

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Pinewood Manor Nursing Home & Rehabilitation Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 277 Commerce Street Hawkinsville, GA 31036	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25117</p> <p>Based on observations, staff interviews, record review and review of facility's policy titled Abuse, Neglect and Exploitation, the facility failed to report an injury of unknown source for one out of one Resident (R) R5 reviewed for abuse.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse, Neglect and Exploitation dated 10/1/2018 revealed under the The Components of the facility abuse prohibition plan are discussed herein section revealed, II. Employee Training .C. Training topics will include: .4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources; Under the section labeled IV. Identification of Abuse, Neglect and Exploitation it was noted B. Possible indicators of abuse include, but are not limited to: 1. Resident, staff or family report of abuse 2. Physical marks such as bruises or patterned appearances such as a hand print, belt or ring mark on a resident's body 3. Physical injury of a resident, of unknown source Continued review of the policy revealed VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>Review of R5's clinical record revealed admitting diagnoses that included but not limited to, Parkinson's Disease, orthostatic hypotension, arthritis, Non-Alzheimer's Dementia, and depression.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed, Section C (Cognitive Pattern), a Brief Interview of Mental Status score of 4, which indicated R5 was severely cognitively impaired and Section GG (Functional Abilities and Goals), indicated R5 required substantial to total assistance with activities of daily living (ADLs).</p> <p>In an observation during the initial tour on 3/4/2025 at 11:55 a.m. revealed, R5 was in his room in the bed and was having a mobile x-ray conducted of his right foot.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Accompanied by Licensed Practical Nurse (LPN) EE, during a follow-up observation on 3/6/2025 at 9:45 a.m. , LPN EE removed R5's right sock and presented that the resident's right foot was swollen with a circular red bruise to the top of the foot. The bruise measured approximately 1.5 to 2 inches in diameter. LPN EE stated that she heard the resident may have had foot injured in the shower or when being transferred by staff. LPN EE confirmed the resident had an x-ray of his right foot, and the results of the assessment indicated there was no fracture to the foot.</p> <p>A follow-up interview on 3/6/2025 at 2:45 p.m. with LPN EE revealed that on Monday, 3/3/2025, Certified Nursing Aide (CNA) FF called her into the shower room and showed her a bruise on the top of the resident's foot. When asked about the protocol for reporting an injury of unknown origin, the nurse said injuries of unknown origin were to be reported to the Director of Nursing (DON). LPN EE did not report the injury of unknown origin to the DON.</p> <p>In an interview with the facility's DON on 3/6/2025 at 5:30 p.m., the DON said that injuries of unknown sources were reported to the Administrator immediately and an investigation was started immediately. The DON confirmed this did not happen for R5's injury of unknown origin that required a mobile x-ray on the morning of 3/4/2025 and said that the injury should have been reported at that time. When asked if an investigation had started, the nurse said that she had started an investigation; however, nothing had been documented yet.</p> <p>An interview with CNA FF on 3/6/2025 at 5:45 p.m. revealed that on the morning of Monday, 3/3/2025, he notified the charge nurse, LPN EE, and the wound nurse, LPN GG about R5's bruise on top of his foot.</p> <p>In an interview with the wound nurse, LPN GG on 3/7/2025 at 9:18 a.m., LPN GG said that CNA FF reported that he discovered a bruise on top of R5's foot and wanted her to look at it. LPN GG said that the bruise was about the size of a quarter on 3/3/2025, and when she saw it again on the morning of 3/4/2025, the resident's foot was swollen, and the bruise had spread and become much larger. She notified the physician, and an x-ray of the foot was ordered. She reported the injury of unknown origin to the charge nurse and to the DON.</p> <p>In an interview on 3/7/2025 at 9:46 a.m., the facility's Administrator said that the protocol in addressing injuries of unknown origin was to ensure an incident report was completed, and if the origin of the injury was unknown, then follow-up was required, and it was a reportable event to the state. The Administrator said that the chain of command for reporting injuries of unknown origin was for the aide to report to the charge nurse; the charge nurse reported to the DON; and then the DON reported to the Administrator. If it was not determined how an injury happened, then an investigation was initiated, and an investigation report was completed. The Administrator confirmed R5's injury of unknown origin was not reported to her on 3/4/2025, as it should have been, and confirmed that an investigation was not initiated regarding the resident's injury of unknown origin.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42991</p> <p>Based on staff interviews, record review, and review of the facility's policy titled Resident Assessment-Coordination with PASARR (Preadmission Screening and Resident Review), the facility failed to refer one out of two sampled Residents (R) R1 with a serious mental disorder for a Level II PASARR.</p> <p>Findings include:</p> <p>A review of the facility's undated policy titled Resident Assessment-Coordination with PASARR, under the Policy section revealed, This facility coordinates assessments with the PASARR program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Under the Policy Explanation and Compliance Guidelines: 1 . b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has mental disorder (MD), intellectual disability, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs . 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 7. Recommendations, such as any specialized services, from a PASRR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care . 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.</p> <p>A review of R1's History and Physical dated 3/13/2016 revealed the facility had admitted the resident on 3/8/2016 with the following diagnoses: paranoid schizophrenia, osteoarthritis (OA), and dementia.</p> <p>A review of the Annual Minimum Data Set (MDS) dated [DATE] for R1 revealed, Section C (Cognitive Pattern), a Brief Interview Mental Status (BIMS) score of three which indicated severe cognitive impairment and not able to complete the interview.</p> <p>A review of the document dated 2/3/2011 and titled, Georgia Department of Community Health stated Attention: Medicaid Prior Approval/Utilization Review (UR) Department revealed On the basis of available clinical information, it is determined that [R1] has met the criteria for Level I PASARR approval. Continued review of the clinical record did not reveal the facility had referred the resident to the appropriate state designated authority for a PASARR II screening despite the resident having a diagnosis of Schizophrenia.</p> <p>An interview, on 3/6/2025 at 12:21 p.m. and on 3/7/2025 at 8:54 a.m. with the Social Worker (SW) revealed the resident did have a PASARR I completed prior to admission but the resident was not diagnosed with schizophrenia until 2016, so PASARR II had not been completed. The SW stated she was not aware a PASARR II had not been completed, and normally the Admissions Department would complete PASARR II.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Medical Records (MR) staff, it was revealed she would complete a PASARR I upon admission if needed, however, he/she did not know who would normally complete a PASARR II.</p> <p>An interview with the Administrator on 3/7/2025 at 9:41 a.m., revealed that a psychiatrist should take the lead role on whether or not a PASARR should be completed on a resident. She stated it was his/her expectation that the facility's policies and procedures be followed in regard to PASARR II.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28734</p> <p>Based on observation, staff interviews, record review, and review of the facility's policy titled Comprehensive Care Plans, the facility failed to implement a comprehensive person-centered care plan for one out of 21 sampled Residents (R) R53. Specifically, R53's care plan was not followed by staff in regard to Enhanced Barrier Precautions (EBP).</p> <p>Findings include:</p> <p>A review of the policy titled Comprehensive Care Plans dated 2025 stated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality .Policy Explanation and Compliance Guidelines: .8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p> <p>A review of the document titled, Diagnosis Report no date, revealed R53 had the following diagnoses: acute respiratory failure with hypoxia, dysphagia, and encounter for attention to gastrostomy tube - (G-tube].</p> <p>In a review of the Admission Minimum Data Set (MDS), dated [DATE] revealed the facility admitted R53 on 12/10/2024. Continued review of the MDS revealed Section C (Cognitive Patterns), the resident had both short-term and long-term memory loss, and Section K (Swallowing/Nutritional Status), the resident had a feeding tube.</p> <p>In a review of R53's care plan dated 12/10/2024 revealed, Focus - Prevent Spread of Multidrug resistant organism: G-tube. Goal - Staff will implement Enhanced Barrier Precautions (EBP) daily to decrease the risk of spreading multi-drug-resistant organisms (MDROs) in facility. Interventions - Follow EBP as designed by the facility. Will be followed during .devices care or use .feeding tube. [sic]</p> <p>Observation of Licensed Practical Nurse (LPN) BB, on 3/5/2025 at 2:00 p.m., during medication administration to R53 revealed the LPN administered quetiapine fumarate 150 milligrams (mg) and valproic acid oral solution 250 mg via the resident's G-tube. Continued observation revealed the LPN had donned gloves but had failed to don a gown.</p> <p>In an interview with the Director of Nursing (DON) on 3/7/2025 at 9:30 a.m., it was revealed it was her expectation that staff follow each resident's care plan, mostly, in order to protect and care for each resident.</p> <p>An interview with LPN CC, on 3/7/2025 at 9:36 a.m., revealed care plans were developed by the MDS Nurse, but any nurse could update the care plans as needed. She revealed the purpose of a care plan was so staff would be aware of how to care for each resident. He/She continued to state if staff did not follow the care plan, the residents would not be properly cared for.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Administrator on 3/7/2025 at 9:41 a.m., revealed it was his/her expectation that staff follow all the facility's policies and procedures related to EHB.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42991</p> <p>Based on observations, staff interviews, record review, and review of the facility's policies titled Manual Warewashing-3 Compartment Sink and Dishwasher Temperature, the facility failed to ensure all dishes, pots, pans and cooking utensils were properly sanitized to decrease the risk of spread of infection and cross contamination. This was evidenced by the facility staff not having the proper method to check the sanitizer solution concentration levels for the dish machine and three compartment sink. The deficient practice had the potential to affect 53 out of 56 residents that received an oral diet from the kitchen.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Manual Warewashing-3 Compartment Sink dated [DATE] revealed, Policy: To prevent the spread of bacteria that may cause food borne illness, this facility washes, rinses, and sanitizes pots, pans, and other utensils using a 3 compartment sink in accordance with current standards for food safety .Policy and Compliance Guidelines: . 7. Sanitizing solutions shall be tested by a test kit or other device that accurately measures the concentration in MG/L (milligram/liter). Testing will occur periodically but not limited to: a. When sink is initially filled, b. At least once per shift, c. With extended use, and d. As needed.</p> <p>Review of the facility's policy titled, Dishwasher Temperature dated [DATE] revealed, Policy: It is policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures. Policy Explanation and Compliance Guidelines: .3. For high temperature dishwashers (heat sanitization): a. The wash temperature shall be ,d+[DATE] F (degrees Fahrenheit):. i. For a stationary rack, single temperature machine: 165 F. ii. For stationary rack, dual temperature machine: 150 F. iii. For a single tank, conveyor, dual temperature machine: 160 F . iv. For a multi-tank, conveyor, multi-temperature machine:150 F. b. The final rinse temperature shall be 180 F or above but not exceed 194 F (165 F for stationary rack, single temperature machine). Corrective actions shall be taken for final temperatures below the required rinse temperatures. 4. For low temperature dishwashers (chemical sanitization): a. The wash temperature shall be 120 F. b. The sanitizing solution shall be 50ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse. 5. Chemical solutions shall be maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines. Results of concentration checks shall be recorded. 6. Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes.</p> <p>Review of facility's temperature and sanitizer log dated ,d+[DATE], ,d+[DATE] and ,d+[DATE] with recorded temperatures and sanitizing results reading showing no discrepancies with temperature or test strip results.</p> <p>Review of the [Name] test strip bottle revealed the color-coded levels associated with the parts per million (ppm) concentration levels of the solutions to be tested . The proper range for the dish machine was , d+[DATE] ppm (green) and for the three-compartment sink 400- 500 ppm (green).</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on [DATE] at 8:48 a.m. the Dietary Manager completed a test of the sanitizer solution using a test strip for the dish machine and the three-compartment sink. The test strip reading was around 150 ppm (parts per million) (yellow-ish brown) using [Name] test strips for the dish machine and Quaternary (QAC) strips registered 0 ppm (light olive green) for the three-compartment sink. The color of the test strips were yellow-ish brown and not green, as it should have been for the appropriate concentration level of , d+[DATE] ppm.</p> <p>During an observation on [DATE] at 8:49 a.m. the Dietary Manager completed a test strip for the dishwasher and three compartment sinks. Test strip reading was around 150 ppm (yellow-ish brown) using [Name] lab strips and Quaternary (QAC) strips 0 ppm (light olive green).</p> <p>During an observation on [DATE] at 8:57 a.m. the Dietary Manager completed a test strip for the dishwasher and three compartment sinks. Test strip reading was around 150 ppm (yellow-ish brown) using [Name] lab strips and Quaternary (QAC) strips 0 ppm (light olive green).</p> <p>During an observation on [DATE] at 9:01 a.m. the Dietary Manager completed a test strip for the dishwasher and three compartment sinks. Test strip reading was around 150 ppm (yellow-ish brown) using [Name] lab strips and Quaternary (QAC) strips 0 ppm (light olive green).</p> <p>During an observation on [DATE] at 2:58 p.m., Dietary Aide JJ completed a test of the sanitizer concentration level using a test strip for the dish machine. The test strip reading was around 150 ppm (yellow-ish brown) using [Name] lab strips, which was at a lower level than it should have been.</p> <p>During an observation on [DATE] at 3:01 p.m., the Dietary Manager completed a test of the sanitizer concentration level using [Name] lab strips and Quaternary (QAC) strips for three-compartment sink. The test strip reading was around 150 ppm, which was yellow-ish brown in color, using [Name] lab strips and the Quaternary (QAC) strips, which read 0 ppm was light olive green color.</p> <p>During an interview on [DATE] at 3:01 p.m., the Dietary Manager stated she did not know if the dish machine was serviced, nor could she explain who checked the sanitization log.</p> <p>During an interview on [DATE] at 3:08 p.m., Dietary Aide JJ stated the test strips did not measure at a proper concentration level for the sanitizing solution. Dietary Aide JJ stated they informed the night nurse but was unsure of whom and when this happened. Dietary Aide JJ, when asked how and by whom the sanitizing logs were completed with the information verifying no discrepancies, Dietary Aide JJ hunched their shoulders up and down and said, I don't know. Dietary Aide JJ stated she started working at facility three months ago.</p> <p>During an interview on [DATE] at 3:09 p.m. with Dietary Aide II stated they had worked at the facility for three years. Dietary Aide II stated the dish machine, and sanitizing solutions were checked by [Name], but they were unsure of when [Name] had last serviced the machine or solutions. Dietary Aide II stated that logs were completed to show correct temperature and chemical reading, although things were not working. Dietary Aide II stated they couldn't remember if they told anyone about the solutions or test strips not reading at the proper levels.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 3:11 p.m., with Dietary Aide HH stated she ran the dish machine four wash cycles, and the temperature was 84 F (degrees Fahrenheit), 101 F, 119 F and 121 F. Dietary Aide HH stated the machine did not reach 145 F or hotter until the machine ran two to four wash cycles in a row. Dietary Aide HH stated the log might be incorrect due to the machine's temperature gauge not working correctly.</p> <p>During an interview on [DATE] at 3:13 p.m., the Dietary Manager stated they had 12 containers of [Name] test strips that expired [DATE], [DATE], [DATE], [DATE] and [DATE]. The Dietary Manager stated the test strips were used to ensure the proper concentration for sanitization was reached for three compartments sink and dishwashing machine. The Dietary Manager stated she had not ordered any new strips after she realized they had expired. The Dietary Manager stated she was aware for a while that the dish machine did not get hot right away and staff would have to run the machine at least three to four cycles before the temperature was reached. The Dietary Manager stated they did not make arrangement to have the machine serviced.</p> <p>During an interview on [DATE] at 4:45 p.m., the Administrator stated there was a previous contract with a company that serviced the dish machine and provided sanitation solutions. The Administrator stated she did not know if the facility had been getting serviced by [Name] and was unsure of the prior contract. The Administrator stated she had not been informed they did not have a vendor to supply sanitizing solutions.</p> <p>During an interview on [DATE] at 4:51 p.m., the Housekeeping Supervisor stated the contract with the previous vendor had ended two years ago. The facility had been using the sanitizing chemicals that were left over from two years ago. The machine had not been serviced since the other company left in the summer of 2023.</p> <p>During an interview on [DATE] at 4:41 p.m., the [Name] Technician stated they received a service call on [DATE] to test the chemical sanitizer solutions. The [Name] Technician stated the three-compartment sink sanitizer solutions were expired; the QT test strips were expired, and the dish machine's sanitizing chemical solution was empty. The [Name] Technician stated they did not have any supplies on hand and placed an order for restocking. The [Name] Technician stated the last time they serviced the three-compartment sink and dish machine for chemicals was ,d+[DATE] and it was fine then. The Ecolab Technician further stated they trained the staff today on how to use the test strips and check chemical sanitizing solution.</p> <p>During an interview on [DATE] at 4:43 p.m., the Dietary Manager stated she did not know the dish machine sanitizing chemicals were empty nor was she aware the sanitizing chemicals were expired. The Dietary Manager stated that staff should not have run the dish machine if no chemical solution was available. The Dietary Manager stated that staff were trained by [Name] Technician on [DATE] how to the use of Ecolab test strips to determine sanitation level and also on how to check the sanitizer solution levels for the dishwashing machine.</p> <p>During an interview on [DATE] at 4:45 p.m., the Administrator stated they were actively working with [Name] to get the appropriate test strips and sanitizer solutions. The Administrator stated they were aware of the concern on [DATE], but did not call [Name] until [DATE] because they had to get the account information.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 11:21 a.m., the Administrator stated they started using paper plates and plasticware over the weekend. The Administrator stated that they had supplies and sanitation solutions arriving either [DATE] or [DATE]. The Administrator stated they also had a plumber come on [DATE] to check the thermostat on the dish machine. The Administrator stated the plumber will return [DATE] to add a new thermostat and install a recirculation line. The Administrator stated she expected the Dietary Manager to review temperature and sanitizer logs. The Administrator stated that all of kitchen staff had received a written warning on [DATE] for falsifying temperature lot information.</p> <p>Cross Reference F835</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Pinewood Manor Nursing Home & Rehabilitation Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 277 Commerce Street Hawkinsville, GA 31036	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42991</p> <p>Based on staff interviews and record review, the facility Administration failed to ensure oversight of the kitchen to ensure proper sanitation of pots, pans, dishes, utensils and countertop surfaces. This was evidenced by the Administration not being aware the dish machine and three-compartment sink did not have proper sanitation; and was not aware that the thermostat on the dish machine was inoperable. Also, the Dietary Manager did not have a Certified Dietary Manager (CDM) certification or equivalent. The deficient practice had the potential to affect 53 out of 56 residents that received an oral diet from the kitchen.</p> <p>Findings include:</p> <p>Review of Administrator's job description, Copyright 2023 from The [Name], LLC, revealed, Major Duties and Responsibilities - Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with the current state and federal laws and regulations . Evaluates key performance indicator outcomes with department heads to determine the need for action from leadership and/or management such as re-education or revisions related facility's outcomes, regulatory compliance and/or customer satisfaction.</p> <p>Review of Dietary Manager's job description, Copyright 2023 from The [Name], LLC, revealed, Required Qualifications .Certification as a dietary manger. Certification as a food service manager .Major Duties and Responsibilities - Oversees the budget and purchasing of food and supplies, and food preparation, services, and storage .Dietary Manager Assigned Tasks . Ensures proper sanitation and safety practices of staff.</p> <p>During an interview on 3/6/2025 at 3:01 p.m., the Dietary Manager stated she did not have her Certified Dietary Manager certification (or equivalent) and did not enroll in an online class until January 25. The Dietary Manager stated they did not review the sanitation or temperature logs. She also stated she did not appoint anyone to review or monitor the logs.</p> <p>During an interview on 3/6/2025 at 4:45 p.m. with the Administrator, she stated she did not make sure sanitation test strips and sanitizing chemicals were ordered right away once she was informed the sanitation test strips and did not know the hot water to the dish machine was not working properly. The administrator stated that she did not monitor the Dietary Manager nor ensure oversight of the kitchen. The Administrator stated she started working at the facility 11/2024. The Administrator stated that she knew the Dietary Manager was not certified and did not hire her for the position. The Administrator stated her expectations was the Dietary Manager was monitoring sanitizing logs.</p> <p>During an interview on 3/11/2025 at 11:21 a.m., the Administrator stated they had arranged for a Dietitian to work every day with the Dietary Manager until she was certified. The Administrator stated they also will have the Dietary Manager enroll in an education program to help with the education of the dietary staff.</p> <p>Cross Reference F812</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28734</p> <p>Based on observation, staff interviews, record review, and review of facility's policies titled Hand Hygiene, and Enhanced Barrier Precautions, the facility failed to perform hand hygiene between residents for six out of 21 residents observed during meal service, to prevent the spread of infection and communicable diseases. In addition, the facility failed to don gown prior to administering medications to one of three Residents (R) R53 with a gastrostomy (G-tube).</p> <p>Findings include:</p> <p>Review of the facility policy titled, Hand Hygiene, dated 1/1/2025 read, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table . Hand Hygiene Table: Condition: Between resident contacts. Either Soap and Water or Alcohol Based Hand Rub (ABHR is preferred).</p> <p>A review of the facility policy titled, Enhanced Barrier Precautions dated 2025, stated, It is the policy of this facility to implement enhanced barrier precautions [EBP] for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities . 2. Initiation of Enhanced Barrier Precautions . b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. indwelling medical devices (e.g. feeding tubes .) even if the resident is not known to be infected or colonized with a MDRO [multidrug-resistant organism] . 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident ' s room .4. High-contact resident care activities include .g. Device care or use .feeding tubes .</p> <p>1. During a meal service observation in the main dining room on 3/4/2025 at 11:33 a.m., Registered Nurse (RN) AA, without performing hand hygiene, walked over to a resident seated at the dining room table, and started cutting up their food on their plate for them. Without performing hand hygiene, RN AA went to another table and assisted a resident with cutting up her pork chops. Then RN AA went over to the kitchen door and retrieved a sandwich, wrapped in a clear bag, from the kitchen staff and delivered the sandwich to the resident, seated at another table. RN AA went to another table, sat down beside a resident and, without performing hand hygiene, started feeding the resident with a spoonful of food. The RN continued to feed the resident until the resident finished eating. RN AA got up from the chair after feeding the resident and went over to another table and sat down across from another resident. RN AA picked up the resident ' s spoon and fed the resident a bite of her food. After the RN finished feeding the resident, RN AA got up and walked to the doorway of the kitchen. The RN was handed another sandwich wrapped in clear plastic wrap. RN AA, without performing hand hygiene, brought the sandwich over to another resident seated in the dining room, removed the sandwich from the package and set it on the resident ' s plate in front of her.</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>During an interview on 3/5/2025 at 12:40 p.m., RN AA stated, I didn ' t wash my hands between helping each resident during lunch. I probably should have.</p> <p>During an interview on 3/5/2025 at 1:59 p.m., the Director of Nursing stated, I expect that when staff are helping a resident in the dining room, they wash their hands between each resident, and especially when feeding them. [RN AA] does our in-services for infection prevention and hand hygiene. She also does our hand hygiene audits.</p> <p>42991</p> <p>2. A review of the document titled, Diagnosis Report revealed R53 had the following diagnoses: acute respiratory failure with hypoxia, dysphagia, and encounter for attention to Gastrostomy (G-tube).</p> <p>In a review of the Admission Minimum Data Set (MDS), dated [DATE] revealed the facility admitted R53 on 12/10/2024. Continued review of the MDS revealed Section C (Cognitive Patterns), the resident had both short-term and long-term memory loss, and Section K (Swallowing/Nutritional Status), the resident had a feeding tube.</p> <p>In review of R53's care plan, no date, stated, Focus - Prevent Spread of Multidrug resistant organism: G-tube. Goal - Staff will implement EBP daily to decrease the risk of spreading MDROs in facility. Interventions - Follow EBP as designed by the facility. Will be followed during .devices care or use .feeding tube. [sic]</p> <p>Observation of Licensed Practical Nurse (LPN) BB, on 3/5/2025 at 2:00 p.m., during medication administration to R53 revealed the LPN administered quetiapine fumarate 150 milligrams (mg) and valproic acid oral solution 250 mg via the resident's G-tube. Continued observation revealed the LPN had donned gloves but had failed to don a gown.</p> <p>An interview with DON on 3/7/2025 at 9:30 a.m., revealed R53 should have been on EBP because the resident had received medications through a GT and the staff should have donned a gown. The DON stated some staff may not have been trained on EBP.</p> <p>A review of the document titled, Inservice Sign-In Sheet, Enhanced Barrier Precautions dated 4/2/2024 revealed LPN BB had not received training on EBP.</p> <p>A telephonic interview with LPN BB on 3/7/2025 at 9:38 a.m., revealed he/she could not recall if he/she had or had not received training on EBP and he/she had not been aware R53 was on EBP. The LPN stated in the past, the DON, or the ADON would post signage on the resident's door, as well as provide a (Personal Protective Equipment) PPE cart.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 3/7/2025 at 10:14 a.m., revealed R53 had changed rooms recently; however, the signage and PPE cart had not been transferred along with the resident during the move.</p>		