STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115379	A. Building B. Wing	05/05/2024

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Pruitthealth - Monroe	4796 Highway 42 North Forsyth, GA 31029

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33548 Based on record review, staff interview, and review of facility policy titled, MDS Assessment Accuracy, the facility failed to accurately code an annual Minimum Data Set (MDS) assessment for Pre-Admission Screening and Resident Review (PASRR) Level II for one of 26 sampled residents (R) (R2) from a sample of 26 residents. The deficient practice had the potential to affect the accurate assessment of R2's care needs. Findings include: Review of the facility policy titled MDS Assessment Accuracy revealed it is the policy of this healthcare center that each Minimum Data Set (MDS) reflect the acuity and the medical status of each patient/resident in accordance with acceptable professional standards and practices. The assessment will be scheduled to accurately account for the acuity and complexity of the patient/resident. Each Assessment Reference Date (AFD) will be chosen to capture services rendered and reflect an accurate clinical profile of each patient/resident. Review of the electronic medical record (EMR) revealed a document from the Georgia Collaborative ASO (Administrative Services Organization) dated February 26, 2018, that a PASRR Level II assessment had been completed for R2. Review of a document provided by the facility titled, PASRR Level II, listed all residents in the facility that have had a PASRR Level II assessment. R2's name was listed. Review of R2's annual MDS assessment dated [DATE] revealed in section A-Identification Information that a PASRR Level II assessment had been completed but was not marked indicating that the assessment had been completed. Interview on 5/4/2024 at 1:45pm with the Senior Nurse Consultant DD revealed the facility's current MDS Coordinator is on a leave of absence, and they have part-time staff filling in to complete MDS assessments. The Senior Nurse Consultant confirmed that R2 had a PASRR Level II assessment in the EMR and stated that it should have been captured and reflected on the annual MDS assessment. The Senior Nurse Consultant revealed that she was not sure of the process the MDS Coordinator uses to identify residents with a PASRR Level II assessment and how that is coded on the MDS assessment. (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/4/2024 at 1:52pm with the Social Service Director (SSD) revealed that she provided the MDS Coordinator with a list of residents in the facility that have a PASRR Level II assessment completed. The SSD revealed if the PASRR list was updated, she provided a new document to the MDS Coordinator. The SSD revealed that the PASRR list was used by Social Services and MDS for care planning.

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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, and record review, the facility failed to follow the care plan for three of 26 sampled Residents (R) (R14, R24, and R30). Specifically, the facility failed to create a care plan for nutrition services for R14; failed to follow a physician's order for oxygen (O2) that was care planned for R24; and failed to add refusal of hand splint in the care plan for R30. The deficient practice had the potential for R14, R24, and R30 not to receive needed care services. Findings include: 1.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for R14 documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. Review of R14's Physician Orders revealed an order for a regular, no added salt (NAS) diet. Review of R14's care plans revealed no care plan created for nutrition. Review of a Registered Dietician Note/Nutrition assessment dated [DATE] documented etiology: poor appetite intake, with intervention large protein portions, and refer to provide to eval [evaluation] for potential benefit of a trial of an appetite stimulant given weight loss and low body weight, hyper metabolic condition. Interview on 5/5/2024 at 10:31 am with the Director of Health Services (DHS) and the Regional Consultant (RCC), both staff confirmed that there was no care plan for nutrition for R14. The DHS confirmed that the MDS Coordinator was out on leave and not available for interview. The RCC confirmed that a care plan was created for R14 after it was brought to her attention during the survey that R14's care plan was missing a nutrition care plan. She reported contacting her Regional MDS Coordinator to create the nutrition care plan. 2. Review of the annual MDS assessment for R24 dated 2/4/2024 documented a BIMS score of five, indicating severely impaired cognition. Review of R24's Physician Order dated 4/27/2024 revealed an order for oxygen 2 liters (liters per minute-LPM) by nasal cannula (NC) as needed (PRN). Review of R24's care plan dated 5/3/2024 revealed a plan of care for oxygen therapy with an intervention to administer oxygen at 2 liters per minute via nasal cannula as she will allow. Interview on 5/5/2024 at 11:29 am with the Director of Health Services (DHS) confirmed that O2 was set on the wrong liter flow and nursing staff had not followed the order. She reported that the MDS Coordinator was not available for an interview. She stated that her expectation was for staff to follow the physician's order. She confirmed that staff was not following the order and the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the quarterly MDS assessment dated [DATE] for R30 documented a BIMS score of 5, indicating severely impaired cognition. Review of R30's care plan created 4/9/2024 documented a plan of care titled Activities Daily Living (ADLs) Functional Status/Rehabilitation Potential Resident requires splint/brace assistance to Right hand with intervention right hand orthotic 7am [7:00 am] to 7pm [7:00 pm]. Continued review of the care plan revealed no plan of care for refusal to wear hand splint. Interview on 5/5/2024 at 10:02 am with the DHS, the DHS reviewed the care plan with the Surveyor and confirmed that R30 had a care plan for a hand splint and staff was not following the care plan.

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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** 45813 Based on observations, record review, resident and staff interviews, and review of the facility's policies titled, Restorative Nursing Program and Restorative Nursing Process, the facility failed to follow an Occupational Therapy (OT) Restorative Nursing Program (RNP) recommendation for orthotic application for two of 26 sampled residents (R) (R1 and R30) reviewed for ROM and mobility. This deficient practice had the potential of resulting in progression of contractures. Findings include: Review of the facility's policy titled Restorative Nursing Program revised 11/4/2021 revealed it is the policy of the healthcare center to provide restorative nursing which actively focuses on achieving and maintaining optimal physical, mental, and psychological functioning and wellbeing of the patient/resident. Documentation: 1. Restorative nursing care will be documented in the electronic health record (EHR) or paper form. 2. The nurse will evaluate patient's progress. Document in patient's care plan. Review of facility's undated policy titled Restorative Nursing Process revealed Restorative Team (any health personnel providing restorative nursing interventions) Documentation: Restorative team will document exact number of minutes provided for each restorative service in the electronic health record. Nursing Evaluation/Progress Notes: 1. License Nurse to complete evaluation of each service monthly in Restorative Nursing Care Plan. 1. Review of R1's EHR revealed that she was admitted to the facility with diagnoses including, but not limited to cerebrovascular disease, generalized muscle weakness, right hand contracture, stiffness of right-hand, left-hand contracture, and stiffness of left hand. Review of R1's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she had functional limitation in range of motion on both sides of the upper and lower extremities and was dependent for activities of daily living (ADL). Review of R1's care plan revealed a problem related to resident having limited ability to use bilateral hands related to contractures. Review of R1's record revealed an Occupational Therapy Progress and Update Plan of Care dated 3/4/2024 which indicated prosthetic/orthotic use new goal resident will allow caregiver assistance to appropriately don (put on) and doff (remove) bilateral hand orthotics and tolerate wear of 1-2 hours in order to maintain skin/joint integrity. The patient does not consistently allow application of orthotic devices. Maximum assistance required to right hand orthotic. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Occupational Therapy Progress and Discharge Summary for dates of service 1/16/2024 through 3/26/2024 revealed R1 and caregiver educated on proper splint wear/care/schedule. Resident from skilled therapy services where she would remain a long-term care (LTC) resident of the facility with 24/7 caregiver assistance for all needs. Recommendations for restorative program assistance to be provided following discharge to continue assisting resident in maintaining splint schedule/care/ management. Review of the EHR revealed there was not an order or any documentation in residents electronic record related to contracture management after resident was discharged from skilled therapy services on March 26, 2024. Verified by the Director of Health Services (DHS) and Regional Senior Nurse Consultant on 5/5/2024 at 10:01 a.m. Observation on 5/3/2024 at 8:54 a.m. revealed R1 lying in the bed with both eyes closed. Both of R1's hands were positioned in body alignment, fingers on both hands were clenched closed into a fist. Further observation revealed an orthotic device on R1's dresser. Observations on 5/4/2024 at 9:37 a.m. and 12:29 p.m. revealed R1 out of bed in an adjustable position wheelchair in her room. RR1's right hand was clenched closed, and the left hand was observed partially open during these observations. Observation on 5/4/2024 at 1:54 p.m. revealed resident lying in bed with right hand exposed and clenched closed. There was not anything in her hands for contracture management. The orthotic device remained on the dresser. Observation on 5/5/2024 at 8:39 a.m. revealed R1 lying in bed with both hands clenched closed. The orthotic device remained on the dresser. Interview on 8/5/2025 at 8:54 a.m. with the DHS revealed she was responsible for the Restorative Nursing Program. The DHS acknowledged R1 has had a restorative plan of care since discharge from skilled therapy sometime during the month of March. DHS also stated the Therapy Manager verbally informed her that R1 was being discharged from skilled care and started on the restorative program. She stated typically the Therapy Department was responsible for putting the restorative plan of care in the EHR. The DHS verified the restorative plan of care was not entered into the EHR. The DHS further stated she should have checked to make sure it was done, but she did not do so. The DHS stated there are two restorative aides in the facility, but for the past two months the restorative aides had been working as an assigned group rendering care to residents. She stated the Certified Nursing Assistants (CNAs) assigned to R1 were responsible for applying the splint. The DHS also stated she did not check to make sure splints were applied daily as it should be, she just trusts the CNAs to do it. She stated it should be done every day, but she was sure it was not being done every day. Additionally, the DHS stated she informed the Restorative Aides of R1 needing range of motion (ROM) and splinting. (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 5/5/2024 at 9:20 am with CNA/Restorative Nursing (RNA) EE revealed she had not worked directly with the restorative program for about two months. CNA/RNA EE further stated she was assigned to R1 today and on 5/3/2024 and did not apply the splint. She stated she was not aware the documentation was not in the EHR but was aware of the service, because the Therapy Manager informed her verbally. CNA/RNA EE further stated sometimes residents will resist and not allow the splint to be applied, but when she went back later, R1 allowed the splint to be applied and she usually wore it for about two to three hours. Interview on 5/5/2024 at 9:28 am with Licensed Practical Nurse (LPN) FF revealed she had seen R1 wearing the right-hand splint from time to time, but not consistently. She further stated refusals of care should be documented in the electronic record when they occur. LPN FF verified R1 had not had the hand splint on during the three-day survey. Post Survey telephone interview on 5/5/2024 at 12:22 pm with the Therapy Manager revealed that she was aware that R1 was recently discharged from skilled therapy services to the restorative program for passive range of motion (PROM) and splinting to the right hand. She further stated that it was the responsibility of the discharging therapist to write the restorative order and update the care plan at the time of discharge from skilled care. She further stated she does not always check the record to ensure the therapist had followed the process, some she does check but she did not check this one. The Therapy Manager also stated that she verbally informed the DHS and the caregiver of the restorative services needed for R1. 36377 2. Review of R30's EMR revealed the following diagnoses but not limited to dementia and contracture right hand. The Minimum Data Set (MDS) assessed a Brief Interview Mental Status score (BIMS) of 5, indicating severe cognitive impairment. Review of R30's care plan created 4/9/2024 documented a plan of care titled, Activities Daily Living (ADLs) Functional Status/Rehabilitation Potential resident requires splint/brace assistance to right hand with intervention right hand orthotic 7:00 am to 7:00 pm. Continue review of care plan revealed no plan of care for refusal to wear hand splint. Observation and interview on 5/3/2024 at 10:11 am, R30 revealed that staff were not applying her hand splint on a routine basis. Observation revealed R30's hand splint on her bedside nightstand. Observations on 5/3/3024 at 11:30 am and 3:30 pm revealed R30 in bed with no hand splint on. The splint was on the bedside nightstand. Observation on 5/4/2024 at 9:25 pm revealed no hand splint was on R30 and the hand splint was on the bedside nightstand. Review of the CNA Point of Care (POC) charting revealed gaps in staff documenting applying R30's hand splint. Interview on 5/5/2024 at 9:25 am, CNA EE reported being unaware that R30 had a hand splint to be applied daily. She reported that she was only aware of the leg brace. She stated that what she was documenting in the POC was the leg brace. She confirmed receiving in-service on the leg brace only. (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 5/5/2024 at 9:37 am, CNA KK confirmed applying the hand splint only one day during the survey, 5/4/2024, and applying the leg brace daily. She reported that she was aware of the hand splint and received in-services. She confirmed that she did not always document a refusal in the POC for R30 refusing to wear her hand splint. CNA KK confirmed receiving restorative training on the leg brace and hand splint. Interview on 5/5/2024 at 9:46 am, CNA GG reported being unaware that R30 had a hand splint. This was the first time that she had seen R30 with the hand splint on. She observed R30 wearing the hand splint yesterday, 5/4/2024, and had removed the hand splint from the resident hand. She confirmed receiving restorative training on the leg brace and range of motion on R30's hand, but not to apply a hand splint. Interview on 5/5/2024 at 9:48 am, LPN AA reported being aware of the hand splint and only documenting on the leg splint. She reported only being aware of what the CNAs had told her in the past, that R30 refused the hand splint. She stated one time she attempted to try to help the resident to understand. She reported that R30 seemed like she understood but at times will refuse. She confirmed not documenting and providing this information to restorative. Interview on 5/5/2024 at 10:02 am with the DHS confirmed being unaware of the missing gaps on CNA POC documentation. She confirmed that her staff was not following the care plan for R30 to wear the hand splint and apply the hand splint daily. She also stated that because the care plan was not triggered to run on the flow sheet for the leg brace to distinguish it from the hand brace, this caused the confusion on the CNA's POC documentation. She confirmed that this confusion was most likely why the CNA was thinking only to document for the leg brace, missing documentation on POC Restorative and ADL Sheets that the CNA's used to communicate and to document for hand brace application.

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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** 36377 Based on observations, staff and resident interviews, record review, and review of the facility policy titled, Oxygen Administration, the facility failed to ensure oxygen (O2) was administered in accordance with the physician order for one of 20 residents (R) (R24) receiving oxygen therapy. The deficient practice had the potential for respiratory difficulty for R24. Findings include: Review of facility policy titled Policy titled Oxygen Administration revealed under category Policy Statement It is the policy of [NAME] Health Hospice and Healthcare Centers/Veteran Homes to provide oxygen safely and accurately to appropriate patients /residents. Oxygen will be administered by licensed personnel only when ordered by the physician, PA, or NP. The physician order may be written PRN [as needed] for comfort /dyspnea [shortness of breath] or may specify the number or liters, method of administration and length of time the oxygen is to be administered. Review of R24 's electronic medical record (EMR) revealed the following diagnoses of unspecified dementia, hypoxia, and anxiety disorder. The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Review of R24's care plan created 5/3/2024 revealed a plan of care of oxygen therapy with an intervention Administer oxygen at 2 LPM via NC [nasal cannula] as she will allow and explain the importance of keeping oxygen at the prescribed setting. Review of the Physician Order Form dated May 2024 revealed an order for oxygen at 2 LPM (liter per minute) via nasal cannula prn start date of 3/4/2024. Observations on 5/3/2024 at 8:48 am, 10:00 am, and 12:00 pm revealed R24 lying in bed receiving O2 by NC and the O2 concentrator (oxygen machine) set on four LPM. Observations on 5/3/2024 at 1:00 pm and 4:00 pm revealed R24 lying in bed receiving O2 by NC and the O2 concentrator was set on three LPM. Observation/Interview on 5/3/2024 at 2:24 pm, Unit Manager/Licensed Practical Nurse (LPN) confirmed that R24's O2 was set on three LPM instead of two LPM. She reported that she will notify the nurse to get the order changed to three LPM. She could not provide an explanation for R24 's O2 was set on three LPM and four LPM instead of two LPM. Interview on 5/5/2024 at 11:29 am, the Director of Health Services (DHS) reported being unaware that R24 O2 was set on the wrong liter flow. She confirmed that her licensed nursing staff was not following the physician order and the resident 's care plan. She reported that her expectation was for staff to follow the physician order. The DHS reported that her plan was to provide in-services to her nurses.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46691 Based on observations, staff interviews, record review, review of the facility's policies titled, Medication Administration: Oral Medications and Medication Administration: Insulin Injections and review of the facility document titled, Oral Dosage Forms That Should Not Be Crushed 2016, the facility failed to ensure the medication error rate was less than 5%. There were two errors with 27 opportunities for two of five residents (R) (R38 and R56) for a medication error rate of 7.41%. These failures had the potential to result in medication not being given in accordance with the physician's orders or manufacturer's recommendations and the potential to adversely affect R38 and R56's clinical conditions. Findings include: 1. A review of the facility's policy titled Medication Administration: Oral Medications, revised 12/10/2021, revealed the Policy Statement of It is the policy of [facility name] Pharmacy that oral medications are administered in an organized and safe manner. The Special Considerations section included 1. Refer to Crush List prior to crushing any medication for assurance that it can be pulverized safely. The Procedure & Key Points: section included 9. Crush medication if indicated by Physician's order for this resident only after checking the Crush List. For tablets that appear on the Do Not Crush List check with Pharmacist regarding a suitable alternative and get new order from physician if appropriate. A review of the facility-provided document titled Oral Dosage Forms That Should Not Be Crushed 2016 revealed that metoprolol extended-release (ER) (a medication used to treat high blood pressure, heart failure, and chest pain) was on the list. A review of R38's electronic medical record (EMR) revealed diagnoses including, but not limited to, hypertensive heart, chronic kidney disease with heart failure, and paroxysmal atrial fibrillation. A review of the physician's orders included an order dated 9/18/2023 for metoprolol succinate 25 milligrams (mg) ER tablet, one tablet oral, once a day at 9:00 am. During a medication pass observation on 5/4/2024 at 9:00 am, Licensed Practical Nurse (LPN) AA was observed to crush R38's medications, including one metoprolol succinate 25 mg ER tablet, mix the medications with applesauce, and administer the medications to R38. In an interview on 5/4/2024 at 1:40 pm, LPN AA verified she had crushed the metoprolol succinate 25 mg ER tablet and administered it to R38. She stated she normally crushed the medications at R38's request, including the metoprolol succinate 25 mg ER tablet. LPN AA verified the instructions on the metoprolol succinate 25 mg ER tablet pharmacy packet included Do not crush. She stated she did not notice the instructions not to crush on the medication. Further interview revealed she was aware of the medication Do Not Crush list on the medication cart and verified she did not check to see if any of R38's medications were on the list before crushing them. She verified that administering the crushed metoprolol succinate 25 mg ER tablet could cause R38 to have adverse medical complications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/4/2024 at 1:45 pm, the Director of Health Services (DHS) revealed her expectation was for the nurses to ensure medications were not on the facility's Do Not Crush list, which was located on each medication cart before crushing the medication. She stated all residents had a physician's order to allow medications to be crushed, but if the medication was on the Do Not Crush list or had instruction to not crush on the pharmacy label, the nurse should contact the pharmacy to ask for an alternative form of the medication or contact the physician to request an alternative medication and should not crush the medication. She confirmed administering a crushed medication that was on the Do Not Crush list placed residents at risk for adverse medical complications. She further stated she was unsure whether education had been provided about crushing medications, but the education would be provided immediately to the nurses. 2. A review of the facility's policy titled Medication Administration: Insulin Injections revised 10/27/2020 revealed the Policy Statement of It is the policy of [facility name] that the procedures outlined in this policy must be followed to aid oxidation and utilization of blood sugar by the tissues and to control the blood sugar levels in resident/patients with diabetes mellitus through the correct administration of insulin. The Procedures and Key Points: For Insulin Pens section included 2. Prime pen by dialing up 2 units on the pen and pressing the button on the end of the pen. Repeat priming procedure until insulin secretes from the needle. 3. Turn the knob on the end of the pen (or dial) to the number of units. A review of R56's EMR revealed diagnoses including, but not limited to, type 2 diabetes mellitus. A review of the physician's orders included an order dated 4/11/2024 for Novolog Flex Pen (a medication used to improve blood sugar control in people with diabetes mellitus) 100 unit/milliliter subcutaneous before meals and at bedtime, per sliding scale: If blood sugar is less than 70, call the Medical Doctor (MD). If blood sugar is 251 to 300, give 2 units. If blood sugar is 301 to 350, give 4 units. If blood sugar is 351 to 400, give 6 units. If blood sugar is 401 to 450, give 8 units. If blood sugar is greater than 450, call the MD. During a medication pass observation on 5/4/2024 at 11:30 am, LPN BB checked R56's blood sugar, with results of 411. The observation revealed her to prepare R56's Novolog Flex Pen insulin by dialing the pen's setting to 8 units, attaching the needle to the pen, and administering the insulin to R56. She did not dial the pen's setting to 2 units and prime the pen before dialing the dosage of 8 units. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115379	A. Building B. Wing	05/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Monroe	4796 Highway 42 North Forsyth, GA 31029

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/4/2024 at 11:35 am, LPN BB verified she did not prime the insulin pen with two units of insulin before dialing the ordered dosage on the pen and administering the insulin to R56. She stated she was unaware that she should prime the pen with two units of insulin before setting the dial to the ordered dose. She confirmed if the insulin pen was not primed before dialing the dosage amount, the resident could receive less than the ordered amount of insulin, which could result in adverse medical complications for the resident. In an interview on 5/4/2024 at 2:15 pm, the DHS stated her expectations were for the nurses to follow the manufacturer's guidelines and facility policy when administering insulin. She stated if the insulin pen was not primed as recommended, the resident could receive an inaccurate dose of insulin, which could cause medical complications. She further stated a pharmacy consultant provided education during monthly medication pass observations with the nurses, but she was unsure whether insulin pen or insulin administration education had been provided recently. She stated that education would be provided to the nurses immediately.

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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 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. 33548 Based on observations, staff interviews, and review of the facility policy titled, Pot/Pan Washing and Sanitation and review of the Sanitizing Solution Product Specification document, the facility failed to ensure dishware was air dried before usage to prevent the potential for cross contamination and bacteria contamination. The deficient practice had the potential to affect 62 of 63 residents receiving an oral diet. Findings include: Review of the facility policy titled Pot/Pan Washing and Sanitation revealed Air dry pots and pans on the drain board. Never use a dish towel. Review of the [name of company/product] Sanitizer Product Specification Document revealed Allow equipment to drain thoroughly and air dry. Observation on 5/4/2024 at 10:45 am of Dietary Cook CC taking the food processor bowl, lid, and blade out of the sanitizing solution from the three-compartment sink revealed she placed them on the drying rack for 10 seconds. Dietary cook CC was observed drying the food processor lid and the food processor bowl with a white paper towel. Dietary Cook CC did not allow the dishware to completely air dry. Further observation of the three-compartment sink revealed that the facility was using a quaternary (potent disinfectant solution) sanitizing solution. Interview on 5/4/2024 at 10:45 am, dietary cook CC revealed that the Health Department told them that they could use paper towel to dry dishware if needed after the items have been in the sanitizing solution. Dietary Cook CC revealed that the Dietary Manager (DM) would like dietary staff to air dry dishware when washed in the three-compartment sink. Interview on 5/4/2024 at 10:45 am, the DM revealed that she prefers dietary staff to air dry dishware after washing in the three-compartment sink. The DM revealed that the Health Department told her that they could wipe dry wet dishware with paper towels. The DM confirmed that the facility was using a quaternary sanitizing solution for washing dishware in the three-compartment sink and the DM confirmed that the manufacturer's recommendation for using quaternary sanitizing solution was to air dry.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 33548 Based on observations and staff interview, the facility failed to properly maintain the walk-in freezer to prevent ice build-up on food storage shelves and food products. The deficient practice had the potential to affect 62 of 63 residents receiving an oral diet. Findings include: Observation on 5/3/2024 at 8:30am of the walk-in freezer revealed ice build-up on the food storage shelf under the air condenser. The food storage shelf had six mounds of ice, the mounds were two inches in height and two inches in diameter. Continued observation revealed ice build-up on the top of food item inside a clear, plastic, resealable bag. The ice build-up on the plastic bag had a mound of ice on the left side that was about three inches in height and two inches in diameter. Further observation revealed ice build-up on top of a food item that was inside a box. The food item had a small ice mound on top that was about one inch in height and half inch in diameter. Observation on 5/5/2024 at 9:00 am of the walk-in freezer revealed that the previous ice build-up on the food storage shelf and on the food products remained. Continued observation revealed an open box of hushpuppies with a thin layer of ice covering the top lid and ice noted near the open area to the inside of the box. Interview on 5/5/2024 at 9:00 am, the Dietary Manager (DM) confirmed that there was ice build-up on the food storage shelf under the air condenser. The DM confirmed that there was ice build-up on the food item in the clear, plastic, resealable bag, on top of the food item inside the box of food, and ice build-up on top of the open box of hushpuppies. The DM revealed that she had not noticed the ice build-up, this was the first time she noticed the ice.