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	12/04/2025

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 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. Based on observation and staff interviews, the facility failed to ensure that food was properly labeled and dated and stored under sanitary conditions to prevent foodborne illness. The deficient practice has the potential to affect 79 of 86 residents receiving food from the kitchen.Findings include: A food storage policy was requested but was not made available to the surveyor.A tour with the Dietary Manager (DM) on 12/2/2025 at 9:21 am revealed the following concerns: -The cooler was observed with raw bacon, raw porkchops, cooked turkey, cooked cornbread, cooked dressing, cooked ham, and cooked pork, that were not labeled with open, expiration or use by dates.-The pantry was observed with open pasta noodles, macaroni noodles, corn bread meal/ batter, rice, vanilla wafers in containers and zip lock bags that were not labeled with expiration dates.-The air conditioner vent filter had a layer of thick dust, including the adjacent wall and ceiling in the kitchen. Interview with the DM during the kitchen tour on 12/2/2025 at 9:21 am confirmed all identified concerns. DM immediately discarded all expired food and the items that were not labeled or dated. She confirmed it is her responsibility to ensure all items received and cooked are stored and labeled properly.

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and policy titled Home Trash Management Policy and Procedure the facility failed to ensure trash and garbage refuse was maintained in a sanitary manner for three of three dumpsters observed. The deficient practice created the potential for harboring pests and insects.Findings Include:A record review of policy titled [NAME] Manor Home Trash Management Policy and Procedure revealed [NAME] Manor trash policies require staff to separate general waste from regulated medical waste (e.g., sharps, pharmaceuticals materials) and handle each stream according to specific regulations. General trash is disposed of like typical refuse, while regulated waste needs special containers, storage, and professional pickup services to prevent injury and environmental contamination. The specific rules for pickup frequency and handling vary by state and local regulations.Observation on 12/2/2025 at 10:44 am with the Dietary Manager (DM) revealed the trash and garbage dumpsters located outside adjacent to the building had the following concerns: -A shower bed was located behind the dumpster, wooden flats were leaning against the fence, and various trash articles were scattered around the three-dumpster area including used cups, empty juice containers, and an empty chip bag. Interview on 12/2/2025 at 10:50 am with DM confirmed the area around the dumpsters needs to be decluttered and cleaned. DM immediately addressed the confirmed observations. DM stated that she was going to educate her staff and speak with Director of Nursing and Administrator about the shower bed. She confirmed it is her responsibility to monitor the dumpster area for cleanliness to prevent pests.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, staff interviews, and the facility policies titled Environmental Quality Policy and Procedure and Homelike Environment, the facility failed to ensure the residents' living area was safe, clean, comfortable, and homelike in 16 rooms (Rooms 104, 105, 107, 108, 109, 111, 112, 113, 208, 210, 211, 218, 226, 227, 229 and 303) on three of three halls (100 Hall, 200 Hall and 300 Hall) observed. Specifically, residents' rooms contained dirty air filters in self-contained heating and air system individual wall units (PTAC), cracked outlet cover, bed hand control wires exposed and window handle missing. This failure had the potential to affect patient comfort and safety. Findings include: 1. A review of the facility policy titled Homelike Environment revealed that the residents are provided with safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. An observation and interview with R63 in room [ROOM NUMBER] on 12/2/2025 at 12:17 pm revealed that R63's bed hand control has exposed low voltage wiring, the foot of the bed gets stuck if let up and a broken outlet cover. R63 stated the electrical outlet was broken for 6 months and states he has told the staff and maintenance is aware of the bed and outlet issues. An observation on 12/3/2025 at 10:15 am revealed the bed hand control has exposed low voltage wiring and the outlet remained unrepaired. An interview with Maintenance Supervisor on 12/3/2025 at 2:30 pm confirmed that the wiring was exposed, foot of the bed did not function correctly, and the outlet cover was broken. He states that he has repaired the cover several times but continues to break because the bed is hitting the outlet. An interview with Director of Nursing (DON) on 12/4/2025 at 12:16 pm revealed that staff can place repairs tickets to maintenance when a repair need is identified. The Certified Nursing Assistant would notify nurse then the nurse would complete the ticket and place on the log for the Maintenance Supervisor to review. The DON stated she was made aware of the outlet repairs and bed control repairs today. An interview with Administrator on 12/4/2025 at 12:16 pm confirmed that staff are to report repair needs even if the resident does not report a repair need. The Administrator stated she was made aware of the need for outlet and bed control repairs yesterday and stated the Maintenance Supervisor was working on making the repairs. 2. Record review of policy titled Environmental Quality Policy and Procedure revealed that the facility will do its best to provide a safe, clean and comfortable environment to fit the needs of all residents. Ultimately to create a home-like environment and de-emphasize the institutional character of the facility to the extent possible. Observations of resident rooms on 12/2/2025 from 10:35 am through 12:35 pm revealed the following concerns: -Rooms 104, 105, 107, 108, 109, 111, 112, 113, 208, 210, 211, 218, 226, 227, 229 and 303, self-contained heating and air system individual wall units (PTAC) contained heavily coated dusty air (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	filters. Observation and interview on 12/3/25 starting at 2:33 pm with the Maintenance Director (MD) during walking rounds confirmed the filters in Room's 211, 226, 227, 229, and 303 were dirty/dusty, and needed to be cleaned. MD stated that he was going to do a complete sweep of the building and clean all the filters in the building. 3. Observation of room [ROOM NUMBER] on 12/2/2025 at 10:40 am revealed cold air coming through an opening created by a missing window handle. An interview with the MD on 12/3/2025 at 2:30 pm confirmed the room was cool and that he was not aware of the missing handle. An interview with the Director of Nursing (DON) 12/4/2025 at 12:16 pm revealed that she was not aware of the missing window handle until today. DON stated that staff can place repairs tickets to maintenance when a repair need is identified. The Certified Nursing Assistant would notify the nurse who would complete the ticket and place on the log for the Maintenance Department to review. An interview with Administrator on 12/4/2025 at 12:16 pm confirmed that staff are to report repair needs even if the resident does not report a repair need. The Administrator stated if staff sees disrepair, they should report the repair even if the patient does not report the needed repair.

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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. Based on observations, record review and staff interviews, and policy titled, Care Planning, the facility failed to develop and/or implement the care plan for two of seven residents (R) (R12 and R9) reviewed for care planning. This deficient practice has the potential to place R12 at risk of dehydration and clinical decline and R9 from reaching the highest practicable level of functioning. Findings include: 1. A review of the facility policy titled, Care Plan, dated 5/5/2023, revealed the initial admission care plan will be completed within 48 hours of admission to the facility. A comprehensive care plan will be completed for all residents by the 14th day after admission. A review of the face sheet for R9 revealed an initial admit date of 10/6/2025 and a readmit date of 10/22/2025. A review of the admission Minimal Data Set (MDS) for R9 dated 11/3/2025 revealed that Section C (Cognitive Patters) documented a Brief Interview for Mental Status (BIMS) score of 15 indicating little to no cognitive impairment. Section I (Active Diagnosis) revealed diagnoses but not all inclusive of diabetes mellitus, hyperlipidemia, non-Alzheimer's dementia. A review of the Physician Orders dated 10/27/2025 revealed that R9 was to receive Donepezil HCl Oral Tablet 10 MG (Donepezil Hydrochloride) Give 1 tablet by mouth at bedtime for dementia. A review of R9's care plan dated 10/6/2025 revealed there was no care plan problem or interventions for dementia. An interview with MDS Coordinator LL on 12/4/2025 at 8:30 am revealed that all residents have a comprehensive care plan completed within 14 days of the resident coming to the facility, it was revealed that all care plans are updated quarterly. An interview with Director of Nursing (DON) on 12/4/2025 at 12:08 pm revealed that if a resident has a diagnosis of dementia, then they should be care planned for that diagnosis. 2. A review of facility policy titled, Care Planning, revealed that the facility care plans will be reviewed quarterly and any incidents are updated on the care plan as needed. A review of the admission Minimal Data Set (MDS) for R12 dated 9/29/2025 revealed that Section C (Cognitive Patters) documented a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. Section I (Active Diagnosis) revealed diagnoses but not all inclusive of anemia, atrial fibrillation, hypertension, cerebrovascular accident. A review of R12's care plan dated 9/23/2025 revealed that R12 had a feeding tube in place for a diagnosis for nontraumatic cerebrovascular accident. R12 is at risk for dehydration due to having a gastrostomy tube [tube inserted into the stomach for supplemental feeding] (G-tube). She is to receive G-tube feedings and flushes as ordered. A review of the Physician Orders dated 10/28/2025 revealed that R12 was to receive Jevity 1.5 cal/fiber [liquid food supplement] oral liquid one can via g-tube six times a day and supplement flush (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with 100 cc [cubic centimeters equivalent to milliliters] of water before and after feeding. An observation of R12 enteral (G-tube) feeding process on 12/3/2025 at 11:22 am revealed that Licensed Practical Nurse (LPN) AAA applied gloves. LPN AAA checked for placement and residual prior to connecting syringe for bolus administration of formula. LPN AAA flushed with 40 milliliters (ML) of water, then she administered one can of Jevity 1.5. She flushed with 60 ML of water. LPN AAA disconnected the syringe. A concurrent interview with LPN AAA confirmed that she flushed with 40 ML of water prior to the formula and 60 ML of water after formula. She confirmed that she did not flush with the 100 ML of water before and after formula according to the physician order. An interview with MDS Coordinator LL on 12/4/2025 at 8:30 am revealed that nurses are to follow the interventions. She states that staff can see the care plan in the electronic medical record. An interview with Director of Nursing (DON) on 12/4/2025 at 12:08 pm revealed that nurses should follow the interventions on a care plan and the physician orders.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, staff interview, record review and facility policy titled, Enteral Nutrition, the facility failed to follow physician orders regarding water flush for one of seven residents (R) (R12) that received enteral feedings via gastrostomy tube (G-tube) [tube inserted into the stomach for supplemental feeding]. This deficient practice had the potential to place R12 at increased risk for complications and adverse clinical outcomes. Findings Include:Review of the facility policy titled Enteral Nutrition, revised on 11/2018 documented: 11. The nurse confirms that orders for enteral nutrition are complete. Complete orders include g. instructions for flushing (solution, volume, frequency, timing, and 24-hour volume).A review of the admission Minimum Data Set (MDS) for R12 dated 9/29/2025 revealed that Section C (Cognitive Patters) documented a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. Section I (Active Diagnosis) revealed diagnoses but not all inclusive of anemia, atrial fibrillation, hypertension, and cerebrovascular accident.A review of care plan for R12 dated 9/23/2025 revealed that R12 has a feeding tube in place for a diagnosis of cerebral vascular accident (CVA). Interventions documented that R12 should receive feeding and flushes as ordered.A review of the Physician Orders dated 10/28/2025 revealed that R12 was to receive Jevity 1.5 cal/fiber oral liquid [liquid food supplement] one can via G-tube six times a day for supplement flush with 100 cc [cubic centimeters equivalent to milliliters] of water before and after feeding.An observation of R12 enteral (G-tube) feeding process on 12/3/2025 at 11:22 am revealed that Licensed Practical Nurse (LPN) AAA applied gloves. LPN AAA checked for placement and residual prior to connecting syringe for bolus administration of formula. LPN AAA flushed with 40 milliliters (ML) of water, then she administered one can of Jevity 1.5. She flushed with 60 ML of water. LPN AAA disconnected the syringe. A concurrent interview with LPN AAA confirmed that she flushed with 40 ML of water prior to the formula and 60 ML of water after formula. She confirmed that she did not flush with the 100 ML of water before and after formula according to the physician order.An interview with the Director of Nursing on 12/4/2025 at 12:08 pm revealed that nurses are to follow the physician orders and care plan interventions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, and facility policy titled, Medication Storage in the Facility and Administering Medications, the facility failed to ensure one of three medication storage rooms did not have expired medications and one of one wound care cart was locked and secured when unattended by the nurse. In addition, three of five medication carts had expired medication, medication not stored or labeled correctly, and medications left on the cart for a discharged resident. The deficient practice had the potential to allow unauthorized staff, residents, and visitors access to medications, and place residents at risk of receiving expired medications.Findings Include:Review of the facility's policy titled, Medication Storage in the Facility effective date 4/1/2016 revealed, medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supplies are accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Review of the facility's policy titled, Administering Medications reviewed date 5/5/2023 revealed, no medications are to be kept on top of the cart.An observation on 12/3/2025 at 8:30 am revealed the wound care cart unlocked and no one near the cart.An observation and interview with Wound Care Nurse (WCN) on 12/3/2025 at 11:05 am revealed the wound cart unlocked. She confirmed the wound cart was unlocked both times. She confirmed the wound cart should be locked when not in use.An observation and interview with Director of Nursing (DON) of the medication room at 300 south hall on 12/3/2025 at 12:30 pm revealed three bottles of magnesium citrate expired on 10/13/2025. DON confirmed that the items are expired. She states that she and Central Supplier BBB maintain the medication rooms. An interview with Central Supplier BBB on 12/3/2025 revealed that she stocks the medication rooms. She states that she checks for expiration dates. Supplies should be stocked with new items in the back and older items are moved to the front. If she has expired stock, she gives the expired medications to the Unit Manager.An observation and interview with Registered Nurse (RN) EEE on 12/4/2025 at 3:29 am revealed the medication cart for the 100 hall contained two containers of hemoccult developer, one package containing Opticell, and three sets of Intravenous (IV) tubing were all expired. RN EEE confirms these items were expired. RN EEE states she spot checks the medication carts and that dayshift nurses are responsible for monitoring and maintenance of the medication carts. She confirmed that she does not routinely check the medication carts.An observation and interview with Licensed Practical Nurse (LPN) DDD on 12/24/2025 at 4:47 am revealed the medication cart for the 200 north hall contained albuterol unit dose vials without an open date and saline flush syringes that expired 12/1/2025. LPN DDD confirmed the items are expired. She stated that nurses should be checking the carts.An observation on 12/3/2025 at 1:39 pm revealed an insulin syringe on top of the 100 hall medication cart located next to the nursing station.An observation on 12/3/2025 at 1:50pm revealed an insulin syringe on top of the 100 hall medication cart located next to the nursing station.An observation and interview with RN FFF on 12/3/2025 at 2:01 pm revealed an insulin syringe on top of the 100-hall medication cart. RN FFF confirmed the insulin syringe was on top of the medication cart that was left unattended. RN FFF states she was distracted on her way to the refrigerator. She confirmed the insulin syringe should not have been left on the medication cart unattended.An interview with the Director of Nursing (DON) on 12/4/2025 at 12:24 pm confirmed that it is unacceptable to have expired medications, medications with missing open dates, and medications left unattended on medication carts. She states the nurses should check the carts daily, every shift.