

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/31/2025
NAME OF PROVIDER OR SUPPLIER  Thomasville Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  120 Skyline Drive Thomasville, GA 31757	

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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>34318</p> <p>Based on resident interviews, staff interviews, and record review, the facility failed to ensure two of 11 sampled residents (R) (R4 and R5) were not served identified food allergens. The deficient practice had the potential to place R4 and R5 at risk for medical complications, unmet needs, and a diminished quality of life.</p> <p>Findings include:</p> <p>1. Review of R4's Admission Record revealed diagnoses that included, but were not limited to, gastro-esophageal reflux disease and vitamin deficiency. The Admission Record revealed shellfish products listed in the allergies section.</p> <p>Review of R4's quarterly Minimum Data Set (MDS) assessment, dated 3/6/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 15 (indicating little to no cognitive impairment).</p> <p>Review of R4's Order Summary Report active orders as of 12/1/2024 revealed an allergy to shellfish products.</p> <p>Review of R4's Progress Notes revealed an entry dated 12/10/2024 that the resident did not have any reactions or issues during this shift. An entry dated 12/11/2024 noted that R4 had no shortness of breath or edema.</p> <p>Review of a Facility Incident Report Form dated 12/10/2024 revealed a Certified Nursing Assistant (CNA) reported R4 received seafood from the dietary department, and the resident took one bite and refused to eat more. The report documented that the physician, family member, and dietary manager were notified. The resident was assessed and showed no signs of allergic reaction throughout a shift.</p> <p>Review of the monthly menu revealed that fish products were served once a week.</p> <p>During an interview on 3/26/2025 at 3:58 pm, R4 revealed that she had been served fish and had asked the CNA what it was. R4 stated that the CNA told her that she didn't know what it was. R4 stated that she took one bite and realized it was a crab cake. She stated that she spit out the fish and rinsed her mouth with water. She stated she was allergic to fish, shellfish, clams, and oysters.</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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/31/2025 at 9:44 am, the Certified Dietary Manager (CDM) confirmed R4 had been served a crab cake on a meal tray. The CDM stated that the nurses and CNAs determined that the resident had received the wrong tray, and the resident was served an alternate meal after the discovery.</p> <p>During an interview on 3/31/2025 at 12:28 pm, Licensed Practical Nurse (LPN) II revealed that everyone had received an in-service to check the resident meal tickets. LPN II stated that CNAs, nurses, and dietary staff were responsible for checking food allergens.</p> <p>2. Review of R5's Admission Record revealed diagnoses that include, but are not limited to, adult failure to thrive. The Admission Record revealed fish was listed in the allergies section.</p> <p>Review of R5's admission MDS assessment, dated 1/23/2025, revealed Section C (Cognitive Patterns) documented a BIMS of 13 (indicating little to no cognitive impairment).</p> <p>Review of R5's Order Summary report dated 2/1/2025 through 3/31/2025 revealed fish allergy was listed in the allergies section.</p> <p>During an interview on 3/24/2025 at 2:42 pm, R5 revealed that he received fish every time it was on the menu and he sent it back.</p> <p>During an interview on 3/31/2025 at 2:56 pm, CNA KK revealed that R5 told her he was allergic to fish, and she saw it on his meal card. She stated that R5 had been served a meal with fish and that she took the entire tray back to dietary and obtained another tray for the resident.</p> <p>During an interview on 3/31/2025 at 9:44 am, the CDM revealed that the Dietary [NAME] was to ensure that residents with food allergies were not served the food allergens and that the nursing staff should check the meal trays as well.</p> <p>During an interview on 3/31/2025 at 3:29 pm, the Director of Nursing (DON) revealed that the staff was responsible for checking meal trays for allergens and that residents should not be served foods they were allergic to.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34318</p> <p>Based on observations, staff interviews, record review, and review of the facility policy titled, Enhanced Barrier Precautions, the facility failed to ensure staff followed infection control processes during wound care for one of one residents (R) (R3) observed for wound care from a sample of 11 residents. The deficient practice increased the risk of staff spreading infection to other residents in the facility.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Enhanced Barrier Precautions, dated 4/1/2024, revealed the Policy section included, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. 3. Implementation of Enhanced Barrier Precautions: 3a. Make gowns and gloves available immediately near or outside of the resident's room. Noted: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). 3b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and my not need to bed donned prior to entering their resident's room. 4. High-contact resident care activities include: a. Dressing b Bathing c. Transferring d. Providing hygiene e. Changing linens f. changing briefs or assisting with toileting g. device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: any skin opening requiring a dressing.</p> <p>Review of R3's Quarterly Minimum Data Set (MDS) assessment, dated 2/27/2025, revealed Section M (Skin Condition) documented the resident had one unstageable pressure ulcer.</p> <p>An observation on 3/24/2025 at 3:10 pm in R3's room revealed Certified Nursing Aide (CNA) AA providing perineal care to R3. Observation revealed CNA AA providing direct care to remove the dirty incontinent brief and was not wearing a protective barrier gown.</p> <p>An observation on 3/24/2025 at 3:31 pm revealed Licensed Practical Nurse (LPN) BB provided wound care to R3's right heel. Observations during the wound care procedure revealed that LPN BB did not wear a gown during the procedure. Further observations revealed LPN BB placed the wound care supplies on a bedside table without sanitizing the surface of the table or placing a barrier on the table.</p> <p>During an interview on 3/31/2025 at 10:46 am, CNA EE stated that the facility had not had any gowns available for the past month. She further stated that gowns should be worn when providing care to residents with urinary catheters, infections, bloody urine, and feces when the facility had gowns.</p> <p>During an interview on 3/31/2025 at 11:48 am, Registered Nurse (RN) HH/Infection Preventionist (IP) stated that staff should wear a barrier gown when providing care to residents who were on enhanced barrier precautions (EBP) and further stated she was unsure why staff were not wearing gowns.</p> <p>Observation on 3/31/2025 at 12:03 pm with RN HH IP revealed a supply of protective gowns in the supply room on 300 Hall.</p>		