STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115502	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Health Care Center	618 Gennett Drive Jasper, GA 30143

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46691 Based on staff interviews, record review, and a review of the facility policy titled, Resident Assessment-Coordination with PASARR (preadmission screening and resident review) Program, the facility failed to submit a PASARR Level II for two of four residents (R) (R5 and R19) reviewed after a new mental illness diagnosis was added. This deficient practice had the potential to affect the appropriate level of care and services provided for R5 and R19. Findings include: A review of the facility policy titled Resident Assessment-Coordination with PASARR Program dated 2/12/2022 revealed the Policy stated, This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. The Policy Explanation and Compliance section stated, 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. 1. A review of the electronic medical record (EMR) revealed that R5 was admitted to the facility with diagnoses including but not limited to generalized anxiety disorder, migraine, and major depressive disorder. Further review revealed a diagnosis of bipolar disorder was added on 2/1/2024. A review of the annual Minimum Data Set (MDS) dated [DATE] in section A (Identification Information) documented the resident was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, section I (Active Diagnoses) documented bipolar disorder, and section O (Special Treatments and Programs) documented R5 did not receive psychological services. A review of the quarterly MDS dated [DATE] revealed section I (Active Diagnoses) documented bipolar disorder, and section O (Special Treatments and Programs) documented R5 did not receive psychological services. (continued on next page)

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the EMR revealed no documentation of psychological services in the last 12 months. A review of the EMR revealed a PASRR Level I request dated 1/7/2021 without bipolar disorder marked on the form. A further review revealed there was no re-submission for a PASRR Level I after the bipolar diagnosis was added on 2/1/2024. The facility did not have a Social Services Director (SSD). The Director of Nursing (DON) was unavailable for an interview. In an interview on 7/20/2024 at 11:30 am, the Interim Administrator verified R5 had a diagnosis of bipolar disorder dated 2/1/2024 and did not have a PASRR Level II. She stated when a resident received a serious Mental Disorder (MD) or Intellectual Disability (ID) diagnosis, the SSD was responsible for submitting for a PASRR Level II. She stated new diagnoses were discussed in the morning meetings and the SSD typically attended the meetings. The Interim Administrator further stated the facility currently did not have an SSD. In an interview on 7/20/2024 at 2:13 pm, Regional Nurse Consultant (RNC) CC stated when a resident was newly diagnosed with a serious MD or ID, the SSD should submit for a PASRR Level II. She stated new diagnoses were discussed in the morning and care plan meetings, and the SSD typically attended the meetings. She further stated the PASRR Level II was used to ensure a resident received the specialized care and services recommended and without the PASRR Level II recommendations, a resident could have adverse effects such as not receiving needed services and medication management by a specialized provider. 35062 2. A review of the Face Sheet revealed that R19 was admitted without a significant mental health diagnosis and a primary diagnosis of fibromyalgia. On 10/19/2023, the resident had a new diagnosis of panic disorder and on 2/1/2024 the resident had a new diagnosis of bipolar disorder. Review of the PASRR Level I dated 5/18/2023 revealed no primary diagnosis of dementia and no primary diagnosis of serious mental illness. Further review of the clinical record revealed no documented evidence that the resident was reevaluated related to a new diagnosis of mental illness. A review of the annual MDS dated [DATE] revealed R19 had a BIMS score of 14, indicating R19 was cognitively intact. Section A (Identification Information) documented the resident had not been evaluated by PASRR Level II. Section I (Active Diagnoses) documented anxiety disorder, depression, and bipolar disorder. Section O (Special Treatments and Programs) documented no psychological therapies or treatments were received. Review of the Physician Orders dated 7/1/2024 revealed R19 had an order for olanzapine (antipsychotic medication) 2.5 milligrams (mg) every morning and at bedtime related to bipolar disorder per psychiatry. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/20/2024 at 2:53 pm with Regional Nurse Consultant CC revealed she was unable to locate a PASRR Level II for R19 and was unsure why the resident was not reevaluated with the new diagnosis. She indicated she attempted to contact the Social Worker who was no longer employed at this time and was unsuccessful.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46691 Based on observations, resident and staff interviews, record review, and review of the facility policies titled Comprehensive Care Plan and Oxygen Administration, the facility failed to develop a person-centered comprehensive care plan for one of 20 sampled residents (R) (R15). This failure increased the potential for R15 not to receive treatment and/or care according to their needs. Findings include: A review of the facility policy titled Comprehensive Care Plans dated 2/12/2022 revealed the Policy Explanation and Compliance Guidelines stated, 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. A review of the facility policy titled Oxygen Administration dated 2/12/2022 revealed the Policy stated, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The Policy Explanation and Compliance Guidelines stated, 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to a. The type of oxygen delivery system. b. When to administer, such as continuous or intermittent, and/or when to discontinue. b. Equipment setting for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen. A review of R15's quarterly Minimum Data Set (MDS) dated [DATE] revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 15 (indicating intact cognition), and section O (Special Treatments and Programs) documented the resident received oxygen while a resident. A review of R15's care plan revealed there was no care area, goals, or interventions for the administration of oxygen. A review of the Physician's orders revealed an order dated 6/27/2024 for oxygen via a nasal cannula (NC) at 2 liters per minute (LPM), continuous. A review of the Medication Administration Records (MARs) dated 7/2024, 6/2024, and 5/2024 revealed oxygen was documented as administered as ordered. During observation and interview on 7/19/2024 at 8:57 am, R15 was receiving oxygen via a NC at 2 LPM. She stated she wore the oxygen most of the time and only removed it during meals and showers. Observations on 7/20/2024 at 7:40 am and 7/21/2024 at 8:35 am revealed R15 was receiving oxygen via a NC at 2 LPM. The Director of Nursing (DON) was not available for an interview. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/21/2024 at 11:30 am, Regional Director of Clinical Operations (RDCO) AA verified there was no care plan area for oxygen administration on R15's care plan. She stated if a resident received oxygen, it should be addressed in the care plan. She further stated the MDS Coordinator was responsible for ensuring the care plan contained the current services and care provided to the resident, and the omission on the care plan was an oversight.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47146 Based on observations, resident and staff interviews, record review, and review of the facility policies titled, Nebulizer Therapy and CPAP/BiPAP (continuous/bilevel positive airway pressure machine) Cleaning, the facility failed to ensure that respiratory supplies were stored properly for two of 21 sampled residents (R) (R14 and R27). This deficient practice increased the risks of spreading microorganisms and placed R14 and R27 at risk for respiratory infections and a diminished quality of life. Findings include: Review of the policy titled Nebulizer Therapy, date implemented 2/12/2022, documented under Care of the Equipment: 1. Clean after each use. 2. Wash hands before handling equipment. 3. Disassemble parts after every treatment. 4. Rinse the nebulizer cup and mouthpiece with sterile or distilled water. 6. Air dry on an absorbent towel. 7. Once completely dry, store the nebulizer cup and the mouthpiece in a [brand name] (re-sealable) bag. Review of the facility policy titled CPAP/BiPAP Cleaning revised 2/12/2022 documented under Policy: It is the policy of the facility to clean CPAP/BiPAP equipment in accordance with the current CDC (Centers for Disease Control and Prevention) guidelines and manufacturer recommendations in order to prevent the occurrence or spread of infections. Under Policy Explanation and Compliance Guidelines: .6. Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclose in machine storage when not in use. 1. Review of the electronic medical record (EMR) revealed R14 was admitted to the facility with pertinent diagnoses listed as but not limited to acute chronic diastolic congestive heart failure, pleural effusion, acute respiratory failure with hypoxia (lack of oxygen), viral pneumonia, and chronic obstructive pulmonary disease (COPD). Review of R14's discharge return expected Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/19/2024 revealed a Brief Interview for Mental Status (BIMS) was not completed, her short-term memory was documented as ok, and her ability to make decisions regarding tasks of daily life was moderately impaired. Section GG (Functional Abilities and Goals) revealed she required substantial/maximum assistance with personal hygiene. Review of R14's care plan, initiated on 2/4/2024, indicated a focus of a potential risk for altered respiratory status related to her diagnosis of COPD. The goals included but were not limited to maintaining a normal breathing pattern. The interventions included but not limited to giving nebulizer treatments (a machine that turns liquid medicine into a mist that can be inhaled through a mouthpiece or mask) and oxygen as ordered. Review of the EMR revealed physician's orders for R14 included but were not limited to ipratropium-albuterol inhalation solution 0.5 - 2.5 milligrams (mg) per 3 milliliters (ml); inhale three ml's orally every six hours as needed for wheezing (a medication administered through a nebulizing machine used to treat lung diseases). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 7/19/2024 at 10:05 am revealed a nebulizer mouthpiece lying on top of the oxygen concentrator (a machine that makes oxygen out of room air) next to R14's bed was not covered with a protective bag, and a nebulizer on top of R14's nightstand with the tubing in the second drawer of the nightstand, also not covered or in a protective bag. Observations on 7/19/2024 at 2:00 pm and 7/20/2024 at 7:45 am revealed R14's nebulizer on top of the oxygen concentrator with the mouthpiece on top of the nebulizer, uncovered and not in a protective bag, and a second nebulizer on top of R14's nightstand with the tubing in the second drawer, not covered or in a protective bag. During an observation and interview on 7/20/2024 at 1:50 pm, Regional Nurse Consultant CC verified and confirmed the nebulizer on top of the oxygen concentrator had a mouthpiece attached, and it was not covered or placed in a protective bag. She verified and confirmed the second nebulizer on R14's nightstand had tubing connected to a mask located in the second drawer of the nightstand that was not covered or stored inside a protective bag. She stated the charge nurse was responsible for ensuring the mask/mouthpiece was clean and stored inside a protective bag. She further stated the mouthpiece and mask should be cleaned and allowed to air dry and then stored in a bag. She stated the possible potential outcomes of this practice could result in residents developing respiratory and/or skin infections. 35062 2. Review of the quarterly MDS assessment dated [DATE] revealed R27 had a BIMS score of 13, indicating little or no cognitive decline. Diagnoses included but were not limited to chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, morbid obesity with alveolar hypoventilation, and chronic obstructive pulmonary disease. Section O (Special Treatment and Services) documented the resident uses a non-invasive mechanical ventilator. Review of the Physician Order for R27 dated 7/8/2024 revealed an order for 'name of manufacturer' BiPAP [bilevel positive airway pressure], VT (Tidal Volume) 450, Rate 20, EPAP [expiratory positive airway pressure] 6, 4L O2 [oxygen] blended at bedtime for elevated CO2 [carbon dioxide] levels. Observation on 7/19/2024 at 8:54 am revealed R27's BiPAP machine on the nightstand with mask laying directly on nightstand unbagged, with no protective covering. Observation and interview on 7/20/2024 at 11:22 am with R27 revealed a BiPAP machine laying on the nightstand with the mask directly on the nightstand, unbagged. R27 stated they assisted her with using it at night, but they never put the mask in a bag or protective covering. She was unsure if they cleaned it.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35062 Based on record review, staff interviews, and review of facility documents titled, Facility Assessment Tool and the PBJ (payroll-based journal) Staffing Data Report, the facility failed to ensure that the facility had adequate nursing staff on the weekends. The deficient practice had the potential to affect the care provided to the 51 residents that resided in the facility. Findings include: Review of The Facility Assessment Tool dated 4/17/2024 revealed the average daily census in the facility was 57 residents. The Facility Assessment Tool documented the average hourly staffing needs per day were 36 - 48 hours for licensed nurses providing direct care, and 105 - 120 hours for nurse aides. Review of the PBJ Staffing Data Report FY (fiscal year) Quarter 2 2024 (1/1/2024 through 3/31/2024) revealed based on the data submitted, the facility triggered Excessively Low Weekend Staffing. Review of PBJ Data Hours Log, provided by the facility, for FY Quarter 2, revealed an average of 77 hours per day for nurse's aides for weekends. Interview on 7/21/2024 at 3:00 pm with the Regional Director of Clinical Operations (RDCO) and the Regional Nurse Consultant (RNC) CC revealed they were both aware of PBJ's excessively low weekend staffing received for the second quarter of 2024.

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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** 35062 Based on record review, staff interviews, and review of the facility policy titled, Use of Psychotropic Medications, the facility failed to ensure that a psychotropic medication, with appropriate diagnoses, including antianxiety medication, was not ordered as needed (PRN) for more than 14 days unless clinically indicated for one of six residents (R) (R19) reviewed for unnecessary medications. Findings include: Review of the facility policy titled Use of Psychotropic Medication dated 8/1/2023 documented the following under Policy Explanation and Guidelines: . 9. PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's record and indicate the duration for the PRN order. A review of the annual Minimum Data Set (MDS) dated [DATE] revealed R19 had diagnoses including but not limited to panic disorder [episodic paroxysmal anxiety] and conversion disorder with seizures or convulsions. Review of the Physician Orders for R19 revealed an order for Ativan Injection Solution 2 milligram (mg)/ milliliter (ml) (antianxiety medication), inject 1 mg intramuscularly (IM) every 4 hours as needed (PRN) for seizure with an original order date of 9/27/2023. An additional order was written for Ativan Injection Solution 2 mg/ml, inject 1 mg intramuscularly every 6 hours PRN for panic attack/seizure with an original order date of 10/18/2023 and was discontinued on 11/13/2023, with no administration. The duplicate order was identified by the pharmacist and discontinued. Review of the medication administration record (MAR) revealed R19 received the Ativan 1 mg every 4 hours as needed for seizures on 10/21/2023, 10/29/2023, 11/21/2023, 11/29/2023, 3/4/2024, 3/10/2024 and 3/12/2024. Review of Nurse's Note dated 3/4/2024 at 11:55 pm revealed resident agitated, yelling out about wanting to call her mother. Jumped out of bed and started to run. Unable to redirect. Ativan IM delivered per orders with good results. In an interview on 7/21/2024 at 2:30 pm with Regional Nurse Consultant CC, she verified R19 had an active physician's order dated 9/27/2023 for Ativan 2 mg/ml injection 1 mg every 4 hours PRN seizures, without an end/stop date for the order. She further stated the Director of Nursing (DON) reviewed resident medications monthly and should have recommended an end date for the Ativan order.

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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. 47146 Based on observations, staff interviews, and review of the facility policy titled, Medication Storage, the facility failed to maintain medications in a locked and secure environment when not under direct supervision of the nurse for one of two medication carts (the 300 Hall cart). This failure placed residents, staff, and visitors at risk of having unauthorized access to residents' medications. Findings include: Review of the facility policy titled Medication Storage date implemented 2/12/2022 revealed under Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Under the section titled Policy Explanation and Compliance Guidelines and subsection General Guidelines letter C revealed during medication pass, medications must be under the direct supervision of the person administering the medications or locked in the medication storage area/cart. An observation on 7/20/2024 at 9:17 am revealed Registered Nurse (RN) DD left the medication cart on the 300-hall locked with five medication cards containing medications, on top of the cart unattended while she went to the medication room to retrieve another medication needed. She returned to the medication cart at 9:21 am. An interview on 7/20/2024 at 9:21 am with RN DD, she verified and confirmed she left five medication cards with medications in them on top of the medication cart unattended while she went to the medication room to retrieve another medication needed. She stated she should not have done that. She further revealed that she should have locked the medication up in the cart prior to leaving the cart and she did not have an excuse for what she did because she knew she should not leave medication on a cart unattended for any length of time. An interview on 7/20/2024 at 1:50 pm with Regional Nurse Consultant CC revealed that the expectation was for the nurses to know that medications were to be locked in the cart unless the nurse was in attendance to the medications. She further stated if the nurse must leave the cart to attend to anything else, the expectation was that the medication be locked in the cart. She stated the possible outcome of not locking medication in the cart and leaving it unattended could be that a resident could remove the medication from the cart and possibly take them and have an adverse reaction to the medication.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 47146 Based on record review, staff interviews, and review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI), the facility failed to ensure the Medical Director or an appointee of the Medical Director's attendance and participation in QAPI committee meetings, at least quarterly. Specifically, the Medical Director or their appointee was not present and did not attend three of the six QAPI committee meetings reviewed. Findings include: Review of the facility policy titled Quality Assurance and Performance Improvement (QAPI) date implemented 8/1/2023 revealed under the section titled Policy Explanation and Compliance Guidelines number two The Quality Assessment and Assurance (QAA) Committee shall be interdisciplinary and shall consist at minimum of the Director of Nursing (DON), Medical Director or his/her designee, and at least three other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member or other individual in a leadership role, and the Infection Preventionist. Review of the QAPI committee meeting sign-in sheets, dated 7/18/2023, 8/24/2023, 9/25/2023, 11/2/2023, 1/26/2024 and 4/25/2024 revealed the medical director nor their appointee's signature was not found on the sign in sheets dated 11/2/2023, 1/26/2024 and 4/25/2024. During an interview on 7/21/2024 at 3:56 pm, the Regional Director of Clinical Operations AA revealed that the QAA committee met regularly. She confirmed that neither the Medical Director's signature nor a designee of the Medical Director's signature was on the QAPI meeting sign-in sheets for 11/2/2023, 1/26/2024, or 4/25/2024. She revealed that neither the Medical Director nor their appointee attended the meetings, nor did they have documentation otherwise.

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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. 47146 Based on observations, staff interviews, record review, and review of the facility policy titled, Clean Dressing Change, the facility failed to ensure hand hygiene was performed during wound care for one of five residents (R) (R1) with pressure ulcers. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: Review of the facility policy titled Clean Dressing Change, date implemented 2/12/2022, revealed the policy of the facility was to provide wound care in a manner to decrease potential for infection and/or cross contamination. The subsection titled Policy Explanation and Compliance Guidelines revealed number 14 stated, Wash hands and put on clean gloves. A review of the electronic medical record (EMR) revealed R1 was admitted to the facility with pertinent diagnoses including but not limited to pressure ulcer of the sacral region, stage IV. Review of R1's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/2/2024 revealed a Brief Interview for Mental Status (BIMS) of 11, which indicates R1 had moderate cognitive impairment. Section GG (functional status) revealed R1 was dependent on staff for dressing, bathing, and toileting. Section H (Bladder and Bowel) revealed R1 was always incontinent of bladder and bowel. Review of R1's care plan initiated on 4/9/2924 indicated a focus of the potential to develop pressure ulcers related to a history of wounds. Goals included but not limited to R1 would be free of preventable skin breakdown. Interventions included but not limited to check frequently for wetness and soiling and provide incontinence care as needed, provide wound care per physician's order, keep dressing clean, dry and intact, and change dressing as needed for soiling. Review of the EMR revealed physician's orders for R1 included but was not limited to clean sacral wound with wound cleanser, fill wound bed with 4x4 gauze soaked with Dakins solution (a topical antiseptic used to treat and prevent infections in wounds, skin, and tissue) with a protective moister absorbent dressing daily and as needed until resolved. Observations made on 7/20/2024 at 10:15 am of wound care performed by Licensed Practical Nurse (LPN) HH with Certified Nursing Assistant (CNA) II assisting revealed LPN HH set up supplies needed for wound care on a table with a barrier after cleaning the table. She performed hand hygiene and donned (put on) gloves, then removed the dressing from R1's sacrum. She removed her gloves and performed hand hygiene, then donned clean gloves. She proceeded to cleanse the wound with gauze soaked with wound cleanser, cleaning from the inside to the outer edges of the wound with a circular motion. Once she completed cleansing the wound she then, without performing hand hygiene or changing gloves, began to pack the wound with gauze soaked in Dakin's solution, and covered the wound with an absorbent foam border dressing. The dressing was dated and initialed by the nurse and all disposable items including the soiled dressing were removed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115502	A. Building B. Wing	07/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Health Care Center	618 Gennett Drive Jasper, GA 30143

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/10/2024 at 10:30 am, LPN HH confirmed she did not change her gloves or perform hand hygiene between cleansing the sacral wound and applying Dakin's soaked packing in the wound bed. She stated she should have stopped after cleaning the wound, removed her gloves, performed hand hygiene, donned clean gloves, applied the Dakins-soaked packing in the wound bed, and covered the wound with an absorbent foam border dressing. An interview on 7/20/2024 at 4:05 pm with the Regional Nurse Consultant CC revealed that her expectation was that the nurse who was performing wound care knew when gloves were contaminated and to perform hand hygiene and don clean gloves prior to packing a clean dressing on a wound. She stated this practice could potentially result in a wound infection.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 46691 Based on observations and staff interviews, the facility failed to maintain the walk-in freezer in a manner to prevent ice buildup from forming on the freezer unit. This failure had the potential to contaminate food items located under the ice and place the 51 residents receiving an oral diet from the kitchen at risk of contracting a foodborne illness. The facility census was 51. Findings include: Observation of the walk-in freezer on 7/19/2024 at 8:00 am revealed ice formations hanging from the freezer unit located to the left side of the door. The ice formations ranged in size from 6 inches in diameter at the top to less than 1 inch in diameter at the floor and were observed on the shelving below the freezer unit and the freezer floor. The Certified Dietary Manager (CDM) verified the ice formation and the buildup of ice on the freezer floor. In an interview on 7/19/2024 at 8:00 am, the CDM stated the walk-in freezer had malfunctioned a while back, and the Maintenance Director and Interim Administrator were aware. She further stated an outside company had inspected the freezer, but it had not been repaired. She stated the dietary staff were aware to avoid storing food items on the shelves under the freezer unit and to use caution when walking in the freezer due to the ice formation on the floor. She further stated she had discarded numerous cases of foods due to ice formation on the foods. In an interview on 7/20/2024 at 10:05 am, the Maintenance Director stated he was aware of the ice formation in the walk-in freezer and that he manually removed the ice periodically. He further stated he thought an outside service provider had inspected the freezer before he was employed at the facility, but he was unsure what the recommendations were. He stated that the Interim Administrator was aware of the concern. In an interview on 7/20/2024 at 10:10 am, the Regional Director of Environmental Services stated he was unaware of a concern with the walk-in freezer prior to this date and that he would address the concern. In an interview on 7/20/2024 at 10:20 am, the Interim Administrator stated she was aware of the ice formation in the walk-in freezer. She stated the concern began before she became the Interim Administrator, and the Regional Director was aware of it. She stated an outside service provider had inspected the freezer, but she was unsure of the date or recommendations. In an interview on 7/20/2024 at 3:05 pm, the Maintenance Director stated he was unable to locate documentation of an outside service provider inspecting or servicing the walk-in freezer. In an interview on 7/21/2024 at 11:40 am, the Interim Administrator stated she was unable to provide documentation of a service visit for the walk-in freezer. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 7/21/2024 at 3:15 pm of the walk-in freezer with the CDM revealed the freezer had ice formation hanging from the freezer unit located to the left side of the door. The ice formation extended onto the shelving and the floor. One case of pie crust located on the lower shelf was covered in ice formation, and there was ice buildup on the floor. The CDM stated staff tried to avoid placing items under the freezer unit, but there was limited space to store frozen foods. She discarded the case of pie crust and stated she had previously discarded numerous cases of foods due to ice forming on them.