| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115362 | A. Building<br>B. Wing | 08/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Macon Rehabilitation and Healthcare | 505 Coliseum Drive<br>Macon, GA 31217 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, staff interviews, and review of the facility policy titled Food Storage: Cold Foods, the facility failed to ensure food items were covered/wrapped, labeled, and dated when opened. In addition, the facility failed to ensure sanitary conditions for two of two ice machines used by the kitchen. Additionally, the facility failed to ensure sanitary conditions in the kitchen. These deficient practices had the potential to place the 89 residents receiving food and hydration from the kitchen at risk of foodborne illness. Findings include:Review of the facility policy titled Food Storage: Cold Food, revised 2/2023, revealed the Procedures section included, . 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross-contamination.1. Observations on 8/18/2025 at 10:02 am, during the initial kitchen tour with the Dietary Manager (DM), revealed the cooler contained:One unwrapped piece of ham. One unwrapped half of a tomato. One 5-pound (lb.) bag of shredded cheddar cheese that was unlabeled and undated. Five hamburger buns, unlabeled and undated.One 5-lb. bag of blueberries, unlabeled and undated. One unwrapped, opened bag containing three boiled eggs. Observation revealed the three-door reach-in refrigerator contained:One 6-quart (qt.) container containing a brown-like food substance, undated and unlabeled. One 6-qt. container with a yellow pudding-like substance, undated and unlabeled.One 6-qt. container labeled as pineapples, with an expiration date of 8/16/2025. The DM confirmed all findings and stated that if a package lacks an expiration date, it is not considered valid. The Dietary Manager stated that he, along with the cooks, was responsible for proper labeling and dating of food items.2. Continued observations on 8/18/2025, beginning at 10:02 am, during the initial kitchen tour, with the DM, of the ice machines revealed an ice scoop inside the machines, along with a black-like substance present on the inside near the ice dispenser in both the north and kitchen hall. The DM stated that the Maintenance Department was responsible for cleaning the ice machines. 3. Observation on 8/19/2025, at 12:26 pm, of the kitchen ceiling revealed a black and gray substance on the ventilation unit next to the meat/produce sink. Continued observation revealed a fan installed on the wall near the steam table, alongside the three-door refrigerator, with a black substance on both the blades and the ceiling. The DM confirmed the findings and stated that he had reported these concerns via the facility's computerized reporting system.In a concurrent interview and observation tour on 8/20/2025 at 12:02 pm, the Administrator and Maintenance Director confirmed that the ceiling ventilation unit and fan had black substances on them and confirmed they needed to be cleaned. The Maintenance Director further stated he was unable to clean the ice machine on a normal schedule. |

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 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>Based on staff interviews, record review, and review of the facility policy titled Behavioral Management Program, the facility failed to refer one of two residents (R) (R5) reviewed for Preadmission Screening and Resident Review (PASRR), from a total sample of 46, for evaluation by the appropriate State-designated authority. This deficient practice has the potential to place R5 at risk of not receiving necessary care and services.Findings Include:Review of the facility policy titled Behavioral Management Program, revised June 2024, revealed the Policy Statement stated, It is the policy of the facility that each resident must receive, and the facility must provide the necessary behavioral health care and services and medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment (483.20) and plan of care. The interdisciplinary team will utilize information from the PASARR process as well as to complete a comprehensive assessment of resident needs, strengths, goals, life history and preference using the resident assessment instrument (RAI) specified by CMS [Centers for Medicare and Medicaid Services].Review of the electronic medical record (EMR) for R5 revealed an admission date of 9/20/2024. Diagnoses included, but were not limited to, anxiety disorder and post-traumatic stress disorder (PTSD). Review of the admission Minimum Data Set (MDS) assessment for R5, dated 9/20/2024, revealed Section A (Identification Information) documented the resident was not considered by the State Level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. Section I (Active Diagnoses) documents diagnoses, including, but not limited to, anxiety disorder and PTSD. Section O (Special Treatments, Procedures, and Programs) documents that the resident did not receive psychological therapy.Review of the Quarterly MDS assessment for R5, dated 6/25/2025, revealed Section D (Mood) documented the resident had little interest or pleasure in doing things 12-14 days. Section I (Active Diagnoses) documents diagnoses, including, but not limited to, anxiety disorder and PTSD. Section O (Special Treatments, Procedures, and Programs) documents that the resident did not receive psychological therapy. Review of the Physician's Orders for R5 revealed an order dated 7/2/2025 for buspirone HCL 5 milligram (mg), give 1 tablet via G-tube [gastrostomy tube] every 12 hours for anxiety. Further review revealed an order dated 7/2/2025 for psychiatric/psychological evaluation and treatment as needed. Review of the PASRR Level I application for R5, dated 9/20/2024, revealed that the resident did not have a primary diagnosis of dementia, anxiety, or PTSD.In an interview on 8/21/2025 at 8:50 am, the Social Services Worker (SSW) confirmed there were no diagnoses of dementia, anxiety, or PTSD on the PASRR Level I application for R5. In an interview on 8/21/2025 at 11:04 am, Admissions Staff GG confirmed a new PASRR submission should have been conducted due to the diagnoses of anxiety and PTSD. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>Based on staff and resident interviews, record review, and review of the facility policy titled Activities of Daily Living, the facility failed to ensure two of 46 sampled residents (R) (R53 and R72) received assistance with Activities of Daily Living (ADL) care. This deficient practice had the potential to place R53 and R72 at risk of unmet care needs and a diminished quality of life.<br><br>Findings include:<br><br>Review of the facility policy titled Activities of Daily Living, revised June 2025, revealed the Policy Statement included, To ensure that all residents receive appropriate assistance with Activities of Daily Living (ADLs) in a manner that promotes dignity, independence, and quality of life. The Definition section included, Activities of Daily Living (ADLs) are basic self-care tasks essential for maintaining health and well-being. These include: Bathing Dressing Grooming and personal hygiene .<br><br>1. Review of the electronic medical record (EMR) for R53 revealed the most recent admission date of 4/22/2025 with diagnoses including, but not limited to, displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, spinal stenosis, lack of coordination, and muscle weakness.<br><br>Review of the Annual Minimum Data Set (MDS) assessment for R53, dated 7/22/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 15 (indicating little to no cognitive impairment). Section GG (Physical Abilities and Goals) documented that R53 required partial to moderate assistance with showering and bathing self.<br><br>Review of the August 2025 Bathing/Shower system revealed R53 was scheduled for showers on Tuesday and Friday on the 7:00 am to 3:00 pm shift. Review revealed that from 8/1/2025 to 8/21/2025, R53 received five showers.<br><br>In an interview on 8/18/2025 at 2:47 pm, R53 stated that her last shower was a month ago. R53 stated that she often performed a self-wash in her bathroom to avoid any unpleasant odors.<br><br>In an interview on 8/19/2025 at 5:00 pm, R53 stated that she did not take a shower today. She stated that staff had informed her that she would receive one tomorrow.<br><br>In an interview on 8/20/2025 at 5:00 pm, R53 stated that she had not received a shower all week. She stated that staff had told her she would receive one today, but later told her that it would be tomorrow. R53 also stated that she had never refused a shower.<br><br>In an interview on 8/20/202, at 5:14 pm, Licensed Practical Nurse (LPN) EE stated there were no additional locations for shower sheets.<br><br>In an interview on 8/20/2025 at 5:45 pm, the Director of Nursing (DON) stated that the facility had ceased enforcing the use of shower sheets and was attempting to transition away from paper usage. The DON affirmed that each resident has been entered into the electronic system for documenting ADL care for several months.<br><br>In an interview on 8/21/2025 at 12:21 pm, the DON stated that she had confirmed with the Certified<br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Nursing Assistant (CNA) responsible for providing a shower to R53 that he failed to provide a shower to the resident on 8/12/2025 and 8/19/2025. The DON further stated that she expected all staff members to review the shower log, inquire about residents' preferences, and if a resident refuses, to inform the nurse. The DON stated that she believed the oversight was a result of the responsibilities associated with the eight-hour and twelve-hour shift schedules.<br><br>2. Review of the EMR for R72 revealed an admission date of 7/12/2023 with diagnoses including, but not limited to, schizoaffective disorder, bipolar type, type 2 diabetes mellitus with hyperglycemia, and a history of falling.<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment for R72, dated 7/26/2025, revealed Section C (Cognitive Patterns) documented a BIMS of 15 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented R72 had lower extremity impairment on both sides, used a wheelchair, and required assistance for ADLs with two or more persons assistance.<br><br>Review of the care plan for R72, dated 8/1/2023, indicated R72 had an ADL self-care performance deficit related to limited mobility. Interventions included, but were not limited to, assisting the resident with bathing and personal hygiene.<br><br>Review of the clinical record revealed no documentation of R72 having her hair washed.<br><br>In an interview on 8/18/2025 at 1:41 pm, R72 stated her hair needed to be washed. She stated it had been a long time since someone had washed her hair and her scalp itched.<br><br>In an interview on 8/19/2025 at 12:40 pm, Certified Nursing Assistant (CNA) JJ stated R72 should ask to have her hair washed and that someone came on Wednesdays to wash and style residents' hair who had requested the service. CNA JJ informed R72 to ask someone for her hair to be washed, and R72 asked who she needed to ask, stating her scalp was itching, and it had been a long time since her hair had been washed.<br><br>In an interview on 8/20/2025 at 1:07 pm, CNA JJ stated that all grooming was documented on the resident's shower sheet.<br><br>In an interview on 8/20/2025 at 1:07 pm, R72 stated she still needed her hair washed.<br><br>In an interview on 8/20/2025 at 1:40 pm, Hairdresser HH stated she worked at the facility once a week. She stated she could not provide services to all residents, made a list of the residents to see a week ahead of time, and was paid through the family. She stated the hair care service was for residents who want something extra for their hair.<br><br>In an interview on 8/21/2025 at 11:44 am, the DON confirmed that hair washing, nail trimming, and personal grooming were part of ADL care that should be provided by staff. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observations, staff interviews, record review, and review of facility policy titled Infection Prevention and Control Program, the facility failed to follow infection control procedures for one resident (R) R68 on Enhanced Barrier Precautions (EBP). This deficient practice had the potential to increase the risk of the spread of infection in the facility. The census was 94. Findings include:Review of the facility policy titled Infection Prevention and Control Program, dated June 2025, revealed the Policy Statement section included, To have a comprehensive program that addresses detection, prevention, and control of infections among residents and staff. This facility's infection prevention and control policies/practices are intended to facilitate in maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The Precaution Guidelines section included, All staff should wear appropriate personal protective equipment (PPE) as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials. Review of the electronic medical record (EMR) for R68 revealed diagnoses including, but not limited to, pressure ulcer of sacral region, stage 3, encounter for orthopedic aftercare following surgical amputation, and acquired absence of left leg above the knee.Review of the Quarterly Minimum Data Set (MDS) assessment, dated 6/20/2025, for R68 revealed that Section GG (Physical Abilities and Goals) documented the resident required substantial to maximal assistance with toileting hygiene. Section H (Bowel and Bladder) documented the resident was always incontinent of bowel and bladder. Section M (Skin Condition) documented the resident had one unhealed stage 3 pressure ulcer. Review of the Order Summary Report for R68 revealed an order dated 7/2/2025 for Enhanced Barrier Precautions related to a wound. In a concurrent observation and interview on 8/20/2025 at 11:20 am, Certified Nursing Aide (CNA) FF was observed providing incontinent care to R68. Observation revealed CNA FF did not have a protective gown on while providing incontinent care. Interview with CNA FF confirmed she did not wear a protective gown while providing incontinent care to R68. CNA FF stated she should have worn a gown during the care. In an interview on 8/21/2025 at 12:30 pm, the Director of Nursing (DON) revealed her expectation was for staff to wear gowns and gloves while providing incontinent care to residents who were on EBP. |