STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115361	A. Building B. Wing	06/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mghp-Brentwood LLC	115 Brentwood Drive Waynesboro, GA 30830

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, staff interviews, and record review, the facility failed to ensure that one of 29 sampled residents (R) (R6) was treated in a manner that maintained or enhanced his/her dignity. Specifically, staff provided care to R6 without providing full visual privacy. This deficient practice had the potential to place R6 at risk of a diminished quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life. Findings include: Review of R6's electronic health record (EHR) revealed diagnoses including, but not limited to, moderate intellectual disability, epilepsy, chronic kidney disease, and anxiety disorder. Review of R6's Annual Minimum Data Set (MDS) assessment, dated 4/1/2025, revealed Section C (Cognitive Patterns) documented a Brief Mental Status Score (BIMS) score of 3 (indicating severe cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident required assistance with Activities of Daily Living (ADLs). Section H (Bladder and Bowel) documented that the resident was incontinent. Observation on 6/13/2025 at 9:30 am revealed Certified Nursing Assistant (CNA) CC providing personal hygiene care and incontinent care to R6. Further observation revealed that R6 resided in Bed A. Observation revealed the privacy curtain was not pulled, and the window blinds were opened, providing full visual observation of R6 to anyone in the hallway outside of R6's room, anyone entering the room, and the resident's roommate. R6 was observed wearing only a brief. In an interview on 6/13/2025 at 9:32 am, CNA CC reported that he was getting ready to shave the resident and provide incontinent care and confirmed he did not provide privacy by pulling the privacy curtain, and further stated that he should have. In an interview on 6/5/2025 at 11:51 am, the Administrator and Director of Nursing (DON) both stated privacy curtains should be pulled to encircle the resident's bed while staff provided ADL care.

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

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to ensure one of five residents (R) (R28) with a qualifying diagnosis was referred to the Georgia Preadmission Screening and Resident Review (PASRR) Utilization Management for review. This deficient practice had the potential to increase the probability of R28 not having her mental and psychological care needs met. Findings include: Review of R28's admission Record revealed admission on [DATE] with the diagnoses including, but not limited to, bipolar II disorder, obsessive-compulsive behavior, major depressive disorder, anxiety disorder, and psychosis. Review of R28's Annual Minimum Data Set (MDS), dated [DATE], revealed Section A (Identification Information) revealed the resident had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Section I (Active diagnoses) documented diagnoses including, but not limited to, anxiety disorder, depression, bipolar disorder, and psychotic disorder. Review of R28's Care Plan Report revealed a Focus of R28 was at risk for adverse effects of antipsychotic medication. R28 uses antipsychotic medications r/t bipolar disorder, obsessive-compulsive disorder, depressive disorder, and anxiety disorder. Interventions included referring to psychological/behavioral health if needed, and/or ordered by the physician. Review of R28's Physician's Orders revealed medications including, but not limited to, Zyprexa (a medication used to treat bipolar disorder) oral tablet 5 MG, diazepam (a medication used to treat anxiety disorder) oral tablet 10 MG, quetiapine fumarate (a medication used to treat bipolar disorder and depression) oral tablet 50 MG. Review of R28's clinical record revealed no PASRR Level II. In an interview on 6/14/2025 at 10:04 am, the Admissions Coordinator revealed that the PASRR Level I screening was obtained before the resident was admitted to the facility and was uploaded into the resident's electronic medical record. During the interview, the Admissions Coordinator was able to locate R28's PASRR Level I for review. In an interview on 6/14/2025 at 10:14 am, the Director of Nursing (DON) revealed that the PASRR Level I should be in the resident's record. Continued interview revealed that when a resident had a qualifying diagnosis, the PASRR Level II should be applied for, and the Social Worker was responsible for ensuring that the request was submitted. The DON confirmed R28 had qualifying diagnoses of bipolar disorder, major depressive disorder, anxiety disorder, and psychosis. The DON also confirmed there was no PASRR Level II for R28. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/14/2025 at 11:30 am, the Administrator revealed that the Social Worker was responsible for ensuring the PASRR Level I and Level II assessments were submitted for residents with qualifying diagnoses. The Administrator confirmed that a PASRR Level II was not in the resident's medical record and could not provide a copy of the requested documentation for submission of the documents. Continued interview revealed that her expectation was for all residents with a qualifying diagnosis to have a PASRR Level II submitted to the appropriate agency for review.

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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. 2. Review of R11's EHR revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease with acute exacerbation, pulmonary candidiasis, and unspecified atrial fibrillation. Review of R11's Care Plan Report revealed a Focus Area, created 6/5/2024, for oxygen therapy. Interventions included oxygen as ordered. Review of R11's Physician Order revealed an order dated 517/2024 for O2 at 5 LPM every shift. Observations on 6/13/2025 at 10:07 am and at 1:04 pm revealed R11 receiving O2 therapy by oxygen concentrator at 3.5 LPM via a NC. Observation on 6/14/2025 at 10:13 am, with LPN EE, revealed R11 receiving O2 therapy by oxygen concentrator at 7 LPM via a NC. LPN EE confirmed that the flow rate was set in error and against the physician's order of 5 liters per minute, and adjusted the flow rate. 3. Review of R122's EHR revealed an admission date of 6/9/2025, with diagnoses including, but not limited to, chronic obstructive pulmonary disease, atherosclerotic heart disease of native coronary artery without angina pectoris, and presence of an automatic (implantable) cardiac defibrillator. Review of R122's Care Plan Report, dated 6/10/2025, revealed a Focus Area of O2 as needed. Interventions included observing the resident for breathing problems and placing O2 as ordered by the physician. Review of R122's Physician Orders revealed an order dated 6/9/2025 for O2 at 2 LPM via NC as needed for SOB [shortness of breath]. May remove as desired. Observations on 6/13/2025 at 10:14 am and 1:10 pm revealed R122 receiving O2 therapy by oxygen concentrator at 3.5 LPM via a NC. Observation on 6/14/2025 at 9:43 am revealed R122 receiving O2 therapy by oxygen concentrator at 4 LPM via a NC. In a concurrent observation and interview, LPN DD confirmed that the O2 was set on the wrong flow rate and not per the physician's order. In an interview on 6/15/2025 at 11:38 am, the MDS Coordinator confirmed R11 and R122's care plans for oxygen therapy. She reported that her expectation was for the staff to follow the physician's orders, since the care plan interventions included administering O2 as an order. Cross-Reference F695 Based on observations, staff interviews, record review, and review of the facility policy titled Care Plans-Comprehensive, the facility failed to implement the care plan for three of 11 residents (R) (R31, R122, and R11) receiving oxygen therapy. This deficient practice had the potential to place R31, R122, and R11 at risk of not receiving treatment and/or care according to their needs. Findings include: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Care Plans, Comprehensive, dated 4/18/2017, revealed the Policy Statement section stated, An individualized comprehensive care plan that includes measurable and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. The Policy Interpretation and Implementation section included, . 5. Care Plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying sources(s) of the problem areas(s), rather than addressing only symptoms or triggers . 1. Review of R31's electronic health record (EHR) revealed diagnoses that included but not limited to malignant neoplasm of endometrium, non-ischemic myocardial injury, paroxysmal atrial fibrillation, chronic obstructive pulmonary disease with (acute) exacerbation, chronic diastolic (congestive) heart failure, transient cerebral ischemic attack, dependence on supplemental oxygen and cerebral infarction, unspecified. Review of R31's care plan dated 6/2/2025 revealed a Focus area for O2 (oxygen) therapy r/t (related to) Ineffective gas exchange. Dx (diagnosis) of COPD (chronic obstructive pulmonary disease); Goals : R31 will have no s/sx (signs and symptoms) of poor oxygen absorption through the review date. Interventions included: Give medications as ordered by physician Oxygen Settings: O2 via NC (nasal cannula) per MD [Medical Doctor] orders . Review of R31's Physician's Orders revealed an order dated 5/29/2025 for O2 at 4 liters per minute (LPM) via a NC continuous every day and night shift for shortness of breath. Observations on 6/13/2025 at 9:03 am, at 11:54 am, and 6/14/2025 at 10:20 am revealed R31 receiving oxygen therapy at 3.5 liters per minute via nasal cannula. During an interview and observation on 6/14/2025 at 12:20 pm with the Director of Nursing (DON), she confirmed O2 setting was infusing at 3.5 LPM via nasal cannula. DON reported that her expectations were for staff to follow the care plan. During an interview on 6/14/2025 at 12:35 pm, Licensed Practical Nurse (LPN)/Minimum Data Set (MDS) Coordinator revealed she was responsible for making sure each resident had a comprehensive care plan in place. She confirmed there was a care plan in place for R31 for the O2 setting to administer O2 via NC per the physician's orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, staff interviews, and record review, the facility failed to ensure one of 29 sampled residents (R) (R6) received care and services to avoid preventable falls. This deficient practice had the potential to place R6 at risk of injury related to avoidable falls. Findings include: Review of R6's electronic health record (EHR) revealed diagnoses including, but not limited to, epilepsy, chronic moderate intellectual disability, chronic kidney disease, age relate nuclear cataract, bilateral, anxiety disorder, and hypertension. Review of R6's Annual Minimum Data Set (MDS) assessment, dated 4/1/2025, revealed Section C (Cognitive Patterns) documented a Brief Mental Status Score (BIMS) score of 3 (indicating severe cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident required assistance with Activities of Daily Living (ADLs). Section V (Care Area Assessment [CAA] Summary) documented that falls were triggered. Review of R6's Fall Risk Assessment assessed the resident as a high risk for falls. Review of R6's Care Plan Report revealed a Focus area, revised 1/2/2025, of the resident was at risk for falls, with a history of falls documented. The Goal was for the resident to be free of fall-related injury through the next review period. Further review revealed a Focus area, dated 5/12/2023, of the resident had an Activities of Daily Living (ADL) self-care performance deficit and required assistance with all ADLs. Observation on 6/13/2025 at 9:30 am revealed R6 lying in his bed with the bed raised to a high position. Certified Nursing Assistant (CNA) CC exited the room, leaving the bed in a high position and the resident unattended by staff. In an interview on 6/13/2025 at 9:32 am, Licensed Practical Nurse (LPN) BB observed and confirmed that CNA CC had left R6 in bed and with the bed in a high position. CNA CC returned to the room and confirmed he had left the resident in the bed, with the bed in a high position, to obtain supplies for resident care. LPN BB and CNA CC stated the resident could independently move in the bed from left to right. They both confirmed the resident was at risk for falls, and the bed should be in the lowest position when left unattended to prevent injury due to falls. In an interview on 6/15/2025 at 11:51 am, the Director of Nursing (DON) her expectation that R6's bed would remain in the lowest position when left unattended. She further stated that the CNA should have called for assistance to obtain supplies or place the bed in the lowest position before exiting the room. In an interview on 6/15/2025 at 11:53 am, the Administrator stated staff would receive education on fall prevention.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of R11's EHR revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease with acute exacerbation, pulmonary candidiasis, and unspecified atrial fibrillation. Review of R11's Annual MDS assessment, dated 5/21/2025, revealed Section J (Health Conditions) revealed R31 exhibited shortness of breath or trouble breathing with exertion, when sitting at rest, and when lying flat. Section O (Special Treatments, Procedures, and Programs) revealed R31 received O2 therapy while a resident. Review of R11's Physician's Orders included an order dated 5/17/2024 for O2 via NC at 5LPM continuous every shift. Observations on 6/13/2025 at 10:07 am and at 1:04 pm revealed R11 receiving O2 therapy by oxygen concentrator at 3.5 LPM via a NC. Observation on 6/14/2025 at 10:13 am, with LPN EE, revealed R11 receiving O2 therapy by oxygen concentrator at 7 LPM via a NC. LPN EE confirmed that the flow rate was set in error and against the physician's order of 5 liters per minute, and adjusted the flow rate. 3. Review of R122's EHR revealed an admission date of 6/9/2025, with diagnoses including, but not limited to, chronic obstructive pulmonary disease, atherosclerotic heart disease of native coronary artery without angina pectoris, and presence of an automatic (implantable) cardiac defibrillator. Review of R122's MDS assessments revealed that the admission assessment was in progress. Review of R122's Physician Orders revealed an order dated 6/9/2025 for O2 at 2 LPM via NC as needed for SOB [shortness of breath]. May remove as desired. Observations on 6/13/2025 at 10:14 am and 1:10 pm revealed R122 receiving O2 therapy by oxygen concentrator at 3.5 LPM via a NC. Observation on 6/14/2025 at 9:43 am revealed R122 receiving O2 therapy by oxygen concentrator at 4 LPM via a NC. In a concurrent observation and interview, LPN DD confirmed that the O2 was set on the wrong flow rate and not per the physician's order. In an interview on 6/14/2025 at 1:17 pm, the DON reported that her expectation was for licensed nurses to monitor the residents' O2 flow rate per shift and ensure the O2 setting was set per physician orders. Based on observations, staff interviews, record review, and review of the facility's policies titled Medication and Treatment Orders and Oxygen Administration, the facility failed to ensure oxygen (O2) was administered as ordered by the physician for three of 11 residents (R) (R31, R122, and R11) receiving O2 therapy. The deficient practice had the potential to place R31, R122, and R11 at risk of respiratory complications and unmet needs. Findings include: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Medication and Treatment Orders, dated 3/22/2017, revealed the Policy Statement section included, Orders for medications and treatments will be consistent with principles of safe and effective order writing. The section titled Policy Interpretation and Implementation included 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Review of the facility's policy titled Oxygen Administration, dated 3/24/2017, revealed the Policy Statement section included, The purpose of this procedure is to provide guidelines for safe oxygen administration. The section titled Policy Interpretation and Implementation included, 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. The section titled Assessment included, . 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. 1. Review of the electronic health record (EHR) for R31 revealed diagnoses that included, but not limited to, malignant neoplasm of endometrium, non-ischemic myocardial injury, paroxysmal atrial fibrillation, chronic obstructive pulmonary disease with (acute) exacerbation, chronic diastolic (congestive) heart failure, transient cerebral ischemic attack, dependence on supplemental oxygen and cerebral infarction, unspecified. Review of R31's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Section GG (Functional Abilities and Goals) revealed R31 required substantial/maximal assistance with mobility. Section J (Health Conditions) documented R31 exhibited shortness of breath or trouble breathing with exertion, when sitting at rest, and when lying flat. Section O (Special Treatments, Procedures, and Programs) revealed R31 received O2 therapy while a resident. Review of R31's Physician's Orders included an order dated 5/29/2025 for O2 at 4 liters per minute (LPM) via [by way of] a nasal cannula (NC), continuous every day and night shift, for shortness of breath. Observations on 6/13/2025 at 9:03 am, at 11:54 am, and on 6/14/2025 at 10:20 am revealed R31 receiving O2 therapy at 3.5 liters per minute via a NC. During an interview and observation on 6/14/2025 at 12:20 pm with the Director of Nursing (DON), she confirmed R31's O2 was flowing at 3.5 LPM via nasal cannula. Review of R31's orders with the DON verified that O2 was ordered at 4 LPM via NC. The DON reported that her expectations were for staff to follow the physician's orders. During an interview and observation on 6/14/2025 at 12:50 pm, Licensed Practical Nurse (LPN) AA revealed she was the nurse assigned to R31 and was responsible for making sure the O2 was administered at the correct setting per physician orders. LPN AA was shown pictures of R31 O2 setting at 3.5 LPM. She then reviewed R31's orders in the EHR and confirmed the O2 setting should have been set at 4 LPM. LPN AA revealed she had been busy passing medications and had not checked the O2 settings.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, staff interviews, review of facility documentation, and review of the facility policy titled Posting Direct Care Daily Staffing Numbers, the facility failed to ensure the number of nursing personnel responsible for providing direct care to residents was posted daily for staff and visitors to review while in the facility. Findings include: Review of the facility policy titled Posting Direct Care Daily Staffing Numbers, dated 3/23/2017, revealed under policy statement: Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Under Policy Interpretation and Implementation: 1. Within two (2) hours of the beginning of the shift, the number of Licensed Nurses (RNs [Registered Nurse], LPNs [Licensed Practical Nurse], and LVNs [Licensed Vocational Nurse]) and the number of unlicensed nursing personnel (CNAs [Certified Nurses Assistant]) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. Observation on 6/13/2025 at 9:22 am revealed the staffing posting was located in a clear glass case going into the main dining area, dated 5/24/2025, with a total number of 2.79. Observation on 6/14/2025 at 7:26 am revealed the staffing posting was located in a clear glass case going into the main dining area, dated 5/24/2025, with a total number of 2.79. Interview on 6/14/2025 at 7:30 am with the Director of Nursing (DON) revealed that she had recently started at the facility as the interim DON and was not sure who was responsible for ensuring that the daily Per Patient Daily Ratio (PPD) staffing was posted. During the interview, it was confirmed that the last posting was dated 5/24/2025. Interview on 6/14/2025 7:33 am with the Human Resources Director confirmed that the PPD had not been posted since 5/24/2025. Interview on 6/14/2025 at 7:34 am, interview with Administrator confirmed that the posting had not been changed since 5/24/2025. Further interview revealed that the staffing posting should be completed daily.

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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. Based on observations, staff interviews, record review, and review of the facility's policies titled Labeling and Dating Guidelines and Standard of the Week Labeling and Dating, the facility failed to ensure food items were labeled with open and/or discard dates and discarded on or before the discard dates. This had the potential to place 64 residents who received an oral diet from the kitchen at risk of food-borne illness. Findings include: Record review of the facility's undated policy titled Standard of the Week Labeling and Dating included, Upon receipt, all items should be inspected and marked with the date it was received into your facility and the date it should be discarded (if the item has a use by or discard date already on it, then you may use this date. After opening any item, the date it was opened must be clearly labeled on the front of the package, and any adjustments to the discard date should be made at this time. Review of the facility's undated policy titled Labeling and Dating Guidelines included, Upon receipt, all items should have a received date and a use by date. Upon opening, all items should have an open date and a use-by date. During the initial tour of the kitchen beginning on 6/13/2025 at 8:00 am, with Dietary Aide (DA) JJ, the following observations were made: Observations in the walk-in freezer revealed: One bag of pre-cooked biscuits, removed from the original container, labeled 6/11/2025 and missing an expiration date. One large gray pan containing two slabs of raw ribs, removed from the original container, and not labeled or dated. One large gray pan containing one slab of ribs, wrapped in plastic wrap, and not labeled or dated. One large gray pan containing chicken pieces in a clear plastic bag, removed from the original container, and not labeled or dated. One package of raw corned beef brisket, with no expiration date. One large bag of French fries, not labeled or dated Two bags of sliced squash, placed in a large brown pan, not labeled or dated One large bag of pre-cooked pepperoni, wrapped in plastic wrap, labeled with a received date of 6/18/25, with no expiration date. One coconut cream pie, not labeled or dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations in the walk-in cooler revealed: Two bags of cooked noodles in a plastic bag dated 6/12/2025, and without a discard date. One bag of sliced peaches in a plastic bag dated 6/10/2025, and without a discard date. One large aluminum pan of cooked ground beef mixed with spaghetti sauce, labeled with a received date of 6/12/2025, and without a discard date. One plastic container, with a red lid, of pudding labeled with a received date of 6/10/2025, and without a discard date. One plastic container, with a green lid, of applesauce, labeled with an expiration date of 6/12/2025. One container of cooked hamburger meat, labeled with an expiration date of 6/12/2025 Observations of three plastic bins with lids revealed that one was labeled as a flour bin, one was labeled as a sugar bin, and one was labeled as a cornmeal bin. The flour, sugar, and cornmeal in the bins were removed from the original packaging. Each bin lid had a label with a date of 6/5/2025. There was no discard date. During an interview, at the time of observations, of all the above-mentioned items, with DA JJ, reported staff had received education to place the received date, opening date, used by date, and expiration date on food items. During an interview on 6/14/2025 at 11:00 am, the Dietary Manager (DM) reviewed photos of the identified food items for labeling and expired food items and confirmed all findings. The DM further stated that once staff remove any food products from their original container, staff should label the item with a discard date. She further stated that dietary staff should label all food items with a receive date, open date, and used-by/expiration date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115361	A. Building B. Wing	06/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mghp-Brentwood LLC	115 Brentwood Drive Waynesboro, GA 30830

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, staff interviews, record review, and review of the facility policy titled Garbage and Rubbish Disposal, the facility failed to maintain two of three facility dumpsters in a sanitary condition by ensuring the dumpsters had fitted lids and doors to prevent exposure to insects and rodents. The deficient practice created the potential to promote the harboring of pests, insects, and other organisms, and create the potential for disease transmission by pests and rodents. Findings include: Review of the facility policy titled Garbage and Rubbish Disposal, dated 2008, revealed the Policy Statement of Garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters. The Policy Interpretation and Implementation section included . 8. Outside dumpsters provided by garbage pick-up services must be kept closed and free of litter around the dumpster area. Concurrent observation and interviews on 6/13/2025 at 8:22 am, with Dietary Aide (DA), HH, and Maintenance Assistant GG, revealed three dumpsters with large gaps between the lids, resulting in large open spaces. Further observation revealed missing doors from the dumpsters, causing the trash not to be secure inside the dumpster and allowing exposure to insects and rodents. One dumpster door was observed sitting on the ramp, propped up against the building wall. DA HH and Maintenance Assistant GG confirmed the observations and reported that the dumpster doors had been off the dumpsters for three to four months. In an interview on 6/14/2025 at 10:17 am, the Dietary Manager (DM) reported that she reached out to the local City Hall in May 2025, but new dumpsters had not been delivered. She stated that the City Hall had informed her that the city did not have a three-door dumpster in May 2025. In an interview on 6/14/2025 at 11:54 am, Receptionist II confirmed that the problems with the dumpsters (missing doors and damaged lids) had existed since April 2025. She reported reaching out to the city for repairs and replacement of a dumpster in April 2025 and a previous follow-up after April 2025. She reported that although the dumpsters were requested, the city did not take action until 6/13/2025. She reported reaching out to the city on 6/13/2025 to request repairs after the surveyor had identified the problem with the dumpster. The receptionist reported that after making the call, a city official visited the site to attach new dumpster doors. She confirmed that the dumpster lids were not replaced.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility policy titled Infection Prevention and Control Program, the facility failed to ensure soiled and clean linen carts were not stored together on three of five halls (300 Hall, 400 Hall, and 500 Hall). The deficient practice had the potential to increase the probability of the spread of infection from the soiled linen to the clean linen used while care services were being provided to residents. Findings include: Review of the facility policy titled Infection Prevention and Control Program, dated 8/24/2022, revealed under Policy statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Under Prevention of infection: The facility will follow recommended and required guidelines to help mitigate or prevent infections as listed below: 1. Identifying possible infections or potential complications of existing infections; . 3. Educating staff and ensuring that they adhere to proper techniques and procedures; . 8. Following established general and disease-specific guidelines, such as those of the Centers for Disease Control (CDC). Observation on 6/13/2025 at 8:30 am revealed a clean linen cart stored directly next to the soiled linen cart by room [ROOM NUMBER] on the 400 Hall. Observation on 6/14/2025 at 9:12 am revealed there was a clean linen cart noted in the hall by room [ROOM NUMBER] that was touching the soiled linen cart that had visibly soiled linen in the container. Observation on 6/14/2025 at 2:30 pm revealed the clean linen cart was noted on the 300 Hall by room [ROOM NUMBER] and was touching the soiled linen cart. Observation on 6/15/2025 at 9:09 am revealed the clean linen cart and soiled linen cart were side by side and touching on the 500 Hall. Interview on 6/15/2025 at 9:10 am with the Director of Nursing (DON) confirmed that the clean linen cart was touching the soiled linen cart. During the interview, DON stated that the clean linen cart should not be that close to the cart at any time to prevent cross-contamination. The DON stated that the staff would be educated. Interview on 6/15/2025 at 9:12 am with the Infection Preventionist (ICP) revealed that the clean linen cart should not be touching the soiled linen cart at any time, and they should be at least six feet apart. The ICP nurse confirmed that the carts were touching and should not have been. During the interview, the ICP stated that the facility staff would be further educated on infection control practices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 6/15/2025 at 9:15 am with the Administrator revealed that the clean and soiled linen carts should not be stored side by side so that they are touching, due to increasing the risk for cross-contamination. Further interview also revealed that the expectation was for staff to understand how to properly store the carts and be knowledgeable of the infection control policies and practices.