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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>115558 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                     | (X3) DATE SURVEY COMPLETED<br><br>03/06/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Dade Health and Rehab |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1234 Highway 301 South<br>Trenton, GA 30752 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50878</b></p> <p>Based on observations, staff interviews, and review of the facility policy titled, Maintenance Service, the facility failed to provide a safe, clean, comfortable, homelike environment for five rooms (room [ROOM NUMBER], 122, 119, 117, 111) on two of three halls. Specifically, these rooms contained broken tiles in toilet areas, dirty ceiling HVAC (heat, ventilation, air conditioning) vents in bathrooms, dirty bathroom exhaust vent fans, and a dirty, damaged Packaged Terminal Air Conditioner (PTAC) unit.</p> <p>Review of the facility policy titled Maintenance Service revealed in the Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment.</p> <p>1. Observations during the initial tour of the facility on 3/ 4/2025 at 11:16 am revealed dirty bathroom ceiling exhaust vent fans and HVAC vents. The PTAC filter was also dirty with particles falling out. The filters were pulled from the unit in room [ROOM NUMBER].</p> <p>Observation on 3/5/2025 at 11:25 am revealed the PTAC filter was dirty with particles falling out as the filters were pulled from the unit in room [ROOM NUMBER].</p> <p>Observation on 3/6/2024 at 11:40 am revealed dirty bathroom ceiling exhaust vent fan in room [ROOM NUMBER].</p> <p>50943</p> <p>2. Initial screening observations on 3/4/2025 at 9:59 am revealed the ceiling return vent was filled with a thick, gray, fuzzy substance in the bathroom of room [ROOM NUMBER]. Further observation of room [ROOM NUMBER] revealed damaged paint on the bathroom floor around the toilet area. The floor was dark brown in front of and behind the toilet.</p> <p>Initial screening observation on 3/4/2025 at 10:02 am revealed the ceiling return vent was filled with a thick, gray, fuzzy substance in room [ROOM NUMBER].</p> <p>Observation on 3/5/2025 at 8:54 am revealed the ceiling return vent was filled with a thick, gray, fuzzy substance in room [ROOM NUMBER].</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Observation on 3/5/2025 at 8:57 am revealed the ceiling return vent was filled with a thick, gray, fuzzy substance in room [ROOM NUMBER]. The paint on the bathroom floor was damaged with brown discoloration in front of and behind the toilet.</p> <p>Interview and observation on 3/6/2025 at 10:09 am with the Maintenance Director (MD) confirmed the bathroom ceiling vents were filled with a thick, gray, fuzzy substance in rooms [ROOM NUMBER]. The MD stated he initially painted the bathroom floor in room [ROOM NUMBER], but someone destroyed the paint near the toilet area before it could completely dry. MD also confirmed the PTAC unit in room [ROOM NUMBER] was filled with dust and food crumbs. The MD confirmed the conditions of the ceiling return air vents, flooring, and PTAC unit were unacceptable and needed to be addressed immediately. The MD stated, Housekeeping is responsible for cleaning the ceiling return vents, but the facility has been experiencing issues with keeping up due to us no longer having a housekeeping supervisor and I have been given the responsibility to oversee both departments and it has caused us to get behind, but honestly, there is no excuse for the conditions of the ceiling vents, flooring, and PTAC units, and I will rectify the concerns as soon as possible.</p> |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51215</b></p> <p>Based on observations, resident and interviews, record review, and review of the facility's policy titled, Oxygen Concentrator, the facility failed to ensure that two of six residents (R) (R20 and R9) receiving oxygen (O2) therapy had an O2 concentrator that was clean, sanitary and free of sediment build up, that O2 supplies were bagged when not in use, that humidifier bottles be supplied with water, and that O2 was set on the prescribed setting. The deficient practice had the potential to put R20, and R9 at risk for medical complications such as hypoxia, respiratory depression, and infection.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Oxygen Concentrator last revised 3/5/2024 documented under Policy Explanation and Compliance Guidelines: . 2. Oxygen is administered under orders of the attending physician. 5. Care of the Concentrator: a. Follow manufacturer recommendations for the frequency of cleaning filters and servicing the device, external filters will be cleaned weekly. b. Only trained individuals, such as the Maintenance Director or supplier shall service the device. c. The Housekeeping Department Responsibilities: i. Clean the outside casing of the concentrator and nebulizer units during routine room cleaning with an EPA- registered disinfectant in accordance with label instructions. d. Nursing Responsibilities: . ii. Change humidifier bottle when empty, every seventy-two hours, or as recommended by the manufacturer when in use.</p> <p>1. Review of the clinical electronic record revealed R20 was admitted with diagnoses that include but not limited to chronic obstructive pulmonary disease (COPD), emphysema, congestive heart failure (CHF), and anxiety disorder.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE] for R20 revealed in Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) score of 14, indicating minimal cognitive decline. Section GG (Functional Abilities), Impairment to left lower extremity, uses walker and wheelchair, eating- set up, oral-independent. Toileting- independent, shower- partial/ moderate assist, independent with upper and lower body. Section J (MDS): Received as needed medication, short of breath (SOB) with exertion, sitting and lying flat. Resident has a condition or chronic disease that may result in a life expectancy of less than six months. Section O (Special Treatments, Procedures, and Programs), On oxygen (O2) therapy. Hospice care.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of care plan for R20 dated 12/30/2024 revealed focused area of (CHF) (congestive heart failure) with goal: Signs and symptoms of exacerbation of CHF will be identified early and appropriate interventions. Interventions: Administer furosemide as ordered per doctor (MD). Administer potassium as ordered per MD. Monitor intake and output. Monitor lab work per physician order. Notify MD if indicated. Monitor/report PRN (as needed) any s/sx signs/symptoms) of CHF dependent edema of legs and feet, periorbital edema, SOB upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation (listening with stethoscope) of the lungs, orthopnea (shortness of breath when lying flat), weakness and/or fatigue, increased heart rate (Tachycardia) lethargy and disorientation. Monitor/report PRN any s/sx of hypokalemia (low potassium) receiving diuretic therapy: fatigue, muscle, weakness, diminished appetite, nausea and vomiting and dysrhythmias abnormal heart rhythm), monitor potassium levels. No salt packet on tray unless requested. Oxygen settings: O2 via nasal canula (NC) at 3 liters per minute (LPM).</p> <p>Review of the Physician orders dated 4/14/2024 revealed clean oxygen concentrator filter weekly every night shift every Friday for when oxygen is in use, change O2 tubing weekly every night shift every Friday for when oxygen is in use, change humidifier bottle on oxygen concentrator PRN for when oxygen is in use, and administer oxygen at 3 liters/minute per nasal cannula PRN.</p> <p>Observation on 3/4/2025 at 10:04 am revealed R20 lying in bed with O2 tubing on. The O2 concentrator was noted to be on and running with fluffy, brown/gray/white substance covering the filter area and the entire machine. The O2 tubing was on the floor. No water was in humidifier bottle and the humidifier straw was noted to be crusted over.</p> <p>Observation on 3/5/2025 at 8:04 am revealed R20 lying in bed with the O2 concentrator running with fluffy brown/gray/white substance covering machine and filter area. No water was in humidifier bottle and the humidifier straw was noted to be crusted over. R20 was currently using O2 via NC.</p> <p>Observation on 3/5/2025 at 2:05 pm revealed R20 lying in bad using the O2 concentrator, tubing remained on the floor with the O2 concentrator filter covered with fluffy, light-brown and white substance. Humidifier water bottle remained empty with crusting straw.</p> <p>Interview and observation on 3/4/2025 at 10:05 am of R20 revealed R20 lying in bed with O2 on with NC in place. The O2 tubing was found on the floor with the O2 concentrator covered with white, fluffy substance, no water noted in the humidifier bottle with a thick white substance covering the humidifier straw. R20 stated that she needed the O2 all the time and that the staff came in her room at night to tend to the O2 when she was asleep.</p> <p>Interview and observation on 3/06/2025 at 10:56 am with Director of Nursing (DON) and Licensed Practical Nurse (LPN) AA confirmed that R20's O2 setting being at 2 LPM. LPN AA stated R20's O2 saturation was 95%. The DON stated, The filters and concentrators are changed and cleaned on Fridays and the night shift nurse is responsible. The DON confirmed and stated the machine doesn't look clean but that the tubing was changed. The DON confirmed that the physician orders and care plan indicated the O2 concentrator was to be set at 3 LPM PRN. The DON stated that he was supposed to be auditing every Monday morning to make sure the machines were cleaned but admitted he had not been checking behind the responsible nurse to ensure it was done.</p> <p>50943</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>2. Review of the electronic medical record (EMR) revealed R9 was admitted to the facility with diagnoses including but not limited to pneumonia and history of COVID-19.</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) dated [DATE] documented R9 had a Brief Interview for Mental Status (BIMS) score of 00, indicating the resident's cognition was severely impaired. Further review revealed R9's upper and lower extremities were impaired on both sides. Section J0100-Pain Management revealed R9 is also receiving pain management and Section O-Special Treatments, Procedures, and Programs revealed oxygen therapy.</p> <p>Review of the care plan for R9 dated 2/11/2025 documented: Administer oxygen via NC PRN @ 2 LPM, monitor for effectiveness.</p> <p>Review of the physician orders for R9 revealed staff must change oxygen tubing weekly every Friday night shift for when the oxygen is in use and as needed. Staff must clean oxygen concentrator weekly every Friday night shift. Staff must also obtain and document oxygen saturation with use of pulse oxygen meter as needed for shortness of breath, notify MD if results less than 90%, and administer oxygen at two liters/minute per nasal cannula as needed.</p> <p>Initial screening observation on 3/4/2025 at 10:48 am revealed R9's O2 concentrator set at 1 LPM. The O2 tubing was on the floor, and the filter in the back of the O2 concentrator was dirty with a gray, fuzzy substance.</p> <p>Observation on 3/5/2025 at 8:50 am revealed R9 lying in bed. Further observation of R9's O2 revealed an O2 concentrator set at 1.5 LPM. The tubing was on the floor, and the filter in the back of the O2 concentrator was dirty with a gray, fuzzy substance.</p> <p>Observation and interview on 3/6/2025 at 11:04 am with the DON and LPN AA confirmed R9's O2 concentrator was unclean with thick, gray fuzzy substance.</p> |  |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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.</p> <p>51215</p> <p>Based on observations, staff interviews, and review of the facility's policy titled, Medication Storage in the Facility, the facility failed to ensure that all drugs and biologicals were discarded prior to the expiration date. Specifically, there were nine medications found to be past the expiration date. The deficient practice had the potential to put residents at risk for medical complications related to potential changes in their chemical composition, failing to treat the intended condition properly, and in some cases, causing harm due to unexpected side effects. The facility census was 28.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Medication Storage in the Facility dated June 1, 2018, revealed on page 1. Under Procedures: . L. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closure are immediately removed from stock, disposed of according to procedure for medication disposal .Page 3. G. All expired medications will be removed from the active supply and destroy in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.</p> <p>Observation on 3/5/2025 at 10:14 am of the medication storage room/supply room, with the Director of Nursing (DON) revealed medications neatly arranged on multiple shelves. Observation of random bottles of medication revealed a box of three milliliter (ml) syringes with an expiration date of 2/1/2025, moisture balancing hydrogel dressing adhesives (four boxes) with an expiration date of 12/31/2024, and Povidone - iodine 10% solution with an expiration date of January 2025.</p> <p>Observation on 3/5/2025 at 10:14 am of the medication refrigerator located behind the nurse's station revealed two unopened boxes of influenza vaccine located in the medication refrigerator with an expiration date of 5/31/2024.</p> <p>Interview on 3/5/2025 at 10:30 am with the DON revealed that the stock person was to check for expired items and remove them from the stock room. The DON stated, this is old, when handed the two boxes of flu vaccine. The DON removed all expired medications from the storage rooms immediately.</p> <p>Interview on 3/5/2025 at 3:10 pm with the Infection Preventionist (IP) and the DON revealed that no resident nor staff had received the expired medications nor flu vaccine and they were unaware where the unopened vials of flu vaccines came from. The IP stated that, someone must have been cleaning up and found the vials and placed them in the refrigerator. The IP then revealed that the Wound Care Nurse (WCN) used a different vial that was not expired to administer flu shots for this season and had records of the lot number and expiration date to prove it.</p> <p>Interview with the WCN on 3/5/2025 at 3:30 pm revealed a list of residents and staff who had received the flu vaccine this season along with the lot number and expiration dates documented on paper. The WCN stated that this information could also be found in each resident's electronic medical record (EMR) under Immunization along with the date of administration.</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51215</b></p> <p>Based on observations, staff interviews, and review of the facility policies titled, Medication Administration-General Guidelines and Cleaning and Disinfecting Non-Critical Resident Care Items, the facility failed to practice acceptable infection control practices to prevent possible cross-contamination by not practicing proper hand hygiene during medication pass observation for five of 19 sampled residents (R) (R6, R8, R16, R17, and R23). The facility also failed to bag and label wash basins, urinals and bed pans in three Rooms (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]). The facility census was 28.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Medication Administration-General Guidelines dated April 1, 2016, under Procedures: A. 2) Handwashing and Hand Sanitation: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident, before and after administration of ophthalmic, topical, vaginal, rectal, and parenteral preparations, and before and after administration of medications- via enteral tubes. a. Examination gloves are to be worn when necessary. b. Hand sanitization is done with an appropriate sanitizer-between handwashing's, when returning to the medication cart or preparation area . at regular intervals during the medication pass such as after each room .</p> <p>Review of the facility's policy titled, Cleaning and Disinfecting Non-Critical Resident-Care Items last reviewed January 2025 documented the following under Procedures: 1. Single resident use items are for single resident use only. [NAME] with the resident's name and/or room number and discard upon transfer or discharge. 2. Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinals). 3. Staff must return urinals and bedpans to the residents' bedside cabinet once the items have been thoroughly cleaned.</p> <p>1. Observation on 3/5/2025 at 08:10 am of medication pass with Licensed Practical Nurse (LPN) CC revealed her administering medications to R16, R17 and R8. No handwashing nor hand sanitizing was performed before or after medication preparation. Hand hygiene was also not performed in-between residents, even after LPN CC was noted touching R8's straw to assist with drinking, and the bedrails of R17.</p> <p>Interview on 3/5/2025 at 8:42 am with LPN CC confirmed not performing hand hygiene at any time during the medication pass until after the task was completed and stated that she should have performed it when going in and out of all rooms. LPN CC also stated that she had been a nurse for a little over a year and was not sure when to perform soap and water washing or at what times in-between or after how many residents to sanitize her hands, but that she would find out.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Observation on 3/5/2025 at 8:50 am of medication pass with LPN AA revealed medication administered to R6 and R23. No hand hygiene was performed before or after medication preparation. LPN AA was observed putting on gloves on three separate occasions during the medication preparation process when she accidentally dropped pills onto a tissue and picked them up again. She removed the gloves after using them and no hand hygiene was performed either time. LPN AA was observed crushing medications and placing them in apple sauce and administering them without performing hand hygiene before or after the administration.</p> <p>Interview on 3/5/2025 at 9:13 am with LPN AA confirmed that she did not perform hand hygiene at any time during the medication preparation process and stated that she was aware she was supposed to perform hand hygiene before putting on and after removing gloves. LPN AA stated she didn't realize that she had not performed hand hygiene in-between each resident.</p> <p>Interview with the Director of Nursing (DON) revealed that it was his expectation that the nurses performed hand hygiene before and after using gloves, in between residents, and when entering and exiting rooms. He stated that the Infection Preventionist (IP) had in-services in January 2025 and medication pass was evaluated. He also stated that the nurses should be washing with soap and water after using sanitizer three times.</p> <p>50943</p> <p>2. Initial screening observation on 3/4/2025 at 10:02 am revealed a wash basin and urinal were nested together on the bathroom floor near the garbage can in room [ROOM NUMBER]. The wash basin and urinal were unlabeled and unbagged.</p> <p>Observation on 3/4/2025 at 11:27 am revealed a wash basin and urinal were nested together on the bathroom floor underneath the sink in room [ROOM NUMBER]. The wash basin and urinal were unlabeled and unbagged.</p> <p>Observation on 3/5/2025 at 9:52 am revealed a wash basin and urinal were nested together on the bathroom floor near the garbage can in room [ROOM NUMBER]. The wash basin and urinal were unlabeled and unbagged.</p> <p>During a facility tour on 3/6/2025 between 11:06 am to 11:13 am with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) AA and LPN BB, the following was confirmed: A wash basin and urinal were nested together on the bathroom floor underneath the sink in room [ROOM NUMBER]. The wash basin and urinal were unlabeled and unbagged. A wash basin and urinal were nested together on the bathroom floor near the garbage can in room [ROOM NUMBER]. The wash basin and urinal were unlabeled and unbagged. Three wash basins were stacked together on top of the bathroom sink in room [ROOM NUMBER]. The wash basins were unbagged and unlabeled.</p> <p>Interview on 3/6/2025 at 11:15 am with the DON, LPN AA and LPN BB revealed the wash basins and urinals were supposed to be bagged and labeled. The DON, LPN AA and LPN BB confirmed the nature of the wash basins and urinals were incorrect and unacceptable. It was also indicated that the wash basins and urinals should not be stored on the floor nor bathroom sink. The DON and LPN AA and BB were unsure of who was responsible for cleaning and managing the wash basins.</p> |  |  |