

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2024
NAME OF PROVIDER OR SUPPLIER Greene Point Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1321 Washington Highway Union Point, GA 30669	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33548</p> <p>Based on observations, staff interviews, and review of facility policies titled Storage Areas and Food Preparation and Distribution, the facility failed to discard milk by the use by date; failed to remove dented cans from the dry storage area; and failed to properly thaw ground beef to prevent bacteria growth and food borne illness. The facility had a census of 44 out of 48 residents that consumed an oral diet from the kitchen.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Storage Areas dated 12/29/2023 under the section titled Guideline revealed, Dry Storage: Dented cans should be stored separately in a clearly labeled area.</p> <p>Review of the facility's policy titled Food Preparation and Distribution dated 12/29/2023 under the section titled Guideline revealed, Thawing methods: Submerged under running water at a temperature no greater than 70 F.</p> <p>1. Observation on 12/6/2024 at 8:35 am of the two-door reach-in refrigerator near the steam table revealed an open case of 18, eight-ounce cartons of 2% (two percent) milk with a use by date [DATE].</p> <p>During an interview on 12/6/2024 at 8:35 am, the Dietary Manager (DM) confirmed that the cartons of 2% milk had a use by date of [DATE]. The DM revealed that dietary staff should have discarded the milk.</p> <p>2. Observation on 12/6/2024 at 8:45 am of the canned food storage rack revealed a can of black beans with a large dent towards the bottom.</p> <p>During an interview on 12/6/2024 at 8:45 am, the DM confirmed that the can of black beans was in the food storage rack and had a large dent. The DM revealed that dietary staff should have not placed the can in the rack and should have placed the dented can in her office which was the location for damaged cans.</p> <p>3. Observation on 12/7/2024 at 8:50 am of the food preparation sink labeled Meat revealed a large tube of ground beef. The ground beef was on the bottom of the sink with cool water from the faucet running over the top. The ground beef was not covered or submerged in water.</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 12/7/2024 at 8:50 am, the DM confirmed that the tube of ground beef was in the process of being thawed to use for lunch meal. The DM did not want to confirm if the ground beef was being properly thawed using the sink and running water. The DM did confirm that food items thawed in a sink should be submerged in water. The DM revealed that the ground beef should have been taken out of the freezer a few days earlier and placed in the refrigerator to be thawed.</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>47146</p> <p>Based on observations, staff interviews, record review, and review of facility's policy titled Tube Feeding Syringes, the facility failed to clean and store a tube feeding syringe after use for one of four residents (R) (R44) who received nutrition through a gastrostomy tube. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs, increased risk for infection, and a diminished quality of life.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Tube Feeding Syringes dated 12/29/2023 under the section titled Intent revealed, It is the intent of this center to help prevent nosocomial infections (infection that develops during medical treatment) associated with enteral feeding equipment. Under the section titled Guidelines revealed, The following Procedural guidelines should be followed when storing a piston syringe: Tube Feeding and Medication Administration: wash the syringe; separate the piston from the barrel; Store the syringe separated on a clean surface to air dry, or place separated in a bag mounted to the feeding pump pole (the bag should not be airtight).</p> <p>Review of the Electronic Medical Record (EMR) revealed, R44 was admitted to the facility with diagnoses that included but was not limited to aphasia (inability to swallow), dysphasia (difficulty swallowing foods or liquids) following a cerebral infarction (stroke), and gastrostomy (surgical opening to the stomach for introduction of food) status.</p> <p>Review of R44's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 11/8/2024 revealed Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) of five, which indicated R44 had severe cognitive impairment; Section K (Swallowing/Nutritional status) revealed, R44 received 25% or less calories through parenteral or tube feeding and an average fluid intake per day by tube feeding of 1500 millimeters/day or less as a resident.</p> <p>Review of R44's EMR revealed physician's orders that included but was not limited to: Peg-tube flush, 150 milliliter every four hours per feeding tube dated 6/6/2024 and Peptamen 1.5 calories, one carton per feeding tube at bedtime; may be held for activities of daily living care, therapy, and medication administration dated 10/10/2024.</p> <p>Observations on 12/7/2024 at 7:48 am of R44's room revealed, a catheter tipped syringe on the nightstand uncovered with a white colored liquid in the tip of the syringe. There was a clear bag observed next to the uncovered syringe dated 12/6/2024.</p> <p>Observations and interview on 12/7/2024 at 2:55 pm with Licensed Practical Nurse (LPN) Wound Care Nurse AA revealed, a catheter tipped syringe with a white colored liquid in the tip of the syringe. LPN Wound Care Nure AA confirmed the observation and stated the catheter tipped syringe should not be stored on the nightstand. She stated the syringe should be cleaned after use, allowed to air dry, and then placed into a protective covering.</p> <p>(continued on next page)</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>Observation and interview on 12/7/2024 at 3:01 pm with the Assistant Director of Nursing/ Infection Preventionist revealed an observation of a catheter tipped syringe with a white colored liquid in the tip of the syringe lying on R44's nightstand uncovered. She confirmed the observation and revealed the syringe should not be left on the nightstand uncovered. She stated the nurse should clean and rinse the syringe thoroughly with water, allow to air dry, then place the syringe in a protective covering after each use. She stated the possible outcome of this practice would be the resident could develop a possible infection.</p> <p>Interview on 12/8/2024 at 12:19 pm with the Director of Nursing revealed that her expectation was that the nurse rinse the syringe out after use, allow the syringe to air dry, and then place the syringe in a protective covering. She stated the possible outcome of this practice would be the resident could possibly develop an infection.</p>