ensure facial hair was removed when requested for one female resident (R) (R36) of 28 sampled residents. Findings included: A facility policy on ADL care was requested during the survey but was not provided. Record review for R36 revealed the following diagnoses not limited to dementia and cardiopulmonary heart disease. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating little to no cognitive impairment. MDS also revealed R36 required partial moderate assistance with bathing/personal hygiene and required the use of a walker/wheelchair for ambulation/mobility. Record review of R36's Activities of Daily Living (ADL) care plan created 2/24/2023 identified a problem, an ADL Decline related to resident required assistance with set up with ADL. Observation on 10/29/2024 at 11:02 am, 10/30/24 at 1:00 pm, and 10/31/2024 at 8:01 am revealed thick, whisker-like facial hair on R36's chin, on an area the size of a fingertip. Interview on 10/29/2024 at 11:02 am, R36 revealed that staff refused to remove facial hair from her chin upon her request. R36 revealed that she does not like hair on her chin, it is not lady like. She reported having the facial hair on her chin for approximately two weeks and said she was told to wait until her shower days (Tuesday, Thursday, and Saturday), but on the last few shower days, no one shaved her. R36 reported that this has been going on for so long that she stopped requesting staff to shave her. This upsets her but she tries to work with staff. Interview on 10/31/2024 at 1:01 pm, Certified Nursing Assistant (CNA) QQ confirmed that R36's facial hair was not removed until this morning by another CNA, while providing R36 her shower, but was uncertain who the CNA was. CNA QQ reported that facial hair is usually removed during morning care. CNA QQ confirmed being aware of the facial hair on R36 's chin. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/1/2024 at 2:33 pm, the Director of Health Services (DHS) revealed that her expectation is that facial hair be removed per a resident's request. The resident does not have to wait for a long period of time or their shower days to be shaved.

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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** 36377 Based on observations, resident and staff interviews, and record review, the facility failed to ensure unauthorized and expired medications were not stored at the bedside of one of 28 residents (R) (R16). The deficient practice had the potential to allow unauthorized access of unsecured medications to residents and visitors. Findings included: A facility policy on self-administering medications was requested but not provided. Record review for R16 revealed diagnoses of but not limited to unspecified dementia, paroxysmal atrial fibrillation, chronic kidney disease, stage 4 (severe), and pulmonary hypertension. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 indicating little to no cognitive impairment. Continued review revealed that R16 was not assessed to self-administer medications. Observation on 10/29/2024 at 9:53 am revealed a bottle of expired prescription medication labeled premium saline moisturizing nasal spray sitting on the bedside table within view from the doorway. The instruction on the bottle stated give every six hours for congestion and dryness. Continued review of the bottle label listed R16's name and a discard date of 10/28/2023. Interview at time of observation on 10/29/2024 at 11:58 am with R16 and Licensed Practical Nurse (LPN) RR confirmed the medication was in the room. LPN RR removed the medication and revealed that residents are not allowed medications in their room unless they are assessed. R16 acknowledged the medication and revealed using the medication occasionally. R16 revealed being unaware that the medication was expired. Interview with the Director of Health Services (DHS) on 11/1/2024 at 4:13 pm revealed she was not aware of prescription medication in R16's room and acknowledged that R16 was not assessed to self-administer medications. She revealed that residents using expired medication was a risk factor to a resident's health, and that staff are supposed to monitor the resident room for safety.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on resident and staff interviews, record review, and review of the facility's policy titled, Advance Directives, the facility failed to provide residents and/or representatives written information with options regarding their right to accept or refuse medical or surgical treatment for four Residents (R) (R52, R65, R15, R29) out of a sample size of 28 residents reviewed. This failure denied the residents and/or representatives the opportunity to have choices and preferences with their health care decisions and formulating an Advance Directive. Findings included: Review of the policy titled Advance Directives dated 2014, under Procedure revealed, Prior to, or upon Admission, the patient/resident and/or their responsible party will be asked about the existence of any advance directives. The Advance Directive Checklist, which is in the Georgia Admission Packet, will be completed. 1. Record review revealed R52 was admitted to the facility on [DATE] with diagnoses not limited to chronic diastolic congestive heart failure, occlusion and stenosis of bilateral carotid arteries, cardiac murmur, and chronic obstructive pulmonary disease unspecified. Review of the Quarterly MDS assessment dated [DATE] revealed R52 had a BIMS score of three which indicated severe cognitive impairment. Review of the medical record revealed an Advanced Directive & Advance Directive checklist document titled GA (Georgia) Advance Directive of Healthcare dated 3/23/2020. Further review of the document revealed that the document did not include or show signed acknowledgement of receipt or evidence that the facility provided R52 and/or responsible party with written information pertaining to their right to accept or refuse medical and/or surgical treatment. 38154 2. Review of the clinical record revealed R65 was admitted to the facility with diagnoses to include bipolar disorder, major depressive disorder, anxiety disorder, post-traumatic stress disorder, and dementia. Review of the Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment and diagnoses that included manic depression (bipolar disease) and post-traumatic stress disorder (PTSD). Continued review of the clinical record revealed no evidence of an Advance Directive Checklist to inform R65 of the right to refuse medical or surgical treatment. Interview on 11/01/2024 at 4:32 pm with the Social Services Director (SSD) confirmed R65 did not have an Advance Directive Checklist in the clinical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45811 3. Review of the electronic medical record for R15, medical diagnoses included adult hypertrophic pyloric stenosis, muscle weakness (generalized), difficulty in walking, need for assistance with personal care, personal history of traumatic brain injury, chronic pain syndrome, anxiety disorder, major depressive disorder, recurrent, moderate, psychotic disorder with delusions due to known physiological condition, anoxic brain damage, generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus. Review of Physician orders included code status: DNR (Do Not Resuscitate). Interview on 11/1/2024 at 4:32 pm with the SSD revealed the Nurse Navigator got the Advanced Directive signed, and when the Medical Director came to the facility, it is signed by him. The SSD made sure there was an order related to the advance directive; she would make any necessary changes to the care plan, and then the banner was changed to reflect code status. Further interview revealed the Advavanced Directive forms she provided tothe survey team were the only forms they had. Interview on 11/1/2024 at 5:15 pm the Administrator revealed they did not use the Advanced Directive Checklist that they had used in the past. He revealed the form they have now is a revised version of the old checklist and the information was the same. 49675 4. Review of the medical record for R29 revealed no signed acknowledgement or evidence that the resident, or the resident's representative, was provided written information about the right to accept or refuse medical or surgical treatment. Record review revealed R29 was admitted to the facility on [DATE] with diagnoses that included but not limited to, respiratory failure, muscle weakness, need for assistance with personal care, type 2 diabetes mellitus without complications. Review of the Quarterly MDS assessment dated [DATE] revealed R29's cognition was intact with a BIMS score of 14. Interview on 11/1/2024 at 4:32 pm with the SSD revealed that she was unaware if the facility currently asked or provided residents, or resident representative's, information about the resident/representative's right to accept or refuse medical or surgical treatment. The SSD confirmed there was nothing in R29's record that showed the resident was provided written information. She explained that the Nurse Navigator gets the advanced directive signed and then the doctor signed it. The code status was then placed on the medical record banner and updated in the care plan.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 [NAME], [NAME] Based on observations, staff interviews and record reviews, the facility failed to ensure the facility was maintained in a safe, clean, and homelike environment on three of eight halls (Hall 600, 700, and 800). Specifically, the facility failed to replace a stained pillow for R53, failed to ensure the common area on two halls were free of trip hazards from electrical sockets on the floor on the 700 and 800 halls, failed to repair one cracked toilet on the 600 hall, and failed to maintain the sanitation of three water fountains covered in a thick beige/white hard scale substance. The deficient practice had the potential to cause an unsafe and unsanitary environment. Findings included: A facility policy on environment was requested but not provided. 1. Observation on 10/30/2024 at 11:00 am on the 700-hall common area revealed the electrical socket was in the floor. There was one lamp on each end of the couch. Each lamp was plugged into the electrical socket near the hallway. The lamp farthest away from the socket had a cord running behind the couch that was visible to residents and about 6 inches from the base of the couch. Observation on 10/30/2024 at 11:10 am on the 800-hall sitting room revealed the electrical socket was on the floor and the left corner of the socket was raised about 1.5 inches above the wooden floor; the socket was 6-8 inches in front of the furniture. Observation and interview on 11/1/2024 at 9:00 am with the Maintenance Director (MD), he confirmed issues with electrical outlets on the 700 and 800 halls. He stated he would get the issues fixed on the 700 hall and he pushed the couch closer to the socket and put the cord under the couch. Barber, [NAME] 2. Observation on 10/29/2024 at 9:59 am, 10/30/2024 at 12:55 pm, 10/31/2024 at 1:00 pm, and 11/1/2024 at 1:30 pm on the 200 and 800 Halls revealed three public drinking water fountains, accessible for residents, visitors and staff to use for hydration. A closer observation revealed two of the water fountains on 800 hall and one of the fountains on 200 Hall, the spout and basin of the fountain were coated with a thick beige/white hard scale substance. 3. Observation on 10/29/2024 at 10:49 am, 10/30/2024 at 1:00 pm, 10/31/2024 at 11:01 am, and 11/1/2024 at 1:15 pm of room [ROOM NUMBER]'s bathroom revealed, the commode had a large diagonal crack at the base. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the environmental tour of the facility beginning on 11/1/2024 at 1:30 pm with the Administrator, Director of Health Services (DHS), and Maintenance Director, all three observed and confirmed that the drinking water fountains served as hydration for the facility residents, had build-up noted, and they revealed they were not aware of the condition of the fountains. The Administrator stated he would have the Maintenance Director turn off the water flow immediately and have housekeeping staff clean the water fountains. Administrator revealed his expectation was that the housekeeping department cleaned the fountains and monitored them for calcium built up. The Maintenance Director reported that water fountains were included in the testing for legionella and there were no findings. Interview on 11/1/2024 at 2:04 pm with the Maintenance Director and the Administrator, both confirmed the cracked toilet base in room [ROOM NUMBER] was broken and needed repair. They revealed they were unaware it was broke, and repairs would begin today. 49675 4. Review of the medical record revealed R53 was admitted with diagnoses of but not limited to muscle weakness (generalized), dysphagia, oropharyngeal phase, need for assistance with personal care, type 2 diabetes mellitus without complications. Observations on 10/29/2024 at 1:29 pm, 10/30/2024 at 8:30 am, and 10/31/2024 at 9:46 am revealed R53 lying on a soiled, yellow stained pillow without a pillowcase. Interview on 11/1/2024 at 5:53 pm the Director Health Services (DHS) revealed her expectations were that anyone working with the resident could replace a soiled pillow. If a pillow was observed to be discolored or soiled it should be replaced and a clean pillowcase should be provided. She also revealed her expectation that call lights be within reach of the residents.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 38154 Based on interview and review of the facility's policy titled, Grievances: Healthcare Centers, the facility failed to ensure residents were informed of the name of the Grievance Official and how to file a grievance. Spceifically, the facility failed to ensure that all residents who resided in the facility were knowledgeable of the grievance process. Findings include: Review of the facility policy titled, Grievances: Healthcare Centers, revised 1/10/2024 revealed the following under Policy Statement: The Administrator of each healthcare center serves as its grievance official and is responsible for the following: overseeing the grievance process; receiving and tracking grievances through to the conclusion; leading necessary investigations; maintaining confidentiality of all information associated with grievances (for example, the identity of the patient for those grievances submitted anonymously); issuing written grievance decisions to the person who filed the grievance (if known); and coordinating with state and federal agencies as necessary in light of specific allegations. During the Resident Council review meeting on 10/29/2024 at 2:18 pm, when asked if the residents knew how to file a grievance or the name of the Grievance Official, three of seven residents that attended the council meeting stated they did not know the answer to either. During the Resident Council review meeting, the council President stated the Grievance Official was the Social Services Director, however the Activities Director (AD) did not confirm it. The AD stated she was new to the position and recorded the first meeting as AD last month. She revealed she did not review resident rights, filing a grievance, or review the name of the Grievance Official during that meeting and did not recall if they were discussed in the past. AD revealed she would add those items to the agenda moving forward. Review of the Resident Council meeting minutes dated 10/30/2023 through 9/30/2024 revealed the topic of resident rights, filing a grievance, and the name of the Grievance Official were not discussed.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45811 Based on observations, staff interviews, and record review, the facility failed to submit applications for Level II PASARR (Pre Admission Screening and Resident Review) to the appropriate state designated mental health authority for evaluation and determination of the need for specialized services for five of five sampled residents (R) (R15, R16, R61, R65, R23). This deficient practice increased the potential for residents with mental health diagnoses not to receive care and services to maintain or improve their quality of life. Findings included: A facility policy on PASARR was requested but was not provided. 1. Review of electronic medical records for R15 included medical diagnoses, personal history of traumatic brain injury, chronic pain syndrome, anxiety disorder, unspecified, major depressive disorder, recurrent, moderate, psychotic disorder with delusions due to known physiological condition, anoxic brain damage. Physician orders included amitriptyline tablet; 50 mg (milligram) 1 tab (tablet) at bedtime, clonazepam 2 mg for anxiety every 6 hours, Cymbalta delayed release 60 mg daily, levetiracetam 750 mg 2 tabs twice a day, Seroquel 25 mg 1 tab at bedtime. Interview on 10/31/2024 at 3:30 pm with the Social Service Director (SSD) revealed R15 had a PASARR Level I but no level II. R15's diagnoses were reviewed with the SSD, and she confirmed the resident had diagnoses of Psychosis and major depressive disorder, and confirmed other diagnoses listed in the electronic medical record. The admission diagnoses included anxiety, and major depressive disorder. Psychotic disorder with delusions was diagnosed on [DATE]. The SSD stated if there was a new diagnosis after admission she would apply for a level II. Continued interview with SSD revealed R15 had a psychiatrist when first admitted , and she talked with R15 and will start services with psych/behavioral services. Interview on 10/31/2024 at 3:40 pm with the regional nurse consultant revealed if there was a change in diagnosis after a resident's admission, there should be a system in place to monitor for additional psychiatric diagnosis. Interview on 11/1/2024 at 4:00 pm with the Director of Health Services (DHS) revealed the SSD took care of getting the PASARR Level II for residents with severe mental disorders. 36377 2. Record review revealed R16 was admitted on [DATE] with diagnoses of anxiety and dementia, with dementia being the primary diagnosis. Resident had an order for psychiatric services and received psych counseling services for anxiety during her stay. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Physician Order Form (POF) dated October 2024 revealed R16 received the following medications, alprazolam (Xanax) 1 mg tablet twice a day (order start date 5/9/2024). Resident also had an order for Effexor 75 mg twice a day (start date 6/1/2023). Record review revealed no PASARR Level ll. Review of progress notes revealed R16 had a history of displaying irrational behaviors since admission as defined/documented in the care plan. Record review revealed a care plan created 4/21/2022 (last revised 4/10/2024) documented and identified problems as irrational behaviors of, canceling medical appointments, refusing care, refusal for family to receive notifications about her significant changes, making false allegations regarding her care, keeping over the counter medications at her bedside, etc. Interventions included respect resident's right to refuse care/treatment, avoid power struggles with resident, maintain a calm environment and calm approach to the resident, and psych eval prn (as needed). 3. Review of the medical record revealed R61 was admitted with the following diagnoses, Major Depressive Disorder recurrent moderate (onset 6/14/2023), and later Post Traumatic Stress Disorder (PTSD) (onset 9/15/2023). Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], and Quarterly MDS dated [DATE], revealed an assessment coding for PTSD and Depression. R61 's Brief Interview for Mental Status (BIMS) score was 13 which indicated little to no cognitive impairment. Record review revealed no PASRR Level ll. Interview on 10/29/2024 at 10:10 am, R61 reported not receiving counseling psych services and had a desire to receive counseling services. R61 reported having depressed moods from loss of her husband due to his death. Resident also reported depressed mood about wanting to return home in the community. Review of Physician Order Form (POF) orders from June 2023 thru October 2023 (Date of Admission 6/14/23) revealed no order for psych eval. Review of R61's POF and Medication Administration Record (MAR) revealed that R61 was receiving the following medications, Cymbalta 30 mg for depression and received melatonin for sleep aide 3 mg; amt: 2 tablets at bedtime prn (as needed). Review of the Annual Social Psychosocial assessment dated [DATE] completed by the SSD documented and notated on the form that R61 did not have a PASRR Level ll. There was documentation on the form that described R61's behaviors as: having problems with noise, being frightened of situations of unknown thing, and experiencing depression at times. Interview with SSD on 10/30/2024 at 3:53 pm, SSD confirmed that R61 did not have a PASRR Level ll. Interview on 10/30/2024 at 4:02 pm, the Medical Records staff member confirmed that R61 did not have a PASARR Level II. 38154 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the clinical record revealed R65 had diagnoses of but not limited to sepsis-(primary admitting dx), altered mental status, bipolar disorder, anxiety disorder, major depressive disorder, post-traumatic stress disorder (PTSD), and dementia. Review of the Admission MDS assessment dated [DATE] documented in Section A-1500 that R65 had not been evaluated for a Level II PASARR and determined to have a serious mental illness and/or mental retardation or a related condition. In addition, the assessment documented medications received during the seven-day lookback period included antipsychotic (routine), antidepressant, and opioid medications for all seven days. Review of the care plan dated 9/26/2024 revealed a focus area to include psychotropic drug use related to side effects from antidepressant, anti-anxiety, and antipsychotic medications. Interventions included monitor for side effects and psych consultation as ordered. Review of the list of PASARR level II residents revealed only two residents listed and did not include R65. Interview on 11/1/2024 at 4:32 pm the SSD confirmed there was no PASARR level II on file for R65 and she had not submitted an application even though R65 may qualify for psych services based on her diagnoses. 49675 5. Record review revealed R23 admitted on [DATE] with diagnoses not limited to depression; dementia without behavioral disturbance; psychotic disturbance; mood disturbance and anxiety disorder. Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 8 indicating moderate cognitive impairment. The MDS also indicated R23 took antipsychotic, anti-depressant, and antianxiety medications. Review of the care plan dated 10/29/2024 revealed R23 had behavioral symptoms indicating a history of yelling out and/or banging on the wall/window for assistance without using call light. R23 had a history of refusing medications, refusing labs (UA and blood work), and refusing to be weighed. Interventions included obtain a psych consult/psychosocial therapy, behavior management as needed, assess whether the behavior endangers the resident and/or others, intervene if necessary. The care plan also revealed R23 received psychotropic medication for treatment of depression, anxiety, insomnia and agitated psychosis. Review of R23's medical record revealed no evidence or documentation of a Level II PASARR referral or assessment. Interview on 11/1/2024 at 4:32 pm with the SSD revealed she had not made any Level II referrals since working at the facility. She further revealed she was not sure if R23 had been screened for PASARR Level II services in the past, but she had not done so. The SSD revealed she thought only residents with the diagnosis of schizophrenia required a PASARR level II. She was unsure of any other diagnosis that would trigger a level II assessment, revealing she did not know the criteria.

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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** 36377 Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Care Plans, the facility failed to develop and/or implement a comprehensive care plan for five of 28 sampled residents (R) (R36, R52, R56, R25, R65). Specifically, the facility failed to implement care plans for activities of daily living (ADL) and incontinence care for R36 and R52; psychiatric services for R25 and R65; and vision services for R56. These deficiencies had the potential to adversely affect their quality of care and services, as well as their quality of life. Findings included: Review of the facility policy titled Care Plans revised 7/27/2023 revealed 3. The comprehensive person-centered care plan is developed to include measurable goals and timeframes to meet a patient/resident's medical, nursing, and psychosocial needs, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial needs that are identified in the comprehensive assessment. 1. Review of medical record revealed R36 had diagnoses of but not limited to atrial fibrillation, vertigo of central origin dizziness and giddiness, atherosclerotic heart disease of native coronary artery. Interview on 10/31/2024 at 1:00 pm R36 revealed her had not received showers per the bath schedule, and her preference on the weekend. R36 also reported she had missed showers during the weekdays. Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated little to no cognitive impairment and was dependent on staff for assistance with bath and grooming. Review of facility form titled Bath/Shower Log (bath sheets) documented R36 was scheduled on Tuesday, Thursday, and Saturday, preference was a shower. The log sheets revealed missed showers days on Saturday as, 10/12/2024, 10/17/2024, and 10/26/2024. The log sheet revealed on 10/15/2024 resident was given a bed bath which was not her preference. Review of the Activities of Daily Living (ADL) skills care plan created 2/24/2023 (last reviewed 2/26/2024) identified a problem, ADL decline related to CAD (Coronary Artery Disease, CHF (Congestive Heart Failure), and Dementia. Intervention and goal included, ADL needs will be met; independence potential maximized within constraints of disease. Observation on 10/31/2024 at 10:00 am to 1:20 pm revealed R36 lying in bed, room door open and strong odor of urine noted in the room and hallway. A closer observation revealed bed linen soiled and a deep dark greyish color spot the size of resident's body frame from his shoulder to his thigh. Staff could be observed passing by the room, and no staff entered the room. (continued on next page)

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	115326	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Magnolia Manor	3003 Veterans Parkway S Moultrie, GA 31788

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/1/2024 at 1:27 pm, Unit Manager/Register Nurse (RN) CC reported being unaware of R36 having missed showers, and baths not given per resident preferences. She reported that weekend staff are responsible for ensuring resident's received showers. 2. Record review of R52's medical record revealed diagnoses of but not limited to vascular dementia, chronic diastolic congestive heart failure, cardiac murmur, and chronic obstructive pulmonary disease. Observation on 10/29/2024 R52's room had a very strong urine smell and resident lying in bed. Resident's eyes were closed, the bed linen was soiled, and brief appeared heavy and soiled. Observation on 10/31/2024 at 10:00 am to 1:20 pm R52 was lying in bed soiled, wet, and brief appeared heavy and puffy with urine. The bed linen has a large circle dark greyish color covering over half of the bed, room had a strong urine smell, and near the pillow was a large dark brownish color stain. R52 reported being in his urine and wet since last night. He reported that staff refused to get him up. R52 reported that he can use the bathroom with staff help. He was too weak to walk by himself. He reported that this happened often. He reported that the morning shift is no help either. Review of the Quarterly MDS assessment dated [DATE] revealed R52 was dependent for bath/showering, wheelchair for ambulation, personal hygiene, and toileting, can be independent with staff assisting with ambulation. BIMS score of three which indicated cognitive impairment. Resident assessed for frequent incontinent for bowel and bladder (not assessed for a bowel and bladder program). Review of R52's care plan created 12/19/2022 identified a problem,with start date 12/19/2022-Category: Urinary Incontinence, risk for B&B incontinence due to impaired cognitive status, potential side effects of psychotropic medications, diuretic, impaired mobility and end of life. Interventions included, provide assistance with toileting as needed, and provide incontinent care after each incontinent episode. Review of the care plan created 4/11/2022 identified a problem, Bowel and bladder incontinence (category prevention of pressure injuries) to address pressure injuries. Interventions included, provide incontinence care after each incontinent episode and keep linens clean and dry. Observation on 10/29/2024, R52 was observed lying in bed, eyes closed. A strong odor of urine could be smelled from the hallway. Interview and observation on 10/31/2024 at 9:00 am R52 reported being soiled and wet since last night. R52 continued to report staff refused to change him and assist him to the bathroom. Interview with 10/31/2024 at 12:54 pm Unit Manager/RN CC-reported that R52 was dependent for staff taking him to the bathroom due to weakness and mental status. R52 had a history of wanting to remain in bed. Staff was expected to provide incontinent care and checks every two hours and take resident to the bathroom. Interview on 10/31/2024 at 1:21 pm with the Hospice Certified Nursing Assistant (CNA) confirmed not checking the resident for incontinent care services until 1:10 pm. She revealed she arrived to work at 7:00 am and was busy with other assigned residents. She denied shortage of staff. She stated that R52 always wanted to go back to bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/31/2024 at 1:45 pm, CNA QQ confirmed entering the resident room that morning at 8:00 am. She reported observing the resident asleep and not stopping to check the resident for incontinent care. She reported R52 required assistance to go to the bathroom and was on a B & B (bowel and bladder) program. They were required to check the resident every two hours. The resident wears a brief. If the resident does not want to get up he can be changed in bed. Interview on 11/1/2024 at 1:01 pm the Director of Health Services (DHS) reported expectation of staff. She revealed that her expectations for the night shift and all staff to follow the care plans and provide the resident's with incontinence care every two hours. Interview on 11/1/2024 at 3:40 pm MDS revealed her expectation was that staff follow the care plan for residents who required incontinent care. 38154 3. Review of the clinical record for R65 revealed diagnoses included sepsis (primary/admission), altered mental status, bipolar disorder, anxiety disorder, major depressive disorder, post-traumatic stress disorder (PTSD), and dementia. Review of the Quarterly MDS assessment, dated 10/25/2024, documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated little to no cognitive impairment. Review of the Care Plan, dated 9/26/2024, revealed focus area concerns to include psychotropic drug use related to side effects from antidepressant, anti-anxiety, and antipsychotic medications with interventions to include monitor for side effects and psych consultation as ordered. Interview on 10/30/2024 at 3:50 pm with R65 in her room, she stated she was not currently receiving psych services but had received counseling in the past. R65 revealed she was interested in receiving counseling services again. Interview on 11/1/2024 at 4:32 pm the Social Services Director confirmed she had not submitted a PASARR II (Preadmission Screening and Resident Review) to the appropriate authority for mental health and R65 had not received psychiatric services at this time even though for her diagnoses indicated she might receive some benefit from them. Interview on 11/1/2024 at 6:15 pm the DHS confirmed R65 had not received psychiatric, or counseling services related to her diagnoses of PTSD, confirmed psych services was a documented intervention in R65's care plan, and confirmed these services might help to improve her quality of life. 49675 4. Review of R56's medical record revealed he was admitted with diagnoses of but not limited to heart failure, need for assistance with personal care, muscle weakness (generalized), dementia, Xerosis cutis, and peripheral vascular disease. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R56's Quarterly MDS dated [DATE] revealed a BIMS score of 10, indicating moderate cognitive impairment. His care plan last reviewed on 10/10/2024 revealed, problem: Resident has impaired vision R/T (related to) cognitive impairment. Goal: Resident will not experience negative consequences of vision loss as evidenced by remaining physically safe and participating in social and self-care activities Approach: Arrange ophthalmologist/optometrist consult, prn (as needed). Implement recommendations: as indicated. Assure that the lenses of the glasses are clean and in good repair. make sure call light is within reach. Record review revealed a progress note dated 5/1/2024 that confirmed the resident had an eye exam and glasses were recommended. However the resident never received eye glasses. Interview on 11/1/2024 at 2:37 pm with Licensed Practical Nurse (LPN) HH who is also an MDS Coordinator revealed if a resident saw an eye doctor and got orders or recommendations for new glasses, it would be discussed at the morning meeting the facility has and the care plan would be updated to include the recommendations. She revealed it would be up to the DHS/Unit Managers to ensure the resident received eyeglasses. Interview on 11/1/2024 at 5:53 pm with the DHS confirmed that social services should be following through with eye glass prescriptions. DHS revealed MDS enters care plans. The interdisciplinary team (IDT) discusses as a group in morning meetings and all changes are discussed. Her expectations are that staff follow and implement care plans. 5. Review of R25's medical record revealed she was admitted with diagnoses of but not limited to muscle weakness (generalized), acute chronic diastolic (congestive) heart failure, type 2 diabetes mellitus with other specified complication, anxiety disorder, and depression. R25's Quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating cognition was intact. Section D indicated that she sometimes socially isolates herself and feels sad. Her care plan last reviewed on 9/17/2024 revealed, problem: risk for potential side effects of psychotropic drug use used to treat anxiety and depression. Goal: Patient/Resident will benefit from medication use without side effects through next review. Approach: Assess and implement non-drug intervention, monitor side effects, Pharmacist to review medications, psych consult. Record review revealed a psychiatric consult had not occurred. Interview on 11/1/2024 at 4:32 pm with Social Services revealed if someone wants or needs psychiatric services they would be referred. Social services confirmed that a psychiatric consult had never occurred because a referral had never been made. Interview on 11/1/2024 at 5:53 pm with the DHS confirmed that social services should be following through with psychiatric referrals. The DHS revealed MDS enters care plans. The interdisciplinary team (IDT) discusses as a group in morning meetings and all changes are discussed. Her expectations are that staff follow and implement care plans.

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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, resident and staff interviews, and record review, the facility failed to provide Activities of Daily Living (ADL) care for six of six residents (R) (R36, R52, R72, R29, R56, and R23) according to the residents care needs. Specifically, the facility failed to ensure that fingernails were trimmed and clean for (R72, R29, R56, R23); failed to ensure incontinence care was provided for R52, and failed to provide a bath/shower on the weekend for R36. Findings included: 1. Record review revealed R36 had diagnoses of but not limited to, vertigo of central origin, dizziness and giddiness, repeated falls, atrial fibrillation, pain in left/right knee, chronic kidney disease stage 3, and systolic (congestive) heart failure. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated little to no cognitive impairments and required assistant with bath/showers/grooming. During the initial tour of the 600 Hall on 10/29/2024 at 11:02 am, R36 was observed with a lot of whiskers and facial hair the size of a fingertip spread across the chin. Additional observations on 10/30/ 2024 at 1:00 pm and 10/31/2024 at 8:01 am revealed R36's facial hair remained intact. Interview at the time of observation on 10/29/2024 at 11:02 am, R36 reported receiving no assistance from staff with removing the hair from her chin. She reported having the facial hair on her chin for approximately two weeks. Resident reported being informed to wait until her shower days (Tuesday, Thursday, and Saturday) for facial hair removal. Review of R36's record revealed missed showers and baths not given based on the resident preferences. During a follow-up interview on 10/31/2024 at 1:00 pm, regarding her facial hair, R36 disclosed that she was upset about not receiving a shower on the weekend. R36 confirmed her shower days were Tuesday, Thursday, and Saturday. She stated that the weekend staff, certified nursing assistants (CNAs) and nurses had informed her that showers are provided only during the weekdays (Monday through Friday) by the facility Bath Team. Resident reported on the weekend she had to wash at the sink using a washcloth provided by the CNAs. R36 reported not being able to provide a clean, thorough wash for herself due to her physical limitations. Resident stated that the shower was in her bathroom, but no one wanted to take the time to assist her to the shower. She reported that she informed the weekend nurse. After she was told no several times about the shower from a nurse and CNA, R36 reported that she stopped asking staff. She also reported missed showers during the weekdays on several occasions from the bath team. Record review of R36's Bath Sheets revealed the following days missed shower/bath on the weekend/Saturday for room [ROOM NUMBER] (which was a private room): 10/12/2024 no bed bath /shower-Saturday. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/15/2024-received a bed bath which was not her preference-Tuesday. 10/17/2024-did not received a shower or any form of bath-Thursday. 10/26/2024-no bed bath/shower-Saturday. Review of the care plan created 2/24/2023 (last reviewed 12/26/2024) documented Goal: Resident's ADL needs will be met, and independence potential maximized within constraint of disease. Interview on 11/1/2024 at 1:27 pm with the Unit Manager/Register Nurse (RN) CC reported being unaware that R36 was not receiving baths or showers per her preference and had missed showers. She revealed that weekend staff were responsible for giving the resident a shower/bath on the weekend. 2. Review of R52's medical record revealed diagnoses of but not limited to vascular dementia, chronic diastolic congestive heart failure, cardiac murmur, and chronic obstructive pulmonary disease. Observation on 10/31/2024 at 10:00 am to 1:20 pm R52 was lying in bed soiled, wet, and brief appeared heavy and puffy with urine. The bed linen had a large circle dark greyish color covering over half of the bed, room had a strong urine smell, and near the pillow was a large dark brownish color stain. R52 reported being in his urine and wet since last night. He reported that staff refused to get him up. R52 reported that he can use the bathroom with staff help. He was too weak to walk by himself. He reported that this happened often. He reported that the morning shift is no help either. Review of the Quarterly MDS assessment dated [DATE] revealed R52 was dependent for tub/showering, wheelchair for ambulation, personal hygiene, and toileting can be independent with staff assisting with ambulation. BIMS score of three which indicated cognitive impairment. Resident assessed for frequent incontinence for bowel and bladder (not assessed for a bowel and bladder program). Record review of R52's care plan created 12/19/2022 identified problem: Problem start date: 12/19/2022 Category: urinary incontinence, risk for B&B incontinence due to impaired cognitive status. Interventions included, provide assistance with toileting as needed, and provide incontinent care after each incontinent episode. Interview on 10/31/2024 at 12:54 pm Unit Manager/RN CC-reported that R52 was dependent for staff taking him to the bathroom due to weakness and mental status. R52 had a history of wanting to remain in bed. Staff was expected to provide incontinent care and checks every two hours and take resident to the bathroom. Interview on 10/31/2024 at 1:21 pm with the Hospice Certified Nursing Assistant (CNA) confirmed not checking the resident for incontinent care services until 1:10 pm. She revealed she arrived to work at 7:00 am and was busy with other assigned residents. Interview on 10/31/2024 at 1:45 pm, CNA QQ confirmed entering the resident room that morning at 8:00 am. She reported observing the resident asleep and not stopping to check the resident for incontinent care. She reported R52 required assistance to go to the bathroom and was on a B & B (bowel and bladder) program. They were required to check the resident every two hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/1/2024 at 3:00 pm CNA NN reported that R52 was always soiled and the bed linen was always soaked with urine. She reported that this happened often on the night shift. She reported that the resident will allow staff to change him as long as he goes back to bed. Interview on 11/1/2024 at 1:01 pm the Director of Health Services (DHS) reported expectation of staff. She revealed that her expectations for the night shift and all staff to provide the resident's incontinence care every two hours. DHS reported being familiar with R52's behavior and the preference to lie in bed but did not mind to be changed by staff. R52 should have more frequent rounds. Interview on 11/1/2024 at 1:33 pm, DHS reported that her expectations were that all residents receive a bath per their bath schedule and preferences. 49675 3. Review of R72's medical record revealed she admitted with diagnoses of but not limited to muscle weakness, occlusion and stenosis of carotid artery, chronic obstructive pulmonary disease, depression, Alzheimer's disease, and anxiety disorder. Review of the Annual MDS dated [DATE] revealed a BIMS score of 10, indicating moderate cognitive impairment. Section GG indicates the resident requires maximal assistance with personal hygiene. The care plan last reviewed on 9/19/2024 revealed the resident has a self-care deficit with activities of ADL's. Goal was to improve ADL function to maintain independence. The approach was to set up resident for ADL's, provide assistive device as needed. Observation on 10/29/2024 at 12:17 pm, 10/30/2024 at 2:20 pm, and 10/31/2024 at 9:04 am revealed R72's nails are long and soiled with a brownish yellow substance. 4. Review of R29's medical record revealed he admitted with diagnoses of but not limited to respiratory failure, muscle weakness, need for assistance with personal care, and type 2 diabetes mellitus without complications. Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14, indicating intact cognition. Section GG revealed the resident required partial or moderate assistance with bathing and hygiene. The care plan last reviewed on 10/24/2024 revealed resident has self-care deficit with ADL and mobility. The goal for resident, ADL needs will be met and independence potential maximized within constraints of disease through next review. Approach was to set up resident for ADLs, provide assistive device as needed, notify doctor of changes. Observations on 10/29/2024 1:56 pm, 10/30/2024 at 2:50 pm, and 10/31/2024 at 8:35 am revealed the resident's fingernails to be dirty with a brown substance. 5. Review of R56's medical record revealed he admitted with diagnoses of but not limited to heart failure, need for assistance with personal care, muscle weakness (generalized), dementia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R56's Quarterly MDS dated [DATE] revealed a BIMS score of 10, indicating moderate cognitive impairment. R56's care plan last reviewed on 10/10/2024 revealed resident has self-care deficit with ADL's and mobility due to the end of life and weakness. Goal is that the resident's ADL needs will be met by clean neat appearance through next review. Approach resident requires two person assist with ADL care, turning and repositioning, set up resident for ADLs, have consistent approach amongst caregivers, provide assistance daily and prn with ADL's. Observations on 10/29/2024 at 1:56 pm, 10/30/2024 at 2:28 pm, and 10/31/2024 at 8:58 am revealed the resident's fingernails to long and dirty with a brown substance. 6. Review of R23's medical record revealed she admitted with diagnoses of but not limited to hypertension, heart failure, non-Alzheimer's dementia, and hemiplegia. Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 8 indicating moderate cognitive impairment. Review of the care plan revealed resident has a self-care deficit with ADL's due to cognitive impairment, impaired mobility and potential side effects of psychotropic medications. Resident's ADL needs will be met, and independence potential maximized within constraints of disease through next review. Provide and assist with bath/shower as scheduled/desired. Provide and assist with daily dressing, grooming and hygiene task. Observations on 10/29/2024 at 11:45 am, 10/30/2024 at 2:10 pm, and 10/31/2024 at 8:52 am revealed the resident's fingernails to be long and soiled with a brownish yellow substance. Interview on 10/31/2024 at 12:25 pm CNA FF revealed that she does not provide nail care of any type to residents. She revealed nurses provide the care. Interview on 10/31/2024 at 12: 30 pm Registered Nurse (RN) EE revealed nail care was not as part of ADL care at the facility. She revealed CNAs when giving a bath, would clean the resident's nails, but cutting them was not standard ADL care. Interview on 10/31/24 at 12:46 pm RN CC revealed it was her expectation that staff, specifically CNAs, clean and trim resident nails when they are given a bath. She revealed they do not document whether or not it is done anywhere in the medical record including refusals. Interview on 10/31/2024 at 1:30 pm DHS revealed the facility did not have a policy on ADL care. On 11/1/2024 at 5:53 pm she confirmed that fingernails were to be cleaned during baths and trimmed when needed. Interview on 10/31/2024 at 2:00 pm with Unit Manager RN DD revealed that ADL care included eating, dressing, grooming, and hygiene. When asked if nail care was included, she did not know and would have to find out. Later, she revealed CNAs are allowed to clean and trim nails when needed or when resident asks. She does not know if it is captured anywhere such as in a progress note.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on resident and staff interviews, record review, and review of the facility's policy titled, Specialty Services: Dental Services Vision Services, Podiatry Services, Hearing Services, and Mental Health, the facility failed to obtain vision services for two of 28 residents (R) (R56 and R78). Findings included: Review of the facility's policy titled Specialty Services: Dental Services, Vision Services, Podiatry Services, Hearing Services, and Mental Health last revised on 1/3/2024 revealed, 2. Nursing partners shall encourage and assist the patient/resident in carrying out the specialty service physician recommendations and instructions. 3. The clinical records shall show documentation of all consultation by the specialty service provider and all recommendations and instructions on patient/resident care related to the specialty service. 1. Review of the medical record revealed R56 admitted with diagnoses of but not limited to heart failure, need for assistance with personal care, muscle weakness (generalized), dementia. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Review of the care plan last reviewed on 10/10/2024 revealed, Problem: Resident has impaired vision R/T (related to) cognitive impairment. Goal: Resident will not experience negative consequences of vision loss as evidenced by remaining physically safe and participating in social and self-care activities Approach: Arrange ophthalmologist/ optometrist consult, prn (as needed). Implement recommendations: as indicated. Assure that the lenses of the glasses are clean and in good repair, make sure call light is within reach. Interview on 10/29/2024 at 12:00 pm with R56 revealed he asked the surveyor if she knew why he never received his eyeglasses. R56 revealed he saw an eye doctor over four months and he had never received his glasses. Record review revealed a progress note dated 5/1/2024 that confirmed R56 had an eye exam and glasses were recommended. The note read New glasses will be ordered pending insurance/payer approval. Interview on 10/31/2024 with Social Worker (SW) at 4:40 pm revealed she was unsure about the status of R56's glasses, stating the provider usually sent them to the facility. SS revealed she would follow-up on the order for eyeglasses and get back with the surveyor. Interview on 11/01/2024 at 4:32 pm SW confirmed there was no follow-up regarding the ordering of the glasses and that R56 did not have glasses that were prescribed in May 2024. Interview on 11/1/2024 at 5:53 pm the Director of Health Services (DHS) confirmed that SW should be following through with prescriptions for F56's eyeglasses. The DHS confirmed that R56's glasses were never ordered. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	36377 2. Review of the medical record for R78 revealed diagnoses of but not limited to gastro-esophageal reflux disease without esophagitis, migraine, repeated falls, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and transient cerebral ischemic attack. Review of the Quarterly MDS assessment dated [DATE] documented a BIMS score of 14 which indicated little to no cognitive impairments. The MDS also documented R78 was assessed for adequate vision and corrective lens. During the initial tour on 10/29/2024 at 11:09 am, R78 was observed sitting close to his television and working on a word puzzle. A closer observation revealed eyeglasses (readers) with a broken frame being held up to the face by R78's right hand as he tried to complete the puzzle. Interview at the time of observation on 10/29/2024 at 11:09 am, R78 revealed that his eyeglasses were only readers and not prescription glasses. R78 reported being diagnosed with cataracts years ago and that his vision had worsened and was very blurry. R78 reported difficulty with watching television and trying to complete his word puzzles. He reported that his last eye appointment was a year ago prior to his nursing home admission. He reported informing an anonymous nurse and Certified Nursing Assistant (CNA) QQ about his vision and the broken glasses. R78 reported that the nurse informed him to wait until his daughter visited so that she could assist him with an appointment. R78 reported that he had been waiting for months. Interview on 10/31/2024 at 1:44 pm, CNA QQ reported being aware that R78 had problems with his vision, used readers (eyeglasses), and that the frame of R78's eyeglasses were broken. CNA QQ reported that she was under the impression that the SW was following up. Interview on 10/31/2024 at 2:06 pm the SW revealed being unaware that R78 had problems with his vision and had requested an eye examination. She reported being aware of R78's hobby of completing crossword puzzles and was aware of his broken eyeglass frames during her visit to the resident 's room. Furthermore, SW reported that if she was made aware by staff that R78 had vision problems, she would have made a referral to a known community optometrist that the facility used. SW reported that usually the resident would be seen within a couple of weeks by this community provider. She revealed that the admission process for eye examination screenings were that newly admitted residents who have been in the facility on the long-term care side for ninety days (90-day stay) would receive a screening by the facility contract vision providers. Any resident who had not met the 90-day stay requirement were referred to the community provider (optometrist). R78 was admitted to the Rehab Unit and later transferred to the long-term care side. Rehab residents are considered outpatient, and their days of stay in Rehab are not counted towards the 90-day stay. All resident's most likely had to be a long-term resident for 90 days to obtain referral to vision services with their contract vision provider. SW reported that her plan was to schedule R78 with an appointment. Interview on 11/1/2024 at 4:10 pm the DHS revealed that all resident's should be screened regardless of their status. She revealed being unaware that R78 had vision problems.

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Pruitthealth - Magnolia Manor	3003 Veterans Parkway S Moultrie, GA 31788

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, resident and staff interviews, and record review, the facility failed to follow an Occupational Therapy (OT) Restorative Nursing Program (RNP) recommendation for orthotic application (splint) for one of eight sampled residents (R) (R78) reviewed for ROM (Range of Motion) and mobility. The deficient practice had the potential to result in progression of contractures. Findings included: Review of the medical record revealed diagnoses of but not limited to a left-hand contracture. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating little to no cognitive impairment. Review of a physician order dated 8/29/2024 revealed, Patient to wear progressive resting hand splint to LUE (Left Upper Extremitties) digits/hand/wrist 6-7 hours daily, seven days/week as tolerated by patient once a day. Review of the OT plan of care dated 8/29/2024 revealed a recommendation and fitting for a left-hand splint device. Review of the care plan created 8/29/2024 included, to capture the use of a resting hand splint device, listed an intervention to wear splint device seven days a week from 7:00 am to 7:00 pm. Observations and interviews with R78, on 10/29/2024 at 10:05 am and 6:30 pm, and on 10/30/2024 at 8:30 am to 6:00 pm of R78 revealed no splint device on. R78 confirmed that staff were not assisting him with applying the splint. He reported he stopped asking staff after no one assisted him. R78 denied staff were applying the splint device. Interview on 10/31/2024 at 2:00 pm, Certified Nursing Assistant (CNA) QQ revealed being aware that R78 had a contracture and required splint use. CNA QQ revealed she worked Wednesday from 7:00 am to 7:00 pm and confirmed not applying the splint on R78's hand on Wednesday 10/30/2024 nor did she attempt to put the splint on today. Interview on 11/1/2024 at 4:01 pm, CNA NN revealed not always applying the splint on R78's hand. She was never informed or in-serviced to apply the splint device every day. She was not aware to place the splint on R78 seven days a week for 6-7 hours as tolerated. CNA NN revealed being assigned to work with R78 on 10/29/2024, and also acknowledged that she did not apply he splint device during her shift from 7:00 am to 7:00 pm. Interview on 11/1/2024 at 2:13 pm, the Therapy Director/Speech Therapist (ST) and Occupational Therapist (OT) confirmed the left-hand contracture and use of a splint device for R78. They revealed that R78 was discharged from therapy on 8/29/2024 to Restorative for hand splint application daily and ROM (Range of Motion). They reported that without use of the splint device daily, R78 was at risk for further contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/1/2024 at 2:05 pm, the Director of Health Services (DHS) revealed that her expectation was for staff to apply splint devices as ordered. She revealed that any nursing staff or certified nursing staff could apply the device.

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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 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** 36377 Based on observations, staff interviews, record reviews, and review of the facility's policy titled, Occurrence Reduction Program, the facility failed to ensure an environment free from potential accident hazards by failing to properly secure oxygen (O2) tank for one of 10 residents (R) (R16) receiving oxygen therapy. In addition, the facility failed to remove aerosol cans from the bedside for one resident (R47); and failed to provide adequate supervision for residents assessed as high risk for falls for three of 10 residents (R34, R75, and R65). Findings included: Review of the policy titled, Occurrence Reduction Program dated 2014 revealed under Policy Statement: This healthcare center recognizes that due to the frailty of the patient/residents served, there is an increased risk of occurrences that may result in injury to the patient/resident and/or others. In an effort to prevent occurrences, each patient/resident will be assessed for risk and appropriate and realistic interventions will be implemented upon identification of risk and after a fall. These interventions will be included in the care plan. 1. Review of R47's medical record revealed the resident was admitted with diagnoses of but not limited to transient cerebral ischemic attack, chronic obstructive pulmonary disease, muscle weakness, need for assistance with personal care, generalized anxiety disorder, and irritable bowel syndrome. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating little to no cognitive impairment. Interview and observation on 10/29/2024 at 4:56 pm revealed numerous aerosol cans stored in a plastic tote in R47's room. R47 revealed that she didn't understand why the tote couldn't be out on her table and had to be put into the closet. Numerous aerosol cans were found in the tote. There was also one aerosol can in the resident's bathroom. Interview on 11/1/2024 at 5:34 pm with Licensed Practical Nurse (LPN) KK revealed that residents were not allowed to have aerosol cans in their room. She revealed it was against company policy to have aerosols and revealed that not even housekeeping used them. Interview on 11/1/2024 at 5:53 pm with the Director Health Services (DHS) revealed her expectations were that no residents have aerosol cans in their rooms. If staff see them, they are to remove them and have family come and get them. 2. Record review of the medical record revealed R16 had diagnoses of but not limited to paroxysmal atrial fibrillation and primary pulmonary hypertension. Review of the Quarterly MDS assessment dated [DATE] assessed resident for a BIMS score of 15 indicating little to no cognitive impairments and an assessment for oxygen therapy use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record of Physician Order Form (POF) and the Medication Administration Record (MAR) dated October 2024 revealed an order for oxygen use. Review of a plan of care revealed oxygen use created 12/27/2022. Interventions included oxygen as ordered and oxygen saturations as ordered. Observation on 10/29/2024 at 9:52 am of room [ROOM NUMBER] revealed an oxygen cylinder tank free-standing on the floor and positioned next to the nightstand within view of anyone entering the resident's room. Interview on 10/29/2024 at 11:58 am with R16, Certified Nursing Assistant (CNA) NN, and Licensed Practical Nurse (LPN) RR, all parties confirmed that oxygen cylinder was in the room. Interview at that time with LPN RR revealed that the risk was that cylinder can tip over and explode. R16 reported that the O2 cylinder has been free-standing for almost a month in her room. She reported being aware of the risk of the O2 not being in a holder and had asked the staff to remove it on numerous occasions. Interview on 11/1/2024 at 4:13 pm with Director of Health Services (DHS) revealed being aware of the free-standing O2 cylinder after being informed by her staff. She confirmed this was a risk factor to the residents. She reported that staff are supposed to monitor the resident rooms for safety. 49675 3. Review of electronic medical records for R34, medical diagnoses included muscle weakness (generalized), need for assistance with personal care, aphasia, difficulty in walking, chronic pain syndrome, dementia, depression, psychotic disorder with delusions due to known physiological condition, Alzheimer's disease, and anxiety disorder. Review of Physician orders included duloxetine capsule, delayed release enteric coated (DR/EC) 30 mg (milligram) 1 cap (capsule) oral once a day, gabapentin capsule 300 mg 1 cap oral once a day, Seroquel (quetiapine) tablet 50 mg oral at bedtime, and tramadol Schedule IV tablet 50 mg 1 tab oral for moderate pain every 6 hours PRN (as needed). Review of the care plan included risk for falls related to impaired mobility, potential side effects of psychotropic medications, poor safety awareness, end of life and cognitive impairment with periods of delirium and modify wheelchair due to fall risk. Observation on 10/29/2024 at 10:00 am, R34 was lying in bed, right side of forehead was bruised; the resident was non-verbal. Observation and interview on 10/30/2024 at 10:00 am with LPN II revealed she provided morning medications to R34, she was moaning and stated she was in pain. LPN II stated R34 fell recently and that was where the facial bruises came from. LPN II remarked that since R34 fell she probably was hurting all over. There was no fall mat at the bedside. Observation on 11/01/2024 at 8:50 am revealed that the resident was sleeping in bed; fall mat leaning against the wall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 11/1/2024 at 9:00 am with LPN II confirmed R34's fall mat was leaning against the wall, and it should be on the floor. LPN II talked to the CNAs and asked them to make sure that residents who had fall mats ordered, that they are in the room and on the floor. Interview on 11/1/2024 at 1:00 pm with CNA AA revealed she made rounds on high risk fall residents at least every 30 minutes; the only bruise R34 had was the one on her forehead, and interventions to prevent falls, included make sure resident is dry and bed is in the low position with fall mat on floor. Interview on 11/1/2024 at 1:15 pm with CNA NN revealed to prevent falls, lower bed to lowest position, put brake locks on, and put a fall mat on the floor. Interview on 11/1/2024 at 2:42 pm with LPN/MDS Coordinator HH, revealed that in the Interdisciplinary Team (IDT) meeting staff will review facility activity report and will create the comprehensive care plan within 14 days of admission. Information related to falls comes from orders, diagnoses, and observations. There is input from the family. Falls are reviewed after the incident and information is put on the care plan. R34 fell out of the wheelchair and the intervention to modify the wheelchair was completed. Interview on 11/1/2024 at 5:57 pm with the Director of Health Services (DHS) revealed prevention was resident centered and they use interventions that are incident prevention. 4. Review of the electronic medical record for R75 revealed medical diagnoses (dx) included dementia, muscle weakness (generalized); Type 2 diabetes mellitus with diabetic polyneuropathy; pain in knee; depression, obstructive sleep apnea, low back pain repeated falls (12/26/2023), Alzheimer's disease, chronic pain and anxiety disorder. Review of Physician's orders included hydrocodone-acetaminophen tablet; 10-325 mg per hospice moderate pain 4-10 every 4 Hours PRN, lorazepam tablet; 0.5 mg; 1 tab; every 8 hours PRN, morphine concentrate 100 mg/5 mL (20 mg/mL); 0.25 ml oral. Review of the care plan included, Risk for falls related to impaired mobility, dementia, ensure proper footwear, landing pads on each side of bed, bed in low locked position, keep environment safe, assist for toileting and transfers PRN, cue for safety awareness, and place call light within reach. Observation on 11/1/2024 at 9:20 am, resident sleeping in bed, call light within reach, no fall mats at bedside. 38154 5. Review of the clinical record for R65 revealed admission to the facility with diagnoses to include generalized muscle weakness, need for assistance with personal care, pain, history of falling, altered mental status, displaced fracture of fifth metatarsal bone, left foot, initial encounter for closed fracture, acute kidney failure, hyponatremia, and difficulty in walking. Review of the admission MDS assessment dated [DATE], documented one fall with injury prior to admission. In addition, she received pain medicine as needed, antipsychotic, antidepressant, and opioid medications. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan revealed problem category dated 9/23/2024, risk for falls related to sepsis, UTI, AKI, AMS [altered mental status], left fifth toe fx [fracture]; resident will not sustain injury related to falling through next review. Approaches include [NAME] [Dysem] to w/c [wheelchair] for fall 10/29/2024; non-skid socks/footwear for fall on 9/29/2024; assist for toileting and transfers PRN [as needed] (9/23/2024); keep environment safe (9/23/2024); place call light within reach (9/23/2024). Review of the Progress Notes for R65 documented a fall on 9/29/2024 resulting in skin tear and right hip pain. Interview on 10/30/2024 at 3:50 pm with R65 in her room, she was alert, oriented, and pleasant. She stated she fell yesterday while trying to get into the bathroom in her wheelchair. She stated she couldn't get her wheelchair over the hump in the doorway and fell forward onto her head which caused swelling to the left forehead. She stated she called out for help to go to the bathroom because she could not reach the call light, but since no one came, she tried to go by herself. She stated she lay on the floor for what seemed like forever but was probably only about 15 minutes until someone finally heard her and came to her rescue. Review of the Progress Notes dated 10/29/2024 revealed no indication of neuro checks as indicated for fall with head injury or increased monitoring post fall. Interview on 10/30/2024 at 1:30 pm the Rehab Director stated R65 was safe for wheelchair mobility in and outside of her room but still required setup/clean-up assistance for chair/bed-to-chair transfers per the PT Therapy Progress Report date 10/26/2024. She stated R65 was cooperative and progressing as expected. Interview on 10/30/2024 at 3:50 pm Registered Nurse (RN) EE stated fall protocol dictated neuro checks for 48 hours, witnessed or not and residents with high fall risk should be monitored closely by all staff. Interview on 10/31/2024 at 5:30 pm the DHS stated she expected nursing staff to adhere to facility policy regarding high-risk falls which included neuro checks, notification to physician, family, and nursing leadership.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on staff interviews and record reviews, the facility failed to provide evidence that nutrition assessments were completed by the Registered Dietitian (RD) for three of three residents (R) (R66, R44, and R46). Specifically, they failed to complete an admission nutrition assessment for one resident (R66), and follow-up assessments for two residents (R44 and R46), who were identified with weight loss. Findings included: A facility policy on nutrition assessments was requested but not provided. 1. Record review revealed that R66 was admitted to the facility on [DATE] with diagnoses of but not limited to Alzheimer Disease, dementia, peripheral vascular disease, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] documented unable to determine Brief Interview for Mental Status (BIMS) score, which indicated severe cognitive impairment. Review of weights at the time of admission on 8/23/2024 documented 130 pounds (lbs). The most current weight on 11/1/2024 was 120 lbs. R66's height was 70 inches (6 feet). Review of the Physician Order Form (POF) included an order for regular puree diet, and an order for Ensure supplement. Review of the care plan for nutrition dated 8/26/2024 identified a problem: Expected to have hydration deficits related to end of life, cognitive impairment, and potential side effects of psychotropic/opioid medications. Review of the Nurse Practitioner's progress note documented R66 continues to decline. Staff reports are poor appetite. Requires total assist w/ADLs (with Activities of Daily Living). 7 lb weight loss over last month. Weight 121 lbs. on 9/1/2024. He transferred from another facility and was weighed on another set of scales. Record review revealed there was no admission nutrition assessment. 2. Review of the medical record revealed R44 had diagnoses not limited to gastro-esophageal reflux disease with esophagitis without bleeding, heart failure, and cardiopulmonary heart disease. Review of the Quarterly MDS assessment dated [DATE] documented a BIMS score of 14 that indicated little to no cognitive impairment. R44 was not assessed for weight gain/weight loss. Review of R44's POF revealed a diet order dated 2/25/2024 for liberalized diabetic NAS (no added salt), chopped. No supplements were added. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of weights at the time of admission on 2/9/2024 documented 208 lbs. The most recent weight was 167 lbs. on 10/1/2024. Height was 74 inches (6 feet and 2 inches). Record review revealed that R44 was last seen by the RD on 2/6/2024. The RD documented on 2/06/2024 at 10:39 am, reviewed: diet NAS liberalized diabetic diet; good po intake at meals. Suggest routine weights per protocol. RD will continue to follow with IDT (interdisciplinary Team). Review of the care plan created 1/10/2024 (last revised 10/10/2024) documented and identified a problem: At nutrition and/or hydration risk as evidenced by: Swallowing problem related to CVA (cerebral vascular accident) with right side hemiparesis, takes diuretic, receives a mechanically altered, therapeutic diet. Category Nutritional Status Start Intervention: record % of meal intake and obtain re-weights prn (as needed). 3. R46 was admitted with diagnoses of but not limited to Alzheimer's disease, cerebral infarction, hyperlipidemia, subsequent encounter, dementia in other diseases classified elsewhere, severe, with other behavioral disturbance. Record review of the Quarterly MDS dated [DATE] assessed a BIMS score of seven which indicates moderate cognitive impairment. Resident was assessed for weight loss. Review of admission weight revealed 181 lbs. and weight at the time of discharge was 130 lbs. on (9/12/2024). R46 was discharged on [DATE]. Resident 's height was 63 inches (five feet and three inches). Record review revealed that R46 was seen only twice by the Registered Dietician, on 5/24/2024 and 7/29/2024. The RD made a note at each visit of an identified weight loss. RD would document continue to monitor. On 7/29/2024, the RD documented significant weight loss of 14 lbs (8/9% x 90 days and 34lbs -19% x 6 months). Interview on 11/31/2024 at 1:20 pm, the Dietary Manager (DM) revealed that the RD was not available at this time. DM reported that she has been filling in with R46's reviews as far as managing the kitchen. The RD came at least twice weekly to perform oversight over the kitchen. Interview on 11/1/2024 at 3:10 pm with RD WW confirmed R66 was not seen by the RD for an admission assessment. RD WW confirmed that both R44 and R66 should have been seen monthly within the last few months based on their weight loss. RD WW revealed that they had hired a new RD to cover this area. This RD was from Florida and had not started yet. They anticipated her being on board very soon. She reported due to lack of coverage of RD's, several residents' nutrition assessments and evaluations were not done at the facility. The company had only one RD in the area, was working out of the Valdosta area and was currently assigned to 12 counties. She visited the facility to provide coverage including monitoring. The facility DM completed some of the weights, and monitoring diets, and made some recommendations. However, the clinical professional part of the assessment, and evaluations that involved professional recommendations, would need to be done by the RD per the State policy. RD WW revealed that her company followed State Regulations for the RD.

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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 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** 36377 Based on observations, resident and staff interviews, and review of the facility's policy titled, Oxygen Administration, the facility failed to ensure two of 10 residents (R) (R16 and R11) receiving oxygen therapy, oxygen tubing and nebulizer masks were covered, and did not rest on the floor. The deficient practice had the probability to increase the risk of infection for residents receiving oxygen therapy. Findings included: Review of the facility policy titled, Oxygen Administration, dated 2014 under Infection revealed, Control Policy of 02 Humidifier Bottles: Change all oxygen tubing when there is visible soiling with respiratory secretions and mucous and weekly. Clean exterior of concentrators weekly and between each patient/resident use with bactericidal surface cleaner. 1. Record review revealed R16 was admitted on [DATE] with Dx (diagnoses) of but not limited to paroxysmal atrial fibrillation, primary pulmonary hypertension, anxiety and dementia, with dementia being the primary diagnosis. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed resident for a Brief Interview for Mental Status (BIMS) score of 15 which indicated little to no cognitive impairments and an assessment for oxygen therapy use. Review of Physician Order Form (POF) and the Medication Administration Record (MAR) for October 2024 revealed an order for oxygen at two liters per milliliter via (by) nasal cannula continuous every shift daily. Review of the care plan created 12/27/2021 (last revised 9/17/2024) identified a problem, Risk for respiratory distress due to use of oxygen and wears a CPAP (Continuous Positive Airway Pressure) at night related/to obstructive sleep apnea and morbid obesity. Interventions included oxygen as ordered and oxygen saturation (O2 Sat) as ordered. Observation on 10/29/2024 at 9:52 am revealed one of two oxygen masks attached to the tubing was lying uncovered and on the floor underneath the bed. The other O2 mask was attached to the tubing and hanging on the wall uncovered. Observation on 10/29/2024 at 9:52 am of room [ROOM NUMBER] revealed an oxygen cylinder tank free-standing on the floor and positioned next to the nightstand within view of anyone entering the resident's room. Interview on 10/29/2024 at 11:58 am with R16, Certified Nursing Assistant (CNA) NN, and Licensed Practical Nurse (LPN) RR, all parties confirmed that oxygen cylinder was in the room. The oxygen cylinder was removed from the room by another staff. Interview at that time with LPN RR revealed that the risk is that cylinder can tip over and explode. R16 reported that the O2 cylinder has been free-standing for almost a month in her room. She reported being aware of the risk of the O2 not being in a holder and had asked the staff to remove it on numerous occasions. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/1/2024 at 4:13 pm the Director of Health Services (DHS) revealed being aware of the free-standing O2 cylinder after being informed by her staff. She confirmed this was a risk factor to the residents. She reported that staff are supposed to monitor the resident rooms for safety. 2. Review of medical diagnoses for R11 included, urinary tract infection, primary Dx; 8/27/24, muscle weakness (generalized), anxiety disorder, morbid obesity, sleep apnea, Type 2 diabetes mellitus, chest pain acute and chronic respiratory failure with hypercapnia, and shortness of breath. Review of Physician Orders in the electronic medical record for R11 included fluticasone furoate-vilanterol blister with device; 100-25 mcg/dose (microgram per dose), 1 puff, inhalation once a day; fluticasone propionate spray, suspension; 50 mcg/actuation, 1 spray; each nostril twice a day, ipratropium-albuterol solution for nebulization; 0.5 mg-3 mg (2.5 mg base)/3 mL, BIPAP (Bilevel Positive Airway Pressure)/CPAP: change respiratory supplies weekly on day shift, once a day on Monday, and as needed (PRN); change water in reservoir daily, use only distilled or sterile water. BIPAP/CPAP: settings: 14/6 during sleep with oxygen at 2 liters per minute mask; wash mask weekly with warm soapy water and allow to air dry once a day on Wednesday nights; Enhanced Barrier Precautions, pulse oximetry check PRN. Review of the care plan revealed, Risk for respiratory distress and requires continuous oxygen therapy and wears a BPAP at night related to chronic obstructive pulmonary disease (COPD), morbidly obese, and obstructive sleep apnea (OSA). Observation on 10/29/2024 at 10:00 am, oxygen equipment in the room was not being used by the resident. R11 revealed she did not use it all the time. The oxygen tubing was laying across the oxygen concentrator and not in a bag. Interview on 11/1/2024 at 12:49 pm with CNA AA related to respiratory care revealed the nurse deals with the tubing and the oxygen setting. CNAs check the saturation level when they get the vital signs. Interview on 11/1/2024 at 6:04 pm with the Director Health Science (DHS) revealed all residents do not have to have humidified oxygen. If they are dry or having problems the nurse may contact the doctor. She confirmed the nurses were responsible for changing tubing and tubing was not labeled when changed.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on resident and staff interviews, record reviews, and review of the facility's policy titled, Specialty Services: Dental Services, Vision Services, Podiatry Services, Hearing Services, and Mental Health, the facility failed to obtain mental health services for three of three sampled residents (R) (R61, R65, and R25). The deficient practice had the probability to affect the overall mental health status of residents requiring psychiatric services. Findings included: Review of the facility's policy titled Specialty Services: Dental Services, Vision Services, Podiatry Services, Hearing Services, and Mental Health last revised on 1/3/2024 revealed 2. Nursing partners shall encourage and assist the patient/resident in carrying out the specialty service physician recommendations and instructions. 3. The clinical records shall show documentation of all consultation by the specialty service provider and all recommendations and instructions on patient/resident care related to the specialty service. 1. Review of the medical record revealed R61 admitted with diagnoses of but not limited to major depressive disorder recurrent moderate (onset 6/14/2023), Post Traumatic Stress Disorder (PTSD) (onset 9/15/2023), and depression (onset 9/15/2023). Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] and Quarterly MDS dated [DATE] documented, Section I coded PTSD & Depression, and a Brief Interview for Mental Status (BIMS) score which indicates little to no cognitive impairment. Further review revealed no PASRR Level II was applied for or completed. Interview on 10/29/2024 at 10:10 am, R61 revealed they had not received counseling or psych services, and that services were never offered to her. R61 reported having periods of depression at times. She reported that somedays she was more depressed than others. Resident reported suffering loss from her husband's death. Review of Physician Order Form (POF) from June 2023 thru October 2023 (Date of Admission 6/14/2023) revealed no order for psych evaluation. Review of POF and the Medication Administration Record (MAR) revealed that R61 received Cymbalta 30 mg (milligram) two capsules delayed release daily for depression (start date 7/22/2024). R61 received melatonin for sleep aide (melatonin tablet; 3 mg; amt: 2 tablets at bedtime prn (as needed). Review of the facility document titled, Social Behavioral Symptom Eval dated 6-15-2023 completed by Social Services Director (SSD) did not capture the resident's PTSD diagnosis, psychotropic medications, history of emotional change or trauma. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Annual Social Psychosocial assessment dated [DATE] completed by SSD documented that R61 had problems with noise, being frightened of situations of unknown thing, and experienced depression at times. The SSD documented on the form that R61's relief was speaking, being able to speak with her son when behaviors occurred, and that R61 did not have a PASRR Level II. Review of Progress notes dated 10/1/2024 through 10/4/2024 documented R61 noted to have confusion of looking for husband, no UTI (urinary tract infection) noted. Record review of SBAR (Situation, Background, Assessment, and Recommendation) form dated 9/20/2024 at 3:56 pm documented, increased confusion looking for husband and not being able to find room. Physician notified suspected UTI -culture & lab done. Results UTI. SBAR dated 10/1/2024 documented, increase confusion and resident not eating, noted on form that episodes had happened before, physician was notified. Resident did not have a UTI per record. Review of the care plan created 9/22/2023 (last revised 10/9/2024) identified a problem, R61 makes non-factual statements, exhibits manipulative behaviors and has periods of delusions. Interventions included, follow up with [named] psych services, follow recommendations as indicated and refer for symptom and mental health evaluation. Interview on 10/30/2024 at 3:53 pm SSD revealed that she was informed by the psych counselor that R61 had refused counseling services on several occasions. SSD revealed that she had never had a conversation with R61 about receiving psych services and she had not addressed counseling services. R61 never verbalized to SSD that she did not want services. SSD was not aware that R61 was depressed. SSD revealed being aware that R61 preferred to be by herself and loved outdoors. SSD reported that in the past, she would follow up with the resident if counselor or psychiatrist informed her of the refusal or if resident refused to participate in counseling sessions. However, in R61's situations she never followed up. She reported that this was not documented. Interview on 10/30/2024 at 4:45 pm SSD provided surveyor with a copy of a document form used by their contract psych service counseling agency. SSD confirmed manually writing a statement on form Resident refused services. When SSD was asked why the resident did not sign the form SSD reported that the resident refused to sign the form. SSD reported that she was only following the instruction of one of her administrative staff, who asked to her to provide the form to the surveyor. SSD did not provide the administrator staff name. She stated that this person was not working in the building today. Interview on 10/31/2024 at 6:00 pm R61 revealed that the SSD took the form to R61 to sign while the surveyor was asking her about signing the form. R61 refused to sign the form because she did not recall speaking with anyone about refusing psych services in the past. 38154 2. Review of the clinical record revealed R65 was admitted to the facility with diagnoses to include sepsis (primary/admission), bipolar disorder, major depressive disorder, anxiety disorder, post-traumatic stress disorder (PTSD), and dementia. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly MDS assessment dated [DATE] documented a BIMS score of 13 indicating little to no cognitive impairment and diagnoses to include manic depression (bipolar disease) and post-traumatic stress disorder (PTSD). Review of the Care Plan dated 9/26/2024 revealed focus area concerns to include psychotropic drug use related to side effects from antidepressant, anti-anxiety, and antipsychotic medications with interventions to include monitor for side effects and psych consultation as ordered. Interview on 10/29/2024 at 4:59 pm with R65 in her room, R65 stated she had received psychiatric services in the past but not since she was admitted to this facility, and no one had spoken with her about it. Interview on 11/1/2024 at 4:32 pm the SSD confirmed R65 was not receiving psychiatric services at this time even though for her diagnoses indicated she might receive some benefit from them. Interview on 11/1/2024 at 6:15 pm the DHS confirmed R65 was not receiving psychiatric, or counseling services related to her diagnoses of PTSD and also confirmed these services might help to improve her quality of life. 49675 3. Review of R25's medical record revealed she was admitted on [DATE] with diagnoses of but not limited to muscle weakness (generalized), acute on chronic diastolic (congestive) heart failure, type 2 diabetes mellitus with other specified complication, anxiety disorder, and depression. Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, little to no cognitive impairment. Section D indicated that R25 sometimes socially isolated herself and felt sad. Review of the care plan, last reviewed on 9/17/2024 revealed, problem: Resident is at risk for potential side effects of psychotropic drug use used to treat anxiety and depression. Goal: Patient/Resident will benefit from medication use without side effects through next review. Approach: Assess and implement non-drug interventions, monitor side effects, Pharmacist to review medications, and psych consult. Record review revealed the resident was taking two anti-psychotics, risperidone 2 mg, and queatiapine 200 mg. Record review revealed a psychiatric consult had not occurred. Interview on 10/30/2024 at 12:01 pm with R25 revealed she felt sad and wanted someone to talk with. Interview on 11/1/2024 at 4:32 pm the SSD revealed if someone wants psychiatric services they would be referred. The resident must sign a consent for social services to make the referral. The SSD revealed if the psychiatric consult was listed on the resident's care plan that it would have been discussed with the Interdisciplianry Team (IDT). The SSD was unsure if she had made a referral for a psychiatric consult but confirmed it was listed on the care plan. She revealed she would follow up with the resident immediately. In a subsequent interview with the SSD, she confirmed that a psychiatric consult had never occurred because a referral had never been made. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/1/2024 at 5:53 pm the DHS confirmed that the SSD should be following through with psychiatric referrals. She stated that social services made referrals to psychiatric services, and she would document if the referrals were made. The DHS revealed her expectations were that staff refer residents for psychiatric services as indicated.

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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 review of the facility's policy titled, Labeling, Dating, and Storage, the facility failed to discard expired items, failed to label and date items in one reach-in refrigerator, one walk-in cooler, and one dry storage area. The facility also failed to ensure food was delivered to residents receiving meals in one of three dining rooms in a sanitary manner related to proper hand washing and sanitation during the delivery of food. This deficient practice had the potential to affect eight residents eating in the 500-hall dining room. The failure had the potential to promote foodborne illnesses associated with bacterial growth and cross-contamination for 89 of 91 residents who received an oral diet. Findings included: Review of the policy titled Labeling, Dating, and Storage revised on [DATE] revealed, 1. Food and beverage items will have an identifying label as well as a received date and opened date, as applicable; for items prepared onsite, a 'use by' date will also be indicated. 4. Food and beverage items will be discarded according to guidance from a government agency such as the USDA and FDA; an example of approved guidance is attached to this policy. The Dietary Manager (DM) was not present during the initial tour of the dietary department on [DATE]. Initial tour started at 9:00 am was conducted with Dietary Aide BB, and the following were observed, identified and confirmed: 1. Stand up cooler- There was one pitcher with a brown liquid that was not labeled or dated. One pitcher with a pale-yellow liquid that was not labeled or dated. One bottle of mayonnaise with an expiration date of [DATE]. 2. Dry pantry area-A box that contained five packages of Flour Tortillas that had an expiration date of [DATE]. Dietary Aid BB confirmed the tortillas were expired and removed them. 3. Walk in cooler-One large package of diced ham that had previously been opened, was not labeled with an open or use by date. Dietary Aid BB confirmed the ham was opened and did not have an open or use by date. On [DATE] at 8:40 am, surveyor showed pictures captured during the initial tour, to the DM who looked at the pictures and confirmed the tortillas had an expired date of [DATE], bottle of mayonnaise had expired date of [DATE], two unlabeled and undated pitchers of liquid in the stand-up cooler, and a package of diced ham that had previously been opened but was not labeled with an open or use by date. Interview at that time, the DM revealed that the dietary aide let her know that expired and unlabeled items were found, and the DM confirmed the expired items by review of the pictures captured during initial tour of the dietary department. The DM revealed her expectations were that staff follow policy, remove and discard expired and past use dated foods, label items/packages with the open date, and the past-use-by date, when they are opened or prepared. At this time the DM discarded the expired bottle of mayonnaise that was still in the cooler on [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 12:43 pm in the dining room located on the 500-hall revealed three tables occupied with residents. Certified Nursing Assistant (CNA) AA was assisting one resident with eating. CNA AA had the resident's plate of food resting on her person and used her fingers to feed the resident instead of using any utensils. Interview on [DATE] at 12:52 pm with Unit Manager/Registered Nurse (RN) CC revealed that staff should be using utensils and not their hands to assist residents with eating. RN CC revealed the plate should be on the table and not on the staff's lap. Interview on [DATE] at 12:37 pm with CNA AA revealed she was to use utensils and not her hands or fingers to assist with feeding. She confirmed that she did feed a resident with her fingers and did not use utensils, and she had the resident's plate on her lap and not on the table. Interview on [DATE] at 5:53 pm with the Director of Health Services (DHS) revealed staff should not use hands or fingers to feed residents, always utensils and the resident's plate should be on the table not resting in the staff's lap.

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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** 45811 Based on observations, interviews, record reviews, and review of the facility's policy titled, Medication Administration: General Guidelines, the facility failed to maintain effective infection control practices for three of four residents (R) (R21, R31, R34) during medication administration. Specifically, the facility failed to maintain infection practices for one resident (R21) during a fingerstick blood sugar check, during inspection of the PPE (personal protective equipment) cart that was not maintained in a sanitary manner, during observation of dining, observation in resident rooms where dirty IV (intravenous) tubing was left, and during resident screening where staff were seen sitting on resident's beds. The deficient practices had the probability to increase the potential for cross-contamination and spread of infection. Findings included: Review of the facility's policy titled, Medication Administration: General Guidelines dated 2014 revealed under the Policy Statement, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Under the section Procedure, If breaking tablets is necessary to administer the proper dose, hands are washed with soap and water or alcohol gel prior to handling tablets, (preferable gloves should be worn). 1. Record review for R21 revealed diagnoses included but not limited to Friedreich ataxia, dysphagia, oropharyngeal phase, Multiple sclerosis, Type 2 diabetes mellitus with hyperglycemia, functional quadriplegia, long term (current) use of insulin, and muscle weakness (generalized). Review of Physician orders included, insulin aspart U-100 solution; 100 unit/mL (100 units per milliliter); amt (amount) 15 units subcutaneous before meals, insulin aspart U-100 solution 100 unit/ml per sliding scale, and Lantus Solostar U-100 Insulin (insulin glargine) insulin pen 100 unit/mL (3 mL) 27 units subcutaneous at bedtime. Observation during medication administration on 10/29/2024 at 11:00 am with Licensed Practical Nurse (LPN) MM the nurse completed a fingerstick blood sugar procedure on R21. LPN MM went into the room and put the glucometer and lancet on the bed before sticking the resident's finger. Once the procedure was completed the nurse laid the glucometer on the bed, discarded his gloves and sanitized his hands. LPN MM then carried the used lancet and glucometer back to the medication cart and laid the glucometer on the medication cart without a barrier. He discarded the lancet in the sharp's container, cleaned the glucometer and put it in a cup to dry. Interview on 10/29/2024 at 11:10 am LPN MM confirmed he put the glucometer and lancet on the resident's bed and did not use a barrier. Observation during medication administration on 10/29/2024 at 11:20 am LPN MM gave insulin because of a blood sugar result of 231. LPN MM used gloves to administer the insulin injection. After he administered the medication he discarded the gloves, sanitized his hands, put the used needle in his pocket, pulled the resident up in bed, and went to the medication cart, which was outside of the nurses station, to discard the used needle in the sharp's container. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/29/2024 at 11:30 am LPN MM confirmed he put the used needle in his pocket after use. 2. Record review for R31 revealed medical diagnoses included but not limited to cerebral infarction due to occlusion or stenosis of left middle cerebral artery, dysphagia, oropharyngeal phase, need for assistance with personal care, muscle weakness (generalized), hemiplegia affecting right dominant side, morbid obesity, obstructive sleep apnea, and shortness of breath. Review of physician orders included fluticasone propionate spray, suspension; 50 mcg (micrograms)/actuation 1 spray each nostril twice a day, ipratropium-albuterol solution for nebulization; 0.5 mg (milligrams)-3 mg (2.5 mg base)/3 mL (milliliters) 1 vial, inhalation every 6 hours PRN (as needed), oxygen: change respiratory circuit/supplies as needed, oxygen: change respiratory circuit/supplies weekly, once a day on Monday, oxygen: oxygen at 2 liters per minute via nasal cannula to keep O2 saturation > 93%, every shift, pulse oximetry check PRN as needed. During medication administration for R31 of Flonase 1 spray each nostril, LPN II used gloves to administer the nasal spray; once medication administration was completed the nurse did not sanitize his hands after using the medication; put container on bedside table and then put it on the medication cart; there was no barrier used on the cart; the medication container was put back on cart without cleaning it. The nurse confirmed he did not use a barrier on the medication cart nor did he sanitize his hands after taking off the gloves. Review of medical diagnoses for R34 included, muscle weakness (generalized), need for assistance with personal care, aphasia, difficulty in walking, chronic pain syndrome, dementia, depression, psychotic disorder with delusions due to known physiological condition, Alzheimer's disease, and anxiety disorder. Review of Physician orders included, duloxetine capsule, delayed release 30 mg; 1 cap, oral once a day, gabapentin capsule; 300 mg 1 cap oral once a day; Seroquel (quetiapine) tablet 50 mg oral at bedtime, and tramadol - Schedule IV tablet; 50 mg, 1 tab oral for moderate pain every 6 hours PRN. Observation on 10/30/2024 at 8:30 am LPN II prepared medication for R34, he poured the medication into his bare hands without using a glove. The nurse confirmed he did not wear gloves, and he poured the medication into his bare hand. 49675 2. Observation on 10/29/2024 at 12:43 pm in the dining room located on the 500-hall revealed three tables occupied with residents. One table had one resident sitting alone in a wheelchair. The other two tables had four residents and three residents respectively. Staff were observed not washing or sanitizing their hands between passing trays. Staff did not ask or offer residents handwashing or sanitizing before eating. Certified Nursing Assistant (CNA) AA was assisting one resident with eating and did not wash or sanitize her hands prior to assisting. Observation on 10/31/2024 at 12:57 pm in the dining room located on the 500 hall revealed staff did not offer residents hand washing or sanitizing before lunch was served. Staff were serving plates, then touching the meal cart door, and then serving more plates of food without sanitizing hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/31/2024 at 12:52 pm with Unit Manager and Registered Nurse (RN) CC revealed she did not know the policy on staff assisting residents with eating in the dining rooms. After consultation with other staff, RN CC revealed that it was her expectation that staff should be sanitizing and or washing hands before assisting residents. Interview on 11/01/2024 at 12:37 pm with CNA AA revealed she and other staff should offer residents handwashing or sanitizing before they eat. She did not recall whether or not she washed her hands, or the resident's hands on 10/29/2024 at 12:43 pm. Interview on 11/1/2024 at 5:53 pm with the DHS revealed that staff should offer residents hand hygiene before meals. It was her expectation that staff wash their hands before assisting residents or handling food. The DHS also confirmed staff should sanitize hands in between serving each resident. 36377 3. During an initial tour of the 600 Hall on 10/29/2024 at 10:00 am revealed one of three carts designated for PPE (Personal Protective Equipment) positioned on the hall by resident's door. Further observation revealed a white sheet with brown stains lying uncovered in the first drawer next to PPE items. On 10/30/2024 at 11:00 am revealed the same uncovered white sheet with brown stains remained in the same position in the drawer. Observation on 10/29/2024 at 11:00 am in room [ROOM NUMBER] revealed bed A's bedside table had an IV tubing (Intravenous line) coated with brown substances lying within open view of anyone entering the room. Interview with LPN RR at the time of observation, LPN RR identified the tubing as an IV tubing. She confirmed that the resident in bed A did not require a IV. She reported that most likely the tubing was assigned to a previous resident. Resident in Bed A reported that the IV tubing had been in the room for a long time. LPN RR removed the IV tubing.