

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/22/2024
NAME OF PROVIDER OR SUPPLIER  Quiet Oaks Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  125 Quiet Oaks Drive Crawford, GA 30630	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>35180</p> <p>Based on observations, staff interview, record review, and review of the facility's policy titled Urinary Catheters, Maintenance of Indwelling, the facility failed to promote, maintain, and protect residents' dignity for one of six residents (R) (R54) with an indwelling urinary catheter.</p> <p>Findings include:</p> <p>Review of the facility's undated policy titled Urinary Catheters, Maintenance of Indwelling in the section titled Procedure revealed under number 5. Apply dignity cover to bag after performing resident care.</p> <p>Review of R54's Face Sheet revealed diagnoses that included but not limited to, obesity and benign neoplasm of ascending colon.</p> <p>Review of R54's physician order dated 12/20/2024 revealed, 1. Catheter care Q (every) shift &amp; PRN (as needed); 2. Check catheter securement Q shift &amp; PRN; 3. Change 16 FR (French gauge) [Name of the indwelling urinary catheter] PRN.</p> <p>Observation on 12/20/2024 at 9:43 am revealed R54's catheter bag secured to the resident's bed, uncovered, and visible from the hallway. The collection bag was noted with approximately 425 mL (milliliters) of clear, yellow urine.</p> <p>Observation on 12/20/2024 at 1:48 pm revealed R54's catheter bag was secured to the resident's bed and uncovered and visible from the hallway. The catheter bag was observed to have approximately 275 mL of clear, yellow urine in it.</p> <p>Observation on 12/21/2024 at 9:58 am revealed R54's catheter bag was secured to the bed, remained uncovered, and contained approximately 575 mL of clear, yellow urine.</p> <p>During an observation on 12/21/2024 at 10:00 am with the Administrator, he confirmed R54's catheter bag was uncovered and visible from the hallway.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46579</p> <p>Based on observations, staff interviews and review of the facility's document titled Housekeeping Duties, the facility failed to provide a clean environment for residents residing on one of two halls by not cleaning the Packaged Terminal Air Conditioner (PTAC) filters in the rooms and air vents in the bathrooms for 12 of 16 rooms (101, 102, 103,104,105,106,107,108,109,110,111, and 112) on A hall.</p> <p>Findings include:</p> <p>Review of the facility's undated document titled Housekeeping duties under Number one revealed, Use disinfectant spray [Name of Spray] in the bathrooms as [Name] has instructed. Let it sit for about 10 minutes while dusting everything in the room .</p> <p>Observation on 12/20/2024 at 9:09 am in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>Observation on 12/20/2024 at 9:17am in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>Observation on 12/20/2024 at 9:02 am in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>Observation on 12/20/2024 at 9:45 am in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>Observation on 12/20/2024 at 9:51am in room 105 revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>Observation on 12/20/2024 at 10:05 am in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>Observation on 12/20/2024 at 10:19 am in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>Observation on 12/202/2024 at 10:25 am in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/20/2024 at 10:59 am filters in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>Observation on 12/20/2024 at 10:22 am in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>Observation on 12/20/2024 at 10:33 am in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>Observation on 12/20/2024 at 10:37 am in room [ROOM NUMBER] revealed, there were two PTAC filters noted to be covered in a grey substance. The vent in the bathroom was also noted to be covered with a grey substance.</p> <p>During an observation on 12/20/224 at 3:50 pm with the Administrator, Maintenance Director (MD) and the Housekeeping supervisor revealed, the PTAC filters and the bathroom vents covered with a grey substance in rooms 101-112 were confirmed by the Administrator and the Maintenance Director. Interview with the MD revealed, PTAC filters were cleaned weekly, and they were just cleaned last Friday. At this time, he was asked if he had documentation that they were completed however, he was able to provide the cleaning schedule. He stated that he did not have any documentation at all for either one of those (PTAC filter or bathroom vents).</p> <p>Interview on 12/20/2024 at 4:25 pm with the Administrator revealed, that there had been a discussion about who was supposed to be cleaning the bathroom vents, and it would be discussed again until a solution was obtained. He stated as far as the PTAC filter, he did talk with the MD and was told that the documentation of the PTAC filters would be completed, because it did not look as though it had been completed a week ago. He revealed that he would have it taken care of prior to the surveyor return the next morning.</p> <p>Observation on 12/21/2024 at 10:35 am revealed, the PTAC filters in rooms 101 through 112 were cleaned. Further observation revealed, the bathroom vents remained covered in a grey substance in the bathrooms of rooms 101 through 112.</p> <p>Interview on 12/22/2024 at 12:20 pm with the Housekeeping Supervisor confirmed that all the vents in bathrooms 101- 112 were covered with a grey substance. She stated that whoever was assigned to the rooms were responsible for cleaning the rooms and bathrooms. She stated that it was her expectation that they were to be cleaned and would make sure that it was taken care of.</p> <p>The facility was unable to provide a policy for maintaining and cleaning of PTAC filters upon request.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>46579</p> <p>Based on observations, staff interview, record review and review of the facility's policy titled Gastronomy Feedings Policy and Procedure, the facility failed to properly label and date the formula bottle and water bag used to provide needed nutrients for one of four residents (R) R26 who received nutrition through a Gastronomy tube (G-tube).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Gastronomy Feedings Policy and Procedure dated 10/14/2022 under the section titled Purpose revealed, G-Tube feedings supply nutrition and medication to residents who are unable to take food by mouth. It is the policy of the facility to ensure optimal safe practices in care for those residents with a Gastrostomy feeding. Under the section titled Procedure revealed, 3. Each syringe will be replaced daily by the night shift. The container will have the resident's name, room number, and date that the bag was changed on the outside of the container.</p> <p>Review of the electronic medical record revealed, R26 was admitted to the facility with diagnoses that included but was not limited to cerebral infarction, metabolic encephalopathy, hemiplegia and hemiparesis, aphagia, dysphagia, and encounter for attention to gastrostomy.</p> <p>Review of the physician orders dated 9/23/2024 for R26 revealed that he was to receive Nurten 2.0 liquid 250 milliliters (ml), two cartons to equal 500 ml at night continuously at 100 ml/hour (hr) with 100 ml of water flush every hour.</p> <p>Review of the care plan for R26 with revision date of 7/5/2024 revealed, that the resident has dysphagia secondary to cardiovascular accident (CVA) and has a diagnosis of gastric reflex, malnutrition, and failure to thrive; He receives tube feedings per orders; Interventions included but were not limited to feedings and flushes as ordered. HOB elevated. Check residual prior to feedings.</p> <p>Observation on 12/20/2024 at 10:59 am in R26's room revealed, the formula bottle and the water bags were not labeled with contents, room number, resident name or the date</p> <p>There were no other observations made related to the resident was sent to the hospital on 12/20/2024.</p> <p>Observation and interview on 12/20/2024 at 12:55 pm with the Director of Nursing (DON) who was asked to observe the formula feeding and water bag for R26, confirmed that the formula bottle and water bag for R26 was not labeled. She stated that it should have at least been labeled with a start date, start time, room number and the residents name and the formula type.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>33548</p> <p>Based on observations, staff interviews, and review of facility's policies titled Dietary Services Policy and Procedure and Food Storage, the facility failed to prevent wet nesting of pans to avoid bacterial growth; failed to serve cold items at or below 41 degrees; and failed to label and date bulk food items after removal from original packing. The facility had a census of 57 out of 60 residents receiving an oral diet.</p> <p>Findings include:</p> <p>1. Review of the facility's undated policy titled Dietary Services Policy and Procedure under the subtitle, Dietary Staff revealed, all pots and pans must be washed utilizing the 3-compartment system and must be left to be air-dried after the final sanitizing rinse. The policy also stated, Dishwashing: Dishes and utensils are stored in a protective manner to protect from disease carrying organisms.</p> <p>Observation on 12/20/2024 at 8:40 am of the stacked steam table pans located under the food preparation table revealed, a stack with three medium sized rectangle pans were pulled apart and the middle pan was wet and had moisture inside.</p> <p>During an interview on 12/20/2024 at 8:40 am, the Certified Dietary Manager (CDM) confirmed that the inside of the stacked steam table pan was wet and had moisture. Continued interview with the CDM revealed, that dietary staff should have allowed that pan to dry longer on the drying rack.</p> <p>2. Review of the facility's policy titled Dietary Services Policy and Procedure under the subtitle, Dietary Staff revealed, Cold food is served from the kitchen at or below 41 degrees F.</p> <p>Steam table temperatures were completed on 12/21/2024 at 12:20 pm with the assistance of the CDM using the facility's calibrated thermometer. A carton of 2% milk was taken from a pre-assembled resident meal tray and the milk had a temperature of 52 degrees Fahrenheit.</p> <p>During an interview on 12/21/2024 at 12:20 pm with the CDM, she confirmed that the carton of 2% milk was on a resident meal tray to be served, and the temperature of the milk was 52 degrees. Continued interview with the CDM revealed that the cartons of milk were placed on the resident meal trays around 11:45 am and that the lunch meal service began at 12:15 pm. The CDM confirmed that cartons of milk sit on the resident meal trays prior to meal service. The CDM stated that cold food should be served at 41 degrees or lower.</p> <p>3. Review of the facility's policy titled Food Storage dated 3/19/2021 under Procedure revealed, All foods that have been opened and partially used shall be dated and sealed before returning to a storage area. Under the section titled A. Dry Storage Practice revealed, Store all open packages in closed and labeled containers.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 12/22/2024 at 9:15 am of the large clear plastic storage containers under the food preparation table near the dish room revealed, the containers had cereals of raisin bran, corn flakes, and rice cereal. Further observation revealed, there was no date to indicate when the cereals were placed in each plastic container.</p> <p>During an interview on 12/22/2024 at 9:15 am, the CDM confirmed that the containers with the breakfast cereals did not have any dates. The CDM stated that she did not realize that she needed to date the cereal containers since they use the cereal quickly.</p>