STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115494	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McRae Manor Nursing Home	160 South First Avenue MC Rae, GA 31055

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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, staff interviews, record reviews, and a review of the facility policy titled Dignity Policy, the facility failed to ensure dignity for two of 25 sampled residents (R) (R62, R29). Specifically, staff were observed standing while feeding R62 and there was no privacy bag used to cover the catheter drainage bag for R29. Findings include: Review of the facility policy titled Dignity Policy (last reviewed 5/5/2023) stated .It is the policy of the facility that staff must promote care for residents in a manner and in an environment that maintains or enhances each resident 's dignity and respect in full recognition of his or her individuality. This means staff must carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth. 1. Record review of R62's medical record revealed the following diagnoses but not limited to vascular dementia with unspecified severity without behavioral disturbances, psychotic disturbance, and anxiety. The Significant Change Minimum Data Set (MDS) dated [DATE] assessed a Brief Interview Mental Status Score (BIMS) of three, a score of three out of 15 indicated severe cognitive impairment. An observation on 7/10/2024 at 1:18 pm revealed Certified Nursing Assistant (CNA) HH standing while assisting R62 with eating his meal. There was no chair observed in R62's room. CNA HH stated that R62 requires total assistance with his meals. Interview on 7/10/2024 at 1:20 pm, with CNA HH, Licensed Practical Nurse (LPN) II, and Assistant Director of Nursing (ADON), CNA HH confirmed standing while feeding R62. She reported being unaware that feeding a resident while standing was not the correct procedure and a dignity concern. She reported receiving no in-services or instructions to sit while feeding a resident at eye level. ADON and LPN II reported that this would be a dignity concern as well as a concern with possibility of a resident being subjective to choking hazards. LPN II confirmed providing in-services in the past to other CNAs who were observed standing while feeding residents. 46431 2. Record review revealed R29 had diagnoses that included (partial list): Spina Bifida with hydrocephalus, periapical abscess without sinus, spinal stenosis and urinary tract infection. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly Minimum Data Set (MDS) for R29 dated 4/26/2024 revealed Section C-Cognitive Patterns: BIMS score of 15 indicating an intact cognition; and Section H-Bowel and Bladder: resident has an indwelling urinary catheter and always incontinent of bowel. An observation of R29 on 7/9/2024 at 9:30 a.m. revealed R29 was in the bed with an indwelling urinary catheter bag attached to the bed. There was no privacy bag in place and the catheter bag was visible from the door. An observation of R29 on 7/9/2024 at 3:32 p.m. revealed the resident was in the bed with an indwelling urinary catheter bag attached to the bed. There was no privacy bag in place and the catheter bag was visible from the door. During an interview with a Licensed Practical Nurse on 7/9/2024 at 3:40 pm it was confirmed the resident was in the bed with an indwelling urinary catheter bag attached to the bed without a privacy bag and the bag was exposed to the hall. During an Interview on 7/10/2024 at 10:00 am with the ADON, revealed residents with catheters should have their catheters always contained in a privacy bag. The ADON further stated that the facility uses privacy bags to cover the catheter drainage bags. The ADON indicated the CNAs and nurses are responsible to make sure that this is being done.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, staff interviews, record review, and review of the facility policy titled Administration Medication Policy and Procedures, the facility failed to ensure one of 23 sampled residents, (R) R23, did not have unsecured medications stored at the bedside. This deficient practice had the potential to allow unauthorized access of medications to other residents and visitors in the facility. Findings include: Record review of the facility's policy titled Administering Medications Policy and Procedures (not dated) stated return drugs to medication cart or medication room. Never leave any drug in a resident 's room. For residents who keep medication in their room check to ensure meds are stored properly out of reach of other residents. Record review of R23's medical record revealed the following diagnoses but not limited to dementia, hypertension, hypokalemia, and anxiety disorder. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed an assessment for a Brief Interview Mental Status Score (BIMS) as unable to be conducted due to R23 being rarely/never understood. Observation on 7/9/2024 at 12:35 pm revealed two bottles of Equate Nasal Spray in R23's room within visual view. One of the bottles was located in a red color pan on dresser and one on a bookshelf within view from the doorway. R23 observed in the bed at the time of the observation. Record review of R23's July 2024 Physician Order Form (POF) and July 2024 Medication Administration Record (MAR) revealed no listing of an order for nasal spray. The POF listed the following medication, albuterol 2.5 one vial for nebulizer every four hours, as needed for shortness of breath and Guaifenesin with codeine solution 5 millimeters(ml) (10ml) by mouth every six hours as needed for cough. During an interview and observation of R23's room on 7/9/2024 at 2:13 pm with the Administrator and the Assistant Director of Nursing (ADON), both confirmed the medications in the resident's room. The ADON removed the medications from the room. The Administrator reported that medications should not be in the resident 's room and should be kept on the nursing med cart. Interview on 7/9/2024 at 2:19 pm with the ADON who reported being unaware of the origin of where the medication came from. She could not recall the last time visiting R23's room. She confirmed that the medications found were not listed on R23 's POF or the MAR. She also acknowledged medications left in the room posed a risk for other residents that may wander into the room. The ADON confirmed that R23 has not been assessed to self-administered medications and does not have a Self -Administration Assessment evaluation to self-administer medications. She stated that their facility does not complete a self -administration evaluation form. She further stated that there are no known residents in the facility who have been assessed to self -administer medications.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138 Based on observations, staff interviews and review of Job Description and Performance Standards - Maintenance Supervisor, the facility failed to provide a safe/clean/comfortable/homelike environment for one hallway (200 hall) of three hallways. Specifically, there was a handrail with loose posts and one handrail with broken brackets. Findings included: Review of Job Description and Performance Standards - Maintenance Supervisor revealed, purpose of this position is to develop and implement maintenance polices and procedures in an effective manner to safely meet residents' needs in compliance with federal, state and local requirement. Review of the primary functions of this position reflected the following: 4. Develop and implement repair and maintenance schedules for all areas of the facility and grounds. An observation on 7/9/2024 at 11:29 am revealed two defective handrails on 200 South between rooms [ROOM NUMBERS]. One handrail was pulling away from the wall due to loosened posts and one had broken brackets. An observation on 7/10/2024 at 11:29 am revealed two defective handrails on 200 South between rooms [ROOM NUMBERS]. One handrail was pulling away from the wall due to loosened posts and one had broken brackets. A walk through on 7/10/2024 at 4:45 pm with Administrator and Maintenance Director confirmed one handrail was loose and the other handrail had broken brackets. The Maintenance Director began to make the repairs immediately. An Interview on 7/11/2024 at 10:07 am with the Maintenance Director revealed he checks the handrails periodically or by work tickets, there is no schedule in place for checking the handrails. The Maintenance Director stated the facility does not have a policy for preventative maintenance or handrail policy. He went on to report that he will implement preventative measures to ensure handrails are in good condition by putting a schedule in place to check the handrails monthly. Interview on 7/11/2024 at 2:51 pm with Administrator revealed she did not have anything in writing regarding the Maintenance Director monitoring the handrails on the halls, but she did expect him to monitor the hall, moving forward he will have a monthly schedule. There was no evidence that any residents had experienced a fall due to the loose and broken handrails.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46431 Based on observations, resident and staff interviews, record review, and review of the facility's policy titled Activities of Daily Living the facility failed to ensure one resident, (R) R44, of 23 residents sampled were given showers as scheduled. This failure had the potential to cause R44 to be unclean and create an environment that could increase the potential for actual infections and cause the residents to feel self-conscious of appearance. Findings include: Review of the facility's policy titled, Activities of Daily Living (last revised March 2018), revealed residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. R44 admitted to the facility with diagnoses that included: Hemiplegia and Hemiparesis, cerebral infraction, personal history of transient ischemic attack and cerebral infarction without residual deficits, and seizures. Review of the most recent Quarterly Minimum Data Set (MDS) dated [DATE] documented R44 had a Brief Interview for Mental Status (BIMS) of 14 indicating the resident had intact cognition. Further review revealed R44 had no behaviors, dependent on staff to shower/bathe self, tub/shower transfer, and personal hygiene. During an observation of R44 on 7/9/2024 at 10:05 am in the resident's room revealed the resident with dry flaky skin. During an interview and observation with R44 on 7/10/2024 at 12:30 pm, in the resident's room she stated that she does not remember the last time she had a shower, and she currently needs a shower. R44 also stated she did not know when her showers days were scheduled but would like a shower at least three times a week. Observation, at this time, revealed the resident had dry flaky skin with dried up substance around her mouth. Review of the Bath Sheets Shower book revealed R44 did not reflect any bath or shower documented since 3/16/2024. During an interview with Certified Nursing Assistant (CNA) BB on 7/10/2024 at 4:00 pm, at the nurse's station, she revealed the CNAs are not required to document showers/baths but if a resident refuses CNAs are to notify the nurse, and the nurse makes a progress note. CNA BB could not confirm when R44 last had a shower or bed bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Assistant Director of Nursing (ADON) at 4:30 pm on 7/10/2024, in the nursing station revealed the bath team completes the bath sheet and are instructed to place them in the bath book, however she expressed the bath sheets are not always placed in the book. When asked how the facility keeps up with residents' baths, she expressed there has been a lot of recent changes in leadership and a lot of documents have not been enforced. ADON went through the shower book and verified there had been no documentation since March 2024, related to R44 getting a shower or bed bath.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, resident interviews, staff interviews, and the facility policies titled Accidents and Incidents-Investigating and Reporting, Oxygen Delivery Policy, and Chemical Safety and Storage, the facility failed to ensure two of 23 sampled residents (R) (R49 and R65) were free from accident hazards. Specifically, the facility failed to ensure R49 was free from exposure to free standing oxygen and R65 was free from exposure to harmful chemicals. Findings include: Review of facility policy titled Oxygen Delivery Policy (revised 2/28/2018) revealed 5. Oxygen cylinders must be in portable carrier or in wheelchair oxygen holders. Cylinders must not be placed on the floor. Review of facility policy titled Chemical Safety and Storage (undated) stated Proper storage of chemicals is necessary to ensure the resident environment remains as free of accident hazards as is possible. Guidelines: All chemicals should be labeled properly and in the correct containers and stored in the locked cabinet at all times. Chemicals used by housekeeping, maintenance, or dietary staff should be close guarded and not left in resident areas. 1. Record review of R49's medical record revealed the following diagnoses chronic obstructive pulmonary disease with acute lower, hypertension, and atrial fibrillation. The Quarterly MDS dated [DATE] assessed a Brief Interview Mental Status Score (BIMS) of 15 which indicated intact cognition. Record review of R49's Physician Order Form dated 12/14/2023 revealed an order for oxygen at 3 liters /minute via nasal cannula continuously. Check oxygen Sat (saturation) check and record oxygen Sats every shift. Observation on 7/12/2024 at 9:00 am of Wing 2 dining area revealed R49 sitting in dining area in his wheelchair with other residents. A closer observation revealed the resident oxygen cylinder tank sitting on the floor next to the wheelchair and directly in front of the vending machine. There were approximately 15 residents in the dining area and random staff passing by. Nurses were observed sitting at Wing 2's nurse station. An interview was conducted with R49 at the time of the observation. R49 reported that he was waiting for the next smoke break and a staff person removed his oxygen from the back of his wheelchair holder for him and set it on the floor next to him. Housekeeping staff (HK) QQ was noted to be standing a few feet from R49. Late interview with R49 on 7/12/2024 at 9:20 am, R49 reported that a nurse removed the oxygen from the floor and took the tank to his room. R49 reported that the routine was to remove the oxygen tank before going outside for the smoke break and leave it in the dining room area until his smoke break was completed. Interview on 7/12/2024 at 9:45 am with HK QQ. HK QQ confirmed observing the oxygen sitting on the floor. He reported that this is a habit of the resident to sit his O2 on the floor. HK QQ reported being unaware of the risk of having O2 sitting on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/12/2024 at 1:10 pm, ADON reported that her expectations of staff are to follow oxygen safety precautions concerning free stand oxygen cylinder tank. She reported that staff have received in-services on accident prevention concerning oxygen. 2. Observation on 7/9/2024 at 11:44 am of room [ROOM NUMBER] (R65's room) revealed Micro Kill bleach sitting on a rack underneath the bathroom sink within view of any resident or visitor entering the bathroom (shared room) for room [ROOM NUMBER] and room [ROOM NUMBER].The resident room door was open. R65's was not in the room. Another observation was observed on 7/9/2024 at 11:45 am reveal outside the door, a large container of Micro Kill Bleach wipes and a can of disinfectant Spray on top of a plastic two tier drawer cart (designated as a PPE Cart Personal Protective Equipment) directly in front of Room in between room [ROOM NUMBER] and room [ROOM NUMBER]. Observation on 7/9/2024 at 11:45 am, revealed a resident wandering the hall and passing the PPE cart. This resident was redirected by Social Services. Record review of R65's revealed the following diagnoses but not limited to Alzheimer 's Disease, glaucoma (blindness), unspecified dementia with severe agitations, chronic obstructive pulmonary disease, and atrial fibrillation. Record review of R65's Quarterly MDS dated [DATE] assessed a BIMS score of four which indicates severe cognitive impairment, severe vision impairment, ambulatory with supervision for short distances (can walk 10 to 50 feet with supervision or verbal cues), and dependent for most ADL except for eating, and frequently incontinent for bladder and occasionally incontinent for bowel. During an observation at the time of interview on 7/9/2024 at 2:04 pm with the Housekeeper Supervisor (HK Supervisor) and ADON, both staff confirmed the chemicals observed in R65 's bathroom and chemical on top of the PPE cart outside room door between room [ROOM NUMBER] and room [ROOM NUMBER]. The HK Supervisor reported that most likely a Certified Nursing Assistant left the chemicals in the bathroom. She stated that her staff were in-serviced not to leave bleach or any chemicals in the bathroom. The ADON confirmed that having chemicals left in the bathroom placed the residents at risk due to harmful ingestion of chemical. The ADON confirmed that they do have residents who wander in the facility. She confirmed that R40 has low cognition and has a history of wandering freely throughout the facility. The HK Supervisor reported that she was informed to leave the disinfectant spray and Micro Kill Bleach wipes on top of the cart outside a resident door if they are on Transmission Base Precautions for the nursing staff and certified nursing assistant to use. The ADON reported that leaving chemicals outside of the doorway was not a part of the facility policy. The ADON reported that she was IPC (Infection Control Preventionist) for the facility. Any chemical left out would be considered harmful to the residents. The Micro Kills wipes are usually kept on the nurses' cart or in a secure place. Disinfectant Spray is kept in a secure place.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, staff interviews, record review, and the facility policy titled Urinary Catheter, Maintenance of Indwelling Policy and Procedure , the facility failed to have a Physician order for one resident, (R) R62, of six residents with catheters. In addition, the indwelling urinary catheter order was omitted on the Medication Administration Record (MAR) to ensure monitoring instructions, and appropriate treatment services for the catheter. This deficient practice had the potential to put residents at risk for complications related to their urinary health with the possibility of urinary tract infections. Findings include Review of facility policy titled Urinary Catheters, Maintenance of Indwelling Policy and Procedure (undated) 1. A physician 's order and medical reason will be obtained for each resident receiving an indwelling catheter. The order will explain the size of catheter, size of balloon, and type of catheter to be used. It will also describe how often the catheter to be used. It will also describe how often the catheter and drainage system is to be changed. 5. Be sure there are no kinks in the catheter tubes and drainage tubing. Maintain an unobstructed downward flow at all times unless the catheter is clamped for a procedure (for example, bladder retraining). The collection bag will be placed below the level of the bladder. Never let the tubing or drainage for each resident. Record review of R62's medical record revealed the following diagnoses but not limited to benign prostatic hyperplasia with lower urinary tract symptoms. The Significant Change Minimum Data Set (MDS) dated [DATE] assessed resident for an indwelling urinary catheter and Brief Interview Mental Status (BIMS) score of three which indicated severe cognitive impairment. Record review of Physician Order Form dated February 2024 revealed no order for an indwelling urinary catheter. The MAR for the month of May record, June, and July 2024 revealed no order for an indwelling urinary catheter and no instructions related to care and monitoring for an indwelling urinary catheter. During an observation on 7/10/2024 at 1:20 pm to 3:00 pm, revealed R62 lying in bed. Continued observation revealed indwelling urinary catheter within view from the doorway and the catheter tubing coiled around the frame of the bed causing the potential for prevention of a steady flow of urine drainage. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/2024 at 11:45 am with Licensed Practical Nurse (LPN) LL and Assistant Director of Nursing (ADON) both staff confirmed that no order was put in place until after being identified during the survey on 7/11/2024. The ADON reported that the MAR was updated at 6:00 pm yesterday (7/10/2024) by her nurse. The ADON stated that she was unable to provide an explanation as to why an order was not written by the resident's physician. ADON reported that when R62 returned from the hospital in February 2024, the resident received an order for an indwelling urinary catheter. She reported that her expectation would have been for the order to be carried over each month. She reported that her licensed nursing staff are responsible for monitoring all orders. ADON reported the likelihood of infection would increase if the catheter was not cleaned and changed. She stated that the February 2024 MAR listed an order urinary output q shift. This was a general statement and not considered as an order related to indwelling urinary catheter care and monitoring. The order should have included indwelling urinary catheter care every shift and as needed, cleaning, and monitor for dislodging.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, interviews, and record review, the facility failed to attempt appropriate alternatives, assess for risk of entrapment, review the risks versus benefits, and obtain informed consent prior to installing side rails for residents' beds for four of five Residents (R) (R60, R1, R14, and R66) reviewed for side rail/bedrail usage. Substandard Quality of Care was identified related to bedrails. Findings include: 1.Observation made on 7/9/2024 during the initial tour, starting at 1:00 pm revealed the presence of full side rails attached to the left and right side of R60's bed. R60 was observed lying in a bariatric bed with side rails up. Record review for R60 revealed the following diagnoses but not limited to [NAME] stenosis of lumbar region. The Annual Minimum Data Set (MDS) dated [DATE] assessed a Brief Interview Mental Status Score (BIMS) of 15 which indicates no cognitive impairment and total dependent for all Activity of Daily Living Skills (ADLs) except for eating. The Annual MDS dated [DATE] and Quarter MDS dated [DATE] documented no assessment for side rails. Record review of R60's medical record revealed no assessment for bedrails and no consent for bed rails. Interview on 7/10/2024 at 9:47 am, the Assistant Director of Nursing (ADON) reported that she inquired with Corporate Office Clinical Operations about side rail assessments. The Corporate Office relayed to her that the facility does not have complete side rail assessments for any resident's bed since they are not considered a restraint for a resident. She confirmed that no resident in the facility has a consent form for side rails. The facility does not require consent for the use of side rails from residents. During an initial walk through and interview at the time of observations of resident's siderails. rounds with Assistant ADON and Maintenance Director on 7/11/2024 at 10:12 am, both staff confirmed R60 to have full size bed rails. Interview on 7/11/2024 at 3:18 pm, R60 reported using her bed rails for support to keep from falling from the bed. She reported using the bedrails to grip when staff is positioning/turning her for incontinent care, and bed bath. Resident was also observed with a trapeze attached to head of the bed and to grip when staff is turning her for bathing and incontinent care. Resident reported that using the trapeze to help pull up in the bed. Interview with the Administrator during Quality Assurance Performance Plan (QAPI) Meeting on 7/12/2024 at 4 pm, the Administrator was informed of the surveyor concerns regarding side rails and no assessment for side rails based on the facility policy. The Administrator offered no comment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	49138 2.Review of the most recent Quarterly Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) of 15 indicating the resident had intact cognition. Further review revealed R1 had no behaviors, dependent for dressing and dependent for hygiene. Review of Care Plan revealed R1 has full bedrails per his request. Record reviews revealed R1 did not have a bed rail assessment completed. During an initial walk through and interview at the time of observations of residents bedrails, with ADON and Maintenance Director on 7/11/2024 at 10:12 am, both staff confirmed the type of rails. R1 was identified to have full size bed rails. The ADON stated that R1 had full rails on his bed per his request. An interview on 7/12/2024 at 1:28 pm revealed R1 to be alert and oriented with no concerns. R1 was sitting in his wheelchair watching television. Resident stated that he uses his bedrail daily. R1 stated that he needs his rails. R1 stated his rails were in good working condition and currently had no concerns with them, and if there were any concerns he would contact maintenance for any repair needed. 3. Review of the most recent Quarterly MDS assessment dated [DATE] documented R14 had a Brief Interview for Mental Status (BIMS) of 15 indicating the resident had intact cognition. Further review revealed R14 requires total care and receive range of motion six days a week. Record reviews revealed R14 did not have a bed rail assessment completed. An observation on 7/10/2024 at 9:52 am revealed R14 lying in the bed with a hand contraction on his left hand, head evaluated and legs in a bent position. R14 was noted to be alert but nonverbal. Bedrails were noted to be up on both sides of the bed. An observation 7/10/2024 1:09 pm revealed R14 was repositioned in the bed. Bedrails were noted to be up on both sides of the bed. An observation on 7/10/2024 at 3:24 pm revealed R14 to be nonverbal. R14 lying in his bed with knees slightly bent, his head lying back on a pillow and feet elevated. An interview during walking rounds with ADON and Maintenance Director on 7/11/2024 at 10:12 am confirmed R14 had half rails on his bed. 49675 4.Review of the clinical record for R66 revealed he was admitted to the facility on [DATE] with diagnoses of but not limited to mood disorder unspecified, paraplegia, and major depressive disorder, recurrent with severe without psychotic features. (continued on next page)

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	115494	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McRae Manor Nursing Home	160 South First Avenue MC Rae, GA 31055

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R66's most recent Annual MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated no cognitive impairment. Section GG (Functional Abilities and Goals) revealed the resident required maximal assistance with some activities of daily living (ADL). R66's Care Plan dated October 26, 2023, revealed, resident may have a hospital bed with a grab bar. During an initial walk through and interview at the time of observations of resident's bedrails. rounds with ADON and MD on 7/11/2024 at 10:12 am, both staff confirmed R66 had half size bed rails. Observation and interview on 7/12/2024 at 10:20 am revealed R66 sitting up in bed. He was alert and oriented. Half bedrails were attached to his bed. R66 stated he uses the rails to reposition himself when receiving ADL care. Rounding with ADON on 7/12/2024 at 10:25 am confirmed the resident had half bedrails on his bed. She verified R66 was not assessed for bedrails.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on record review and staff interview and review of the policy titled Medication Monitoring and Management, the facility failed to ensure a stop date for the use of a PRN (as needed) antipsychotic medication (quetiapine) was not over 14 days for one of five residents, (R) R65, reviewed for unnecessary medications. Findings include: Record review of the facility policy titled Medication Monitoring and Management (dated 3/30/2023) stated PRN (as needed) orders for Psychotropic and Antipsychotic Medications. In certain situations, psychotropic medications may be prescribed on a PRN basis, such as while the dose is adjusted, to address acute or intermittent symptoms or in an emergency, PRN orders for antipsychotic medications Time Limitations -14 days. Record review of R65's medical record revealed the following diagnoses but not limited to chronic obstructive pulmonary disease, Alzheimer 's Disease, unspecified dementia with severe agitations, chronic obstructive pulmonary disease, atrial fibrillation, major depressive disorder, and open angle glaucoma (blind). Record review of Quarterly Minimum Data Set (MDS) dated [DATE] indicated medications that included antipsychotics and antidepressants. Record review of R65's Physician Order Form (POF) documented the following orders: quetiapine 50 milligram (mg) tab 1 tablet by mouth once daily as needed for extreme agitation/ anxiety with a start date 3/6/2024. Record review revealed that medication was last given on 7/1/2024. Interview on 7/11/2024 at 10:00 am with Licensed Practical Nurse (LPN) OO and Assistant Director of Nursing (ADON) both staff confirmed the failure to follow up ensure a stop date for quetiapine. LPN OO reported that she made the call to contact the Medical Director this morning after being notified by the ADON to contact the MD about the changes. She reported that the order was called this morning. The ADON verified that she noticed that Seroquel was listed as a PRN meds on yesterday after reviewing the resident record on yesterday afternoon. She instructed the nurse to contact the Medical Director. She reported that at this time the order has not been changed due to waiting for the physician 's response.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on observation, interview, and review of policy titled Production, Storage and Dispensing of Ice, the facility failed to maintain the cleanliness of one of two ice machines, ensure proper storage of ice scoops for two of two ice machines, and failed to discard expired food items. These deficient practices had the potential to affect 74 out of 76 residents who received an oral diet. Findings include: Review of the policy titled, Production, Storage and Dispending of Ice (2021) revealed the following: 1. The ice dispenser will be cleaned and sanitized at least monthly, and/or as needed. Inside and outside of machine and the area around the machine will be cleaned. 2. Ice scoops will be stored outside the ice dispenser in a closed, clean container or in the ice machine in the scoop storage container provided by the manufacturer. Ice scoops will be cleaned and sanitized daily. During the initial tour of the kitchen on [DATE] at 9:00 am with the Dietary Manager (DM) revealed in the dry storage room, 14 containers of four-ounce (4 oz) thickening lemon-flavored water drinks with a use by date of [DATE]. Interview on [DATE] at 9:05 am with the DM confirmed the best use by dates for the 14 containers of thickening lemon-flavored water drinks were expired. Further interview with the with the DM revealed that kitchen staff are responsible for maintaining, organizing, and cleaning the dry storage area. Observations on [DATE] at 9:10 am and [DATE] at 1:05 pm of the ice machine in the dining room attached to the kitchen, revealed an ice scoop resting in the ice. Interview on [DATE] at 1:10 pm with the DM confirmed the facility's policy is to have the ice scoop stored in the ice machine in the scoop storage container provided by the manufacturer and not resting in the ice. The DM revealed that dietary staff are trained on proper storage of the scoop. Observation on [DATE] at 9:55 am of the ice machine located in the nourishment prep room outside the nurse's station of 200 hall revealed the ice scoop resting in the ice. Additionally, with the lid open, the frame of the machine was exposed and was observed to be dirty with some type of brown residue. Interview and observation on [DATE] at 9:58 am with Certified Nursing Assistant (CNA) AA revealed that the ice machine in the nourishment prep room is used to serve drinks to the residents. She stated she and other staff had training on ice scoop storage and that it should be placed on the holder inside the ice machine. She confirmed that the scoop was resting in the ice. She was unsure who maintained the cleanliness of the ice machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on [DATE] at 10:05 am with Dietary Aid BB revealed that the ice machine in the nourishment prep room is used to serve drinks to residents. She revealed the scoop should not be resting in the ice but on the shelf provided inside the machine. She revealed she thought maintenance cleaned the machine. Dietary Aid BB confirmed the residue/dirt on the inside frame of the machine. Interview on [DATE] at 10:32 am with the Maintenance Director revealed the ice machine in the nourishment prep room is to be deep cleaned every six months per the manufacturer's recommendation (manufacturer's recommendations were provided). Observation on [DATE] at 11:05 am with Maintenance Director confirmed the inside frame of the machine contained a residue/dirty substance. He revealed it would be his expectation that the machine be wiped clean daily and thought the DM would be responsible. Interview on [DATE] at 10:59 am with the DM revealed that she and her staff do not maintain the ice machine in the nourishment prep room, and she was unsure whose responsibility it was to keep clean.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50624 Based on observations, interviews, record review, and review of the facility policy titled Maintenance of Indwelling Urinary Catheters, the facility failed to properly perform infection control practices to prevent the possible spread of infections by allowing an indwelling urinary catheter bag to drag on the floor for one of six residents, (R) (R7), with catheters. Findings include: Review of the facilities, undated, Maintenance of Indwelling Urinary Catheters, documented maintaining indwelling catheters promotes good hygiene and reduces the potential for infection. A physician's order and medical reason will be obtained for each resident receiving an indwelling catheter. The record review for R7 revealed diagnosis that included intellectual disability (a delay in the acquisition of skills needed for independent living and social functioning), lap diverting colostomy (used to treat an intestinal injury or a chronic condition) status post peritoneal (a membrane that lines the inside of your abdomen and pelvis) debridement (medical removal of dead, damaged, or infected tissue), and vulva cancer (most common in the labia majora and labia minora). The 4/12/2024 Quarterly MDS documented a BIMS of 12, indicating mildly impaired cognition. On 7/10/2024 at 11:10 am, R7 was observed sitting in her wheelchair at the intersection of halls on wing three with her indwelling urinary catheter drainage tube on the floor, under her feet, as she rocked back and forth. On 7/10/2024 at 1:11 pm, R7 was observed propelling herself, in her wheelchair, up the hall connecting wing three and the main dining room, as her indwelling urinary catheter drainage tubing dragged on the floor under her wheelchair. On 7/10/2024 at 2:38 pm, R7 was observed with indwelling urinary catheter in place and the drainage tubing rested on the floor as she sat in her wheelchair at the intersection of the halls on wing three. Interview on 7/10/2024 at 2:46 pm with the Assistant Director of Nursing (ADON) and the Unit Manager confirmed that R7 had an indwelling urinary catheter, and that the drainage tubing was on the floor. They confirmed that all parts of the catheter should be kept from touching the floor to prevent infection.