STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115543	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Ridge Health Care Center	22 Maple Ridge Drive S.E. Cartersville, GA 30120

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on staff interview, record review, and review of the facility policy titled, Transfer and Discharge (including AMA [against medical advice], the facility failed to issue two of two residents (Resident (R) 9 and R24) or their responsible party transfer paperwork or to notify the long-term care ombudsman of hospital transfers out of 19 sample residents. This failure could affect the resident and or representative by not receiving the information for the reason of transfer and the resident's right to return to the facility. Findings include: Review of the facility's policy titled, Transfer and Discharge (including AMA [against medical advice]) with an implementation date of 02/01/22, revealed .Emergency Transfers/ Discharges-initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified) .Provide a notice of transfer and the facility's bed hold policy to the resident or representative as indicated . 1. Review of R9's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was initially admitted on [DATE] for long-term care. Diagnoses included type two diabetes mellitus, hypertensive heart disease with heart failure, acute systolic heart failure, syncope and collapse, and a recent diagnosis of non-ST elevation myocardial infarction, a type of heart attack. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident was moderately impaired in cognition. Review of the MISC [Miscellaneous] tab of the EMR revealed there were no documents uploaded reflecting a bed hold form was provided to R9 when she was sent out on 07/17/24 for tingling in her left arm and chest pain. 43353 2. Review of R24's Admission Record in the Profile tab of the EMR revealed an admitted [DATE]. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R24's five-day MDS with an ARD of 08/02/24 and located in the MDS tab of the EMR, revealed a BIMS score of five out of 15 which indicated the resident was severely cognitively impaired. Review of R24's Nursing Note, dated 08/30/24 at 5:57 PM and located in the Progress Notes tab of the EMR, revealed Labs reviewed with NP [Nurse Practitioner], new orders received to send to ER [emergency room] for evaluation, spoke with responsible party and is agreeable with plan of care. Review of R24's Nursing Note, dated 08/30/24 at 6:15 PM and located in the Progress Notes tab of the EMR, revealed emergency medical services (EMS) called and here to transport resident to hospital via stretcher in stable condition. Review of R24's Nursing Note, dated 08/31/24 and located in the Progress Notes tab of the EMR, revealed In hospital . admitted to [Name] Hospital. Review of R24's EMR revealed there was no documentation that a written transfer notice was provided to the resident and/or their representative at the time of the transfer to the hospital on 08/30/24. During an interview on 09/05/24 at 9:48 AM, the Social Services Director (SSD) verified that the facility notified the resident representative by phone that the resident was being sent out and for what reasons. The SSD stated no residents were provided a transfer form when transferred to the hospital for acute care. She stated she was not aware of this requirement or that it was included in the current facility policy.

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NAME OF PROVIDER OR SUPPLIER Maple Ridge Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22 Maple Ridge Drive S.E. Cartersville, GA 30120	

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on record review, staff interview, and review of the facility policy titled, Bed Hold Notice Upon Transfer, the facility failed to issue a bed hold notice for two of two residents (Resident (R) 9 and R24) or their responsible party out of 19 sample residents reviewed for bed holds. The failure to provide a copy of the bed hold notice at the time of transfer could lead to them not knowing their rights in the facility. Findings include: Review of the facility's policy titled, Bed Hold Notice Upon Transfer with an implementation date of 02/01/22, revealed .At the time of transfer for hospitalization or therapeutic leave, the leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed . 1. Review of R9's Face Sheet located in the Profile tab of the electronic medical record (EMR) revealed she was initially admitted on [DATE] for long-term care Diagnoses included type two diabetes mellitus, hypertensive heart disease with heart failure, acute systolic heart failure, syncope and collapse, and a recent diagnosis of non-ST elevation myocardial infarction, a type of heart attack. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/03/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident was moderately impaired in cognition. Review of the MISC [Miscellaneous] tab of the EMR revealed there were no documents uploaded reflecting a bed hold form was provided to R9 when she was sent out on 07/17/24 for tingling in her left arm and chest pain. 43353 2. Review of R24's Admission Record in the Profile tab of the EMR revealed an admitted [DATE]. Review of R24's five-day MDS with an ARD of 08/02/24 and located in the MDS tab of the EMR revealed a BIMS score of five out of 15 which indicated the resident was severely cognitively impaired. Review of R24's Nursing Note, dated 08/30/24 at 5:57 PM and located in the Progress Notes tab of the EMR, revealed Labs reviewed with NP [Nurse Practitioner], new orders received to send to ER [emergency room] for evaluation, spoke with responsible party and is agreeable with plan of care. Review of R24's Nursing Note, dated 08/30/24 at 6:15 PM and located in the Progress Notes tab of the EMR, revealed emergency medical services (EMS) called and here to transport resident to hospital via stretcher in stable condition. (continued on next page)

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R24's Nursing Note, dated 08/31/24 and located in the Progress Notes tab of the EMR, revealed In hospital . admitted to [Name] Hospital. Review of R24's EMR revealed there was no documentation that the facility's bed hold policy was provided to the resident or their representative at the time of the transfer to the hospital on 08/30/24. During an interview on 09/05/24 at 9:48 AM, the Social Services Director (SSD) verified that no bed hold notice was provided to R9 or R24 upon transfer to the hospital. The SSD stated the facility notified the resident representative by phone and the resident received the bed hold information in the admission package. The SSD stated no resident was provided a bed hold notice on transfer to the hospital. She stated she was not aware of this requirement.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on observations, resident, family member, and staff interviews, record review, and review of the facility policy titled, Weight Monitoring Program, the facility failed to obtain an admission weight, perform re-weights for weight losses of five percent or greater and be evaluated and assessed by the facility's Consultant Registered Dietitian (CRD) and Interdisciplinary Team after experiencing an unplanned significant weight loss for one of two residents (Resident (R) 17) reviewed for nutritional status out of 19 sample residents. The facility's failure placed the resident at risk for further unplanned weight loss. Findings include: Review of the facility's undated policy titled, Weight Monitoring Program, indicated, Definitions: Significant weight change- A weight loss or gain of: +/- [plus or minus] 5 percent [%] in 30 days +/- 7.5 percent in 90 days. +/- 10 percent in 180 days .Weight Monitoring Frequency .b. New Admissions: New admissions will be weighed for a period of four weeks. Initial weight and height will be obtained within 24 hrs. [hours] of admission to the center .f. Re-Weights. Re-weights will be obtained on all weight changes of 5% or more in one month. Re-weights should be obtained within 24 hrs.2. Interdisciplinary Team Interventions: a. Assess ROOT CAUSE of significant weight change . e. Monitoring .new interventions should be considered if current interventions are not successful. Review of the Admission Record located in the electronic medical record (EMR) under the Profile tab revealed R17 was admitted to the facility on [DATE] with diagnoses that included severe protein-calorie malnutrition, fracture of left femur, and anxiety disorder. Review of R17's admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 07/31/24, revealed R17 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated moderate cognitive impairment, required setup or clean-up assistance with eating, and had a weight of 159 pounds. Review of R17's Comprehensive Care Plan, developed by staff on 08/01/24, located in the EMR under the Care Plan tab, indicated Nutrition: The resident is at risk for alteration in nutrition/hydration secondary to: recent surgery for fx'd [fractured] femur, confusion- dx. [diagnosis] severed protein/calorie nutrition. A care plan goal specified, The resident will have no significant weight changes through next review date. Care plan interventions included, Monitor weight as ordered and RD [Registered Dietitian] to evaluate and make diet change recommendations PRN [as needed]. Review of R17's Admission Nutritional Assessment completed by the facility's CRD on 08/06/24, located in the EMR under the Assmnts [Assessments] tab, specified Weight: found documented weight of 134# [pounds]. The assessment also specified, Intervention/ Plan 1. Weekly wt [weight] x 4 to establish baseline. 2. Recs [Recommendations] sent to nursing for 2.0 [kilocalerie] kcal oral supplement po [by mouth] BID [twice a day]. RD will continue to monitor oral intake, diet status, weight trends, and skin integrity. Review of R17's Physician's orders, located in the EMR under the Orders tab, revealed the following orders: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Speech Therapy (ST) Clarification Order: Patient is to receive skilled ST intervention five x week for eight weeks for cognitive intervention. Treatment (Tx) may include compensation strategies, problem solving, safety awareness, thought organization, orientation, memory, and group intervention. This order was initiated on 08/01/24. -Regular diet with thin liquids and chopped meat. This order was initiated on 08/10/24. -2.0 Supplement two times a day 120 milliliters. This order was initiated on 08/12/24. -Remeron Oral Tablet 15 milligrams- Give one tablet by mouth at bedtime for appetite. This order was initiated on 08/15/24. Review of R17's weight record located in the resident's EMR under the Wts [weights]/Vitals tab, revealed the following weights: -No weight documented from 07/31/24 to 08/06/24 -08/07/24: 159 pounds (the first facility weight) -08/14/24: 155 pounds (a four pound and 2.51 percent weight loss since 08/07/24) -08/21/24: 144 pounds (a 15 pound and 9.43 percent significant weight loss since 08/07/24) -08/28/24: 126 pounds (a 33 pound and 20.75 percent significant weight loss since 08/07/24) -09/04/24: 122 pounds (a 37 pound and 23.27 percent significant weight loss since 08/07/24) Review of R17's EMR revealed there was no evaluation or documentation from the facility's CRD from 08/07/24 to 09/03/24 to address the resident's unplanned significant weight loss during this time period. During an observation on 09/02/24 at 11:28 AM, R17 was in her room with Family Member (FM) 1 present. R17 appeared thin and was not feeling well. During an interview on 09/02/24 at 11:28 AM, FM1 stated R17 had been a resident at the facility for about a month and was not eating well and had lost weight. FM1 stated the facility had attempted to provide supplements, but the resident had a poor appetite and would not always drink them. During an observation on 09/02/24 at 12:55 PM, R17 was in her room with her lunch meal and FM1 present. FM1 was encouraging R17 to eat her lunch meal, but the resident shook her head and would not open her mouth when FM1 brought food and beverages to her mouth and encouraged her to eat. During an observation on 09/03/24 at 12:50 PM, R17 was in her room with her lunch meal and FM1 present. FM1 was encouraging R17 to eat her lunch meal, but the resident shook her head and would not open her mouth when FM1 brought food and beverages to her mouth and encouraged her to eat. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/04/24 at 1:40 PM, the facility's CRD stated when she completed R17's admission nutrition assessment on 08/06/24 she could not find an admission weight, or a weight obtained by staff since R17 was admitted to the facility on [DATE]. The CRD explained since she was unable to find a facility weight, she reviewed R17's hospital information and found a hospital weight of 134 pounds and this was the weight she documented on the resident's admission nutrition assessment. The CRD stated she was not informed and was not aware that R17 had a weight documented on 08/07/24 of 159 pounds and the resident had a documented weight of 126 pounds on 08/28/24 which equated to a significant unplanned weight loss during this period. The CRD stated if she had been aware of this significant weight loss she would have evaluated the resident's nutritional status. The CRD stated staff should have obtained an admission weight for R17 and re-weighed the resident on 08/21/24 and 08/28/24 when the resident's weight indicated the resident experienced a significant weight loss of greater than five percent to ensure these weights were accurate. The CRD stated she would have expected staff to inform her of the resident's significant weight loss, so she could have evaluated the resident's nutritional status. The CRD stated she would request for R17 to be weighed and if it was found the resident had experienced a significant weight loss, she would evaluate the resident and implement new interventions to prevent further weight loss. Review of the CRD's 09/04/24 progress note, located in the resident's EMR in the Prog [Progress] Note tab, indicated the resident's weight on 09/04/24 was 122 pounds which equated to a 23.3 percent weight loss since 08/07/24. The CRD's note specified, Weight loss of likely multifactorial reasons to include fluids, weight technique, and true weight loss. The note further specified Intervention/ Plan 1. Weekly wt [weight] x 4 to continue to track weights 2. Continue 2.0 kcal [kilocalorie] oral supplement PO BID. 3. Increase feed assist and monitoring to include going to dining room and one to one meal supervision. 4. Tray house shake BID [twice a day]. RD will continue to monitor oral intake, diet status, weight trends, and skin integrity. During an interview on 09/05/24 at 9:54 AM, the Registered Nurse Supervisor (RNS) confirmed the nursing staff failed to obtain an admission weight for R17 on 07/31/24 and the resident's first documented facility weight of 159 pounds was not obtained by staff until 08/07/24. The RNS also confirmed staff failed to re-weigh R17 on 08/28/24 when the resident's weight was documented as 126 pounds which reflected a significant weight loss. During an interview on 09/05/24 at 10:32 AM, the MDS Coordinator (MDSC) reviewed R17's medical record and confirmed the staff failed to obtain an admission weight for the resident. The MDSC stated she could not determine where she obtained the weight of 159 pounds that she documented on the resident's admission MDS assessment of 07/31/24. The MDSC stated she was not aware R17 had experienced a significant weight loss since her admission to the facility on [DATE]. The MDSC stated she expected staff to notify herself and the facility's CRD when a resident experienced significant weight changes to ensure care plan interventions were implemented as planned and revisions to the resident's care plan could be made if needed by the care plan team. The MDSC stated R17's nutritional care plan was developed on 08/01/24 and no changes had been made to the care plan since 08/01/24 to address the resident's subsequent unplanned significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/05/24 at 11:21 AM, the ST stated R17 was on her case load since around the time she was admitted to the facility for safety precautions. The ST stated initially R17 was feeding herself and eating pretty well. However, during the past week she started to have a decline in her PO (by mouth) intake, started to have to be reminded to swallow and currently did not have much of a desire to eat. The ST stated R17 was currently being assisted with her meals by her daughter, and a change in the resident's oral motor process was noticed yesterday (09/04/24). During an interview on 09/05/24 at 11:47 AM, the Director of Nursing (DON) stated R17 experienced a fall on 08/01/24 and was displaying agitated behaviors, so staff were unable to safely weigh the resident on this date. The DON stated she would have expected staff to obtain an admission weight for R17 as soon as the resident was able to safely allow staff to weigh her and to reweigh R17 when staff obtained a weight that reflected the resident had experienced a significant weight loss of five percent or greater.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Therapeutic Diet Orders, the facility failed to provide food in a form that met the needs which included yogurt at meals as requested for one of two residents (Resident (R) 14) reviewed for food out of 19 sample residents. The facility's failure to provide food in the appropriate form to meet a resident's needs could result in decreased intake and an increased risk of choking. Findings include: Review of the facility's policy titled, Therapeutic Diet Orders, dated 02/01/22, indicated, The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by the physician and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. Review of the Admission Record located in R14's electronic medical record (EMR) under the Profile tab indicated she was admitted on [DATE] and had diagnoses which included diabetes mellitus and gastro-esophageal reflux disease. Review of R14's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 06/25/24, revealed R14 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated moderate cognitive impairment. Review of the Resident Dining Meeting minutes dated 01/30/24, provided by the facility, revealed R14 requested to receive double portions yogurt, cottage cheese, and soup. Review of R14's comprehensive Care Plan, located in the EMR under the Care Plan tab and dated 06/26/24, contained a Focus of Nutrition: The resident is at risk for alteration in nutrition/ hydration secondary to ^ [high] BMI [body mass index], edentulous [lacking teeth] and does not wear dentures. She is very selective of the food she will eat. The care plan's goal specified The resident will tolerate prescribed diet daily through next review date. Care plan interventions included Food preferences provided as available, and RD [Registered Dietitian] to evaluate and make diet change recommendations. During an interview on 09/02/24 at 11:40 AM, R14 stated she was unable to chew some of the food she was served at meals because she did not have any teeth. R14 stated she requested cottage cheese and fruit to be served at meals, but she could not always eat the fruit served because it was too hard for her to chew without any teeth. R14 also stated she had previously requested to be served yogurt at meals because it was easy for her to eat, but the kitchen did not always provide yogurt on her meal trays. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R14's current Physician's Orders, located in the EMR under the Orders tab, dated 10/25/23, revealed an order for a no added salt, regular texture, thin consistency diet. Additionally, the following order was written on 08/29/24, Speech Therapy [ST] Clarification: Patient is to be [sic] receive skilled ST 3x [times] a week until 09/27/24 for dysphagia intervention. Tx [treatment] may include: compensation strategies, safe swallow awareness, diet trials, and oral phase intervention. Review of R14's Consultant Registered Dietitian's (CRD) progress note, dated 08/27/24 and located in EMR under the Progress Note tab, specified RD and dietary manager made aware by Ms. [R14's last name] of difficulty chewing certain foods. Current diet order is regular texture. PLAN: 1. Discuss w/SLP [with Speech Language Pathologist]: recommendation for assessment to determine comfort/preferences vs. [versus] true altered texture needs. During an observation on 09/02/24 at 12:57 PM, R14 was served her lunch meal in her room, and she was edentulous. Observation of R14's meal revealed she was served a plate of cottage cheese with large pieces of cubed cantaloupe placed around the cottage cheese and she was not served yogurt with her meal. R14 stated she could not eat the cantaloupe because she could not chew it and did not receive yogurt with her meal as she had previously requested. Review of the meal tray slip served on the resident's meal tray revealed the resident was to receive a regular diet and the tray slip contained a handwritten note which specified cottage cheese with fruit. During an observation on 09/02/24 at 12:58 PM, R14 informed a Certified Nurse Aide (CNA) that she could not eat the cantaloupe that was served on her meal tray and did not receive the yogurt she requested to be served with her meal. The CNA informed R14 that she would get her an alternate fruit in place of the cantaloupe and yogurt. During an observation on 09/03/24 at 12:50 PM, R14 was served her lunch meal in her room and was not served yogurt on her meal tray as she had previously requested. During an interview on 09/04/24 at 8:50 AM, R14 stated she had eaten her breakfast meal, but again did not receive yogurt on her meal tray as she had previously requested. During an observation on 09/04/24 at 12:43 PM, CNA1 served R14 her lunch meal in her room. Observation of R14's meal tray revealed she was not served yogurt on her meal tray. R14 was observed to inform CNA1 that she did not receive yogurt with her meal as she had requested. CNA1 informed R14 that she would get her a yogurt. During an interview on 09/04/24 at 12:50 PM, the CRD confirmed R14 was edentulous and should not receive hard fruits like cantaloupe with her cottage cheese and should receive yogurt as requested with her meals. The CRD stated she would include on R14's tray card to be served soft fruits with her cottage cheese and yogurt with meals. The CRD stated she had recently referred R14 to ST to evaluate her because she was having trouble chewing certain foods. During an interview on 09/05/24 at 11:21 AM, the ST stated R14 was on her current case load, and she was seeing her three times a week. The ST stated she was evaluating R14's ability to eat certain foods because she was edentulous and wanted to remain on a regular diet. The ST stated R14 would not be safe eating hard fruits like cantaloupe and should not receive them because she was edentulous.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on observation, staff interview, and review of the facility policies titled, Sanitation Inspection, Food Safety Requirements, and Resident Refrigerators, the facility failed to keep the kitchen's convection oven, two conventional ovens, stove top's spill pan, and large manual can opener and its base attachment clean. The facility failed to date bread products stored in the kitchen's dry storage area and cover opened food stored in the kitchen's walk-in freezer. In addition, the facility failed to date thawed nutritional supplements and discard food that was spoiled or had expired use by dates that were stored in the facility's kitchen and in the 300-hallway resident refrigerator. This failure had the potential to affect 64 residents who consumed food prepared in the facility's kitchen. Findings include: Review of the facility's policy titled, Sanitation Inspection, dated [DATE], indicated It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary, and in compliance with state and federal regulations. Review of the facility's policy titled, Food Safety Requirements, dated [DATE], indicated It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. Food will be stored, prepared, distributed, and served in accordance with professional standards for food service safety. Review of the facility's policy titled, Resident Refrigerators, dated [DATE], indicated The facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators .3. (Nursing/ housekeeping) staff shall clean the refrigerator weekly and discard any foods that are out of compliance. Nursing staff shall clean up spills as needed, or refer to housekeeping staff. 4. Residents and staff shall comply with safe food handling and storage principles .c. Foods with use-by dates shall be discarded accordingly. d. Any food with potential concerns (i.e. smell, packaging, appearance, frozen foods are not solid) shall be discarded. 1. Observation on [DATE] from 8:55 AM to 9:35 AM, during the initial kitchen inspection with Dietary Aide (DA) 1 present, revealed the following: a. The kitchen's convection oven and two conventional ovens were unclean with heavy accumulated blackened and dried food spills on their interior cooking compartment. b. The kitchen's stove top spill pan was unclean with a heavy accumulation of burnt on food spills. c. The kitchen's large manual can opener, which was attached to a food preparation table, was unclean with accumulated dried and sticky food substances on its blade and table base attachment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Maple Ridge Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22 Maple Ridge Drive S.E. Cartersville, GA 30120	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with DA1 during the initial kitchen inspection on [DATE] from 8:55 AM to 9:35 AM, DA1 confirmed the kitchen's convection oven, two conventional ovens, the stove top's spill pan, and large manual can opener and its base were unclean. DA1 stated the kitchen's food preparation and service equipment should be kept clean. DA1 explained the kitchen's ovens were on the weekly cleaning schedule but had not been cleaned for about three weeks. 2. Observation of kitchen food storage areas on [DATE] from 8:55 AM to 9:35 AM, during the initial kitchen inspection, with DA1 present, revealed the following: a. In the kitchen's dry storage room two packages of thawed raisin bread, three packages of thawed hamburger buns, two packages of thawed hot dog buns, and one package of thawed croissants did not have a use by or expiration date on their package. These undated packages of bread products were stored on bread racks and ready for use. The undated package of croissants was observed to contain 12 croissants that were covered in green mold. b. In the kitchen's walk-in refrigerator 50 thawed, four-ounce nutritional shakes were stored without a thaw date. c. In the kitchen's walk-in freezer one 30-pound box of cauliflower florets and one 144-ounce box of chicken cordon bleu were stored opened and unprotected from possible contamination. During an interview with DA1, during the initial kitchen inspection on [DATE] from 8:55 AM to 9:35 AM, DA1 confirmed the bread products stored on the bread racks in the kitchen were not dated and the undated croissants were molded. DA1 also confirmed the nutritional shakes stored in the walk-in refrigerator were not dated, and the box of cauliflower florets and the box of chicken cordon bleu were stored opened in the kitchen's walk-in freezer. DA1 stated staff were to date and completely close food prior to storage. During an interview on [DATE] at 10:50 AM, the Regional Registered Dietitian (RRD) stated the undated 50 thawed four-ounce nutritional shakes observed in the kitchen's walk-in refrigerator on [DATE] should have been dated by staff when they were removed from the freezer and placed in refrigeration to thaw and should be discarded if not utilized within 14 days. 3. Observation of food stored in the resident refrigerator on the facility's 300 hallway on [DATE] at 3:47 PM, with the Regional Director of Environmental Service (RDEVS) present, revealed the following: a. Observation of food stored in the refrigerator's freezer compartment revealed an opened and undated package of grapes that were discolored, and freezer burnt. Also, stored in this freezer compartment was a container of watermelon cubes which had an expiration date of [DATE]. The watermelon cubes were covered in ice crystals and freezer burnt. b. Observation of food stored in the refrigerator section revealed one four-ounce yogurt with an expired use by date of [DATE] and another four-ounce yogurt with an expired use by date of [DATE]. Also, stored in the refrigerator section were two thawed four-ounce vanilla nutritional shakes and two thawed four-ounce strawberry nutritional shakes that were not dated with a thaw date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 3:47 PM, the RDEVS confirmed the grapes and watermelon stored in the 300-hallway refrigerator's freezer compartment were freezer burnt, and the watermelon had an expired use by date of [DATE]. The RDEVS also confirmed the two yogurts had expired use by dates and the four nutritional shakes were not dated that were stored in the 300-hallway refrigerator. The RDEVS was observed to immediately discard all these food items. During an interview on [DATE] at 11:55 AM, the Director of Nursing (DON) stated it was the night shift nursing staff's responsibility to check and monitor the food stored in the 300-hallway resident refrigerator.