STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115607	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Nursing Center	433 North McGriff Street Whigham, GA 39897

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on record review, interviews, and facility policy review, the facility failed to ensure a resident's wish for a Do Not Resuscitate (DNR) code status as specified in the resident's Physician Orders For Life-Sustaining Treatment (POLST, this is a Physician's Order guided by the patient's medical condition and based upon personal preferences verbalized to the physician or expressed in an Advanced Directive) was ordered and accurately documented in the resident's medical record for one of two residents (Resident (R) 54) reviewed for advanced directives in a total sample of 21 residents. This failure created the potential for residents not to have their wishes followed should they suffer a health emergency. Findings include: Review of the facility policy titled, Advanced Directives, revised on ,d+[DATE], indicated, Policy Statement Advanced directives will be respected in accordance with state law and facility policy. 1. Upon Admission, the resident will be provided with written information concerning the right to refuse or accept medical treatment and to formulate an advanced directive if he or she chooses to do so . 3. If the resident is incapacitated and unable to receive information about his or her right to formulate an advanced directive, the information may be provided to the resident's legal representative . 6. Prior to or upon admission of a resident, the social services director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advanced directives. 7. Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record . 10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive . 18. The interdisciplinary team will review annually with the resident his or her advanced directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument . 20. The director of nursing services or designee will notify the attending physician of advanced directives so that appropriate orders can be documented in the resident's medical record and plan of care. The attending physician will not be required to write orders for which he or she has an ethical or conscientious objection. Review of R54's Admission Record, located in the front of the resident's hard medical record/chart, revealed R54 was admitted to the facility on [DATE] with diagnoses that included dementia, schizophrenia, major depression, and bipolar disorder. The resident was listed as her own responsible party and under the Advanced Directive section CPR [Cardiopulmonary Resuscitation] was listed. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R54's Dashboard, located under the Dash tab in the electronic medical record (EMR), revealed the resident's code status was noted as CPR. Review of R54's current care plan, located under the Care Plan tab in the EMR and with a creation date of [DATE] and a most recent review date of [DATE], contained a Focus which specified, Resident has a Full Code Status. The care plan's Goal indicated, Request to be honored thru review date. Target Date: [DATE]. Care plan Interventions, specified, Full Code status, Notify MD [physician] and Family as needed, and transfer to ER [emergency room] as needed. Review of R54's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] and located under the MDS tab in the resident's EMR, indicated R54 had a Brief Interview for Mental Status (BIMS) score of 08 out of fifteen, which indicated R54 had moderate cognitive impairment. Review of 54's POLST form, located under the Miscellaneous tab of the EMR, indicated the document was signed by the resident on [DATE] and signed by a physician on [DATE]. Under section A Code Status Cardiopulmonary Resuscitation (CPR)/Patient has no pulse and is not breathing Allow Natural Death (AND)-Do Not Attempt Resuscitation was checked. Review of R54's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], located under the MDS tab in the residents EMR, indicated, R54 had a Brief Interview for Mental Status (BIMS) score of 04 out of fifteen, which indicated R54 was cognitively impaired. Review of R54's February 2025 physician orders, located under the Orders tab of the EMR, revealed an order for Full Code with a start date of [DATE]. During an interview on [DATE] at 1:06 PM, Licensed Practical Nurse (LPN)2 was asked what she would do if R54 coded. LPN 2 stated she would check the resident's EMR to see what her code status was on her face sheet. LPN2 then checked the resident's EMR and stated R54 was a Full Code, so, if R54 coded she would initiate CPR by starting compressions on the resident and she would continue compressions until the emergency medical transport (EMT) staff arrived at the facility. During an interview on [DATE] at 1:15 PM, the Director of Nursing (DON) reviewed R54's EMR and stated the resident was noted as being a Full Code which was on the resident's home page, so if the resident coded the staff would initiate CPR. The DON then reviewed the resident's [DATE] POLST information and confirmed it specified the resident had chosen Allow Natural Death (AND)- Do Not Attempt Resuscitation. The DON confirmed the resident's specified wishes on the POLST form were different from what was on the resident's face sheet and as ordered by the physician. The DON stated the facility's Social Services Director (SSD) was responsible for processing changes in a resident's code status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:40 PM, the SSD stated she worked at the facility as the SSD when R54 was admitted to the facility on [DATE]. The SSD stated when R54's POLST was signed by the MD on [DATE], the MD would have faxed her the POLST form to the facility and she was responsible for notifying the nursing staff of the resident's choosing to Allow Natural Death (ARD)- Do Not Attempt Resuscitation on her POLST form and the nursing staff was responsible for writing the DNR order. The SSD stated there was a failure to communicate the change in the resident's code status, so the resident's code status was not changed from a Full Code to a DNR on [DATE]. The SSD also confirmed R54's current care plan also incorrectly specified the resident was a Full Code. The SSD stated the care plan team was expected to review the resident's code states at each quarterly care plan meeting and correctly update the care plan when needed, but the interdisciplinary team (IDT) failed to update R54's care plan from a Full Code to a DNR when her code status was changed on [DATE]. During an interview on [DATE] at 2:50 PM, one of R54's family members (F)54 stated she would have been surprised if R54 did not want to be resuscitated. F54 stated she attended R54's care plan meeting in February 2024 and R54's code status was not discussed during this meeting. F54 stated if it had been discussed she would have asked R54 if she wanted to be a DNR and abided by the residents' wishes. During an interview on [DATE] at 5:02 PM, R54 stated when she was admitted to the facility she did not recall staff going over any regarding whether she wanted to be resuscitated if she was unable to breathe. When R54 was asked if she would want to be revived or resuscitated the resident stated, I do not know if I would. During an interview on [DATE] at 5:20 PM, the SSD stated she was involved with R54's admission on [DATE] and she went over the admission paperwork with the resident. The SSD stated there was no family involved or present when R54 was admitted . The SSD stated she recalled when she discussed the resident's code status with R54, the resident stated, When I am dead I am dead and chose to select DNR as her code status. The SSD stated when R54 was admitted on [DATE], she was her own responsible party and was more cognizant and more capable of making her preferences known than she is currently. During an interview on [DATE] at 6:00 PM, the MDS Coordinator (MDSC) stated when R54 was admitted to the facility on [DATE] she was assessed as having moderately impaired cognition. The MDSC stated the care plan team will go over a resident's code status during the resident's care plan meetings. The MDSC explained R54's care plan was inaccurate because it reflected the resident was a Full Code instead of a DNR. The MDSC stated, I do not know what to tell you. It just fell through the cracks regarding R54's care plan inaccurately specifying the resident was a Full Code since [DATE].

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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** 36190 Based on interview, record review, and facility policy review, the facility failed to provide written notification of a facility-initiated transfer to the resident/responsible party (RP) for two of three residents (Resident (R) R7 and R41) reviewed for hospitalization . The failure had the potential to affect the residents and/or their representative concerning the resident's appeal rights. Findings include: Review of the facility's policy titled Transfer or Discharge, Facility-Initiated, dated 10/2022, revealed The resident and representative are notified in writing of the following information: .d. An explanation of the resident's rights to appeal the transfer or discharge to the state, including: (1) the name, address, email and telephone number of the entity which receives such appeal hearing requests; (2) information about how to obtain an appeal form; and (3) how to get assistance in completing and submitting the appeal hearing request; f. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman; . 1. Review of R7's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 01/12/25, in the Electronic Medical Record (EMR) located in the MDS tab, revealed an admitted [DATE]. R7 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating R7 was cognitively intact and had diagnoses of anxiety, depression, and schizophrenia. Review of R7's Behavior Note, dated 04/11/24, located in the EMR under the Progress Note tab revealed Resident walked to nurses' station and stated she busted her window out in her room with her table. Resident stated, the people on the 3rd floor keeps shaking my window, and I told them to stop but they wouldn't. Review of R7's Health Status note, dated 04/11/24 located in the EMR under the Progress Note tab revealed Resident transported via DON [Director of Nursing] and other staff member to [name] Hospital ER [emergency room] for labs [laboratory] to be admitted in Behavioral Health Center in [City, State]. RP [Responsible Party] is aware of transport. Review of R7's Assessment note, dated 04/18/24 located in the EMR under the Progress Note revealed . R7 was transferred to the hospital Sent To: [name] Behavior Unit Date: 4/11/2024 13:0 Sent From: [facility name] Unit: 2 Reason(s) for Transfer: Behavioral symptoms (e.g. agitation, psychosis). It was a Discharge. A Hospital Transfer Form (HTF) was completed in [EMR]. For further information please see the HTF. Review of R7's Hospital Transfer Form, dated 04/18/24, located in the EMR under the Assessment tab revealed no appeal information or that the resident/representative was provided with a written notice of transfer. The form included the Next of kin was telephoned with no telephone number listed. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/18/25 at 10:15 AM, the DON was asked about the R7's hospital transfer notice for 04/11/24. The DON stated notice of transfer was explained to the Resident Representative (RP). The DON stated a transfer form was in the EMR, but it did not include the appeals rights. The DON stated the notice was placed in the discharge packet to the hospital which was given to the EMT [emergency medical technician]. The DON stated the hospital staff would have given the notice to R7 but had no way of confirming it. On 02/19/25 at 4:20 PM, R7 was awake and dressed while lying in her bed. R7 was asked when she went to the hospital last year, did she receive any paperwork about her transfer. R7 stated she did not get any papers. 2. Review of R41's quarterly MDS with an ARD date of 12/02/24, in the EMR located in the MDS tab, revealed an admitted [DATE], had no BIMS score and was severely impaired. R41 had diagnoses of cancer, Down syndrome, and anxiety. Review of R41's Health Status note, dated 05/16/24, located in the EMR under the Progress Note tab revealed During morning medication pass with writer observed resident in bed, noted cough with congestion, skin cool to touch, resident refused morning meal. V/S [vital signs] obtain BP [blood pressure]- 64/6, P [pulse]-76, R [respiration]-24, T [temperature]-98.0, 02 [oxygen] level 80% room air. [name] NP in facility, new order to apply 02 and to send resident out for eval [evaluation] obtain verbally. @ [at] 9:05 am 911 called and report giving for transport. @9:15am EMT in facility to transport resident via stretcher to [hospital] General. Bed hold policy and medication list, with face sheet given to EMT on arrival. This writer called and gave report to ER nurse at [hospital] General. RP [responsible party] was called and given detail on resident's condition and new orders. Review of R41's Health Status note, dated 05/16/24, located in the EMR under the Progress Note tab revealed Resident was also noted to have discoloration with small open area to left forehead. No bleeding noted. When asked what happened [the] resident stated, leave me alone [the] roommate stated [the] resident fell , got up, and went back to bed. [The] Nurse practitioner in facility and made aware. RP notified. Review of R41's Health Status note, dated 05/16/24, located in the EMR under the Progress Note tab revealed This writer spoke with [name] RN at [hospital] ER [emergency room] in [City, State]. Report was given that resident was transferred to [hospital] in [City, State] to ER for admission with DX [diagnosis]: Pneumonia and Septic, resident's RP made aware. Review of 41's hospital transfer form, dated 05/23/24, located in the EMR under the Assessment tab revealed no appeal information or that the resident/representative was provided with a written notice of transfer. The form included the Next of kin was telephoned. During an interview on 02/18/25 at 10:15 AM, the DON asked about R41's hospital transfer notice for 05/16/24. The DON stated notice of transfer was explained to the RP. The DON stated a transfer form was in the EMR but it didn't included the appeals rights. The DON stated the notice was placed in the discharge packet to the hospital which was given to the EMT. The DON stated the hospital staff would have given the notice to the RP but had no way of confirming it. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/18/25 at 10:35 AM, the Social Service Director (SSD) confirmed she sends the ombudsman monthly notice of transfers/discharges. However, a written transfer form that included the time, location, reason for the discharge/transfer and the appeal rights was not given to residents or their RP when transferred to the hospital.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on observation, interview, record review, and policy review, the facility failed to implement the comprehensive plan of care for one resident ((R) 29) of three residents reviewed for nutrition out of 21 sampled residents. The facility's failure to assist R29 with meals as indicated in the resident's plan of care placed R29 at risk for weight loss and nutritional complications. Findings include: Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised on 03/2022, indicated, Policy Statement A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and nutritional needs is developed and implemented for each resident. Policy interpretation and Implementation 1. The interdisciplinary team (IDT) in conjunction with the resident and his/her family of legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Review of R29's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R29 was admitted to the facility on [DATE] with diagnoses which included psychosis, Alzheimer's disease, other specified eating disorder, and anxiety disorder. Review of R29's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/27/24 and located in the MDS tab of the EMR, revealed R29 had severely impaired cognitive skills for daily decision making, had short term and long-term memory impairment, and required set up or clean up assistance with eating. Review of R29's care plan dated 11/30/24, located in the Care Plan tab of the EMR, revealed a focus of Resident requires assistance with ADLs [Activities of Daily Living] related to impaired cognition. Resident is able to make her simple needs known at times, but her needs are predominantly anticipated and met per staff. Resident uses a wheelchair for locomotion. An Intervention directed staff to, Setup tray and assist resident as needed with meals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/16/25 at 12:58 PM revealed R29 was seated in her wheelchair at a table in the facility's assisted dining room eating her lunch meal with no staff at her table. Observation of the resident's meal tray revealed she was served a chopped fish sandwich, green beans, and French fries. Chewed foods were observed next to the resident's plate, on the table, and on the floor next to the resident. Continuous observations of R29 from 12:58 PM to 1:13 PM revealed R29 remained seated at the dining room table, and she used her fingers to bring food from her plate to her mouth. R29 was observed to place food in her mouth, chew it up, and throw it back onto her plate, onto the table next to her plate, or onto the floor. R29 was observed to repeatedly use her fingers to pick up food from her plate and table that she had previously chewed and spit out, place it back into her mouth, spit the food back into her fingers, and throw it back onto her plate, table or floor. During this continuous observation, a staff member was observed in the dining room seated at a table assisting another resident to eat, but this staff member, nor any other staff member, did not offer to assist R29 with her meal. On 02/16/24 at 1:13 PM staff was observed to roll R29 in her wheelchair from the dining room. Observation on 02/16/24 at 1:13 PM of the R29's finished lunch meal revealed there was a large accumulation of chewed up green beans, pieces of fish, French fries, and bun on the resident's plate, table and on the floor around her table. During an observation and interview on 02/16/25 at 1:15 PM, the Administrator confirmed the large amount of food spillage on the table and floor around where R29 ate her lunch meal. The Administrator stated R29 preferred to eat her meals with her fingers instead of using utensils. During an interview on 02/19/25 at 2:25 PM, the Regional Director (RDG) confirmed R29's care plan specified for staff to assist her at meals.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on interview, record review, and review of the facility's policy, the facility failed to review and revise the care plan for one of two residents reviewed for care plans (Resident (R) 48). R48's care plan was not revised to reflect repositioning and/or limiting the resident's time in her wheelchair per the physician's order. This failure placed the resident at risk for unmet care needs and worsening of a pressure ulcer. Findings include: Review of R48's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/13/24, located in the EMR under the MDS tab revealed an admitted [DATE]. R48 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R48 was cognitively intact. Continued review of the MDS revealed the facility assessed the resident to have impairment on both sides of the lower extremities, required supervision or touching assistance to roll left and right, required substantial/maximal assistance for chair/bed-to-chair transfer, always incontinent of bowel and bladder, had a stage four pressures ulcer, and had diagnoses of type 2 diabetes mellitus without complications, peripheral vascular disease, and a fracture of the tibia or fibula in the left leg after an orthopedic implant is inserted. Review of R48's Skin/Wound note, dated 08/27/24, located in the EMR under the Progress Note tab revealed [Medical Doctor (MD) 1] in [the] facility and eval [evaluate] wounds, new order as following: .Wound to upper right buttocks, clean with wound cleanser, pat dry, apply medi honey to area, cover with island dressing secure with tape, change daily and as needed until resolved. Measurements: 5.2 x 4 x 0.2cm area is unstageable due to necrosis, resident is aware of new orders and measurements. Review of R48's Care Plan, dated 08/27/24 and located in the EMR under the Care Plan tab revealed Resident has potential/actual impairment to skin integrity r/t [related to] incontinence and impaired mobility. Interventions included In house wound care MD to follow weekly until healed, enablers placed on both sides of bed to assist with turning and repositioning, supplements per MD orders and Res. [resident] refused wound care Encouraged to allow nurse to change dressing. The care plan did not address repositioning or limiting time in the wheelchair. Review of R48's Wound Physician notes, dated 02/11/24, located in the EMR under the Miscellaneous tab revealed stage 4 pressure wound of the right buttock full thickness, wound size (L [length] x W [width] x D [depth]): 3.2 x 5.5 x 0.2 cm, Exudate: light serous, granulation tissue: 40 %, recommendations: Limit sitting to 60 minutes; Off-Load Wound; Reposition per facility protocol. Review of R48's Kardex [system for organizing information], dated as of 02/19/25, located in the EMR under the Care Plan tab did not include positioning or limiting time in the wheelchair to 60 minutes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/19/25 at 3:13 PM, the MDS Coordinator (MDSC) was asked who was responsible for updating R48's care plan. The MDSC stated was. The MDSC stated she obtained her information to update the care plan by reviewing notes, talking with staff and the Director of Nursing (DON) reviewing physician notes. The MDSC was asked why the care plan and Kardex didn't include repositioning. The MDSC stated she didn't know as the Kardex was automatically generated. The MDSC was asked why the Kardex or care plan did not include the 60-minute time limit for R48 to be in his wheelchair according to the wound doctor's recommendations. The MDSC stated she was not aware of the 60 minutes limit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on observation, interview, record review, and facility policy review, the facility failed to provide eating assistance for one of three residents (Resident (R) 29) reviewed for nutrition out of 21 sampled residents. This failure had the potential to cause weight loss and/or nutritional complications for this resident. Findings include: Review of the facility's policy titled, Assistance with Meals, revised on 03/2022, indicated, Policy Statement Residents shall receive assistance with meals in a manner that meets the individual needs of each resident . Dining Room Residents: . 2. Facility staff will serve resident trays and will help residents who require assistance with eating . Review of R29's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R29 was admitted to the facility on [DATE] with diagnoses which included psychosis, Alzheimer's Disease, other specified eating disorder, and anxiety disorder. Review of R29's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/27/24 and located in the MDS tab of the EMR, revealed R29 had severely impaired cognitive skills for daily decision making, had short term and long-term memory impairment, and required set up or clean up assistance with eating. Review of R29's care plan dated 11/30/24, located in the Care Plan tab of the EMR, revealed a focus of Resident requires assistance with ADLs [Activities of Daily Living] related to impaired cognition. Resident is able to make her simple needs known at times, but her needs are predominantly anticipated and met per staff. Resident uses a wheelchair for locomotion. A care plan Intervention directed staff to Setup tray and assist resident as needed with meals. Observation on 02/16/25 at 12:58 PM revealed R29 was seated in her wheelchair at a table in the facility's assisted dining room eating her lunch meal with no staff at her table. Observation of the resident's meal tray revealed she was served a chopped fish sandwich, green beans, and French fries. Chewed foods were observed next to the resident's plate, on the table, and on the floor next to the resident. Continuous observations of R29 from 12:58 PM to 1:13 PM revealed R29 remained seated at the dining room table, and she used her fingers to bring food from her plate to her mouth. R29 was observed to place food in her mouth, chew it up, and throw it back onto her plate, onto the table next to her plate, or onto the floor. R29 was observed to repeatedly use her fingers to pick up food from her plate and table that she had previously chewed and spit out, place it back into her mouth, spit the food back into her fingers and throw it back onto her plate, table, or floor. During this continuous observation, a staff member was observed in the dining room seated at a table assisting another resident to eat, but this staff member, or any other staff member, did not offer to assist R29 with her meal. On 02/16/24 at 1:13 PM staff was observed to roll R29 in her wheel chair from the dining room. Observation on 02/16/24 at 1:13 PM of the R29's finished lunch meal revealed there was a large accumulation of chewed up green beans, pieces of fish, French fries, and bun on the resident's plate, table, and on the floor around her table. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/16/25 at 1:15 PM, the Administrator confirmed the large amount of food spillage on the table and floor around where R29 ate her lunch meal. The Administrator stated R29 preferred to eat her meals with her fingers instead of using utensils. Observation on 02/18/25 at 12:46 PM revealed R29 was seated at a dining room table being assisted by Certified Nurse Aide (CNA)1 to eat her lunch meal. Continuous observations on 02/18/25 from 12:46 PM to 1:03 PM revealed CNA1 assisted and prompted R29 to eat her lunch meal and redirected R29 when she used her fingers to eat food and spit them out. R29 was observed to readily accept the assistance provided by CNA1 during this meal. Observation on 02/18/25 at 1:03 PM revealed CNA1 assisted R29 from the dining room. Observation of R29's finished lunch meal revealed there was minimal food spillage which included only five partially chewed lima beans that were on the table where R29 ate her lunch meal. During an interview on 02/18/25 at 1:23 PM, CNA1 stated R29 needed staff assistance and redirection to eat her meals. CNA1 stated R29 would accept food and fluids when offered by staff at meals. During an interview on 02/18/25 at 1:32 PM, the Director of Nursing (DON) stated that R29 would eat food and spit it out at meals, and she required staff assistance with cueing and redirection at meals. The DON stated a staff member should be with R29 to assist her at meals and confirmed that during the 02/16/25 lunch meal R29 should have received staff assistance.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on observation, interview, record review, and policy review, the facility failed to implement interventions to aid in the healing of pressure ulcers for two of two residents (Resident (R) 45 and R48) reviewed for pressure ulcers out of a total sample of 21. This had the potential to cause delay in the healing of the residents' pressure ulcers. Findings include: Review of the facility's policy Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated April 2018, revealed, . The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers, for example immobility, recent weight loss, and a history of pressure ulcer(s) . The nurse should describe, document, and report: a full assessment of the pressure ulcer, including stage, length, width, depth, presence of exudate (drainage) or necrotic (dead) tissue; pain assessment; resident's mobility status; current treatments, including support surfaces, and all active diagnoses. The physician would assist the staff to identify the type and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer . The physician would help identify factors that contribute or predispose residents to skin breakdown; for example, medical comorbidities such as diabetes or congestive heart failure, overall medical instability, cancer, or sepsis causing a catabolic state, and macerated or friable skin . The physician would order pertinent wound treatments, including pressure reduction surfaces, wound cleansing, and debridement approaches, dressings, and application of topical agents . The physician guided the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions . Review of the facility's policy titled, Wound Care, dated October 2010, revealed clinical documentation should include, . Any change in the resident's condition, all assessment data, for example, wound bed color, size, and drainage, obtained when inspecting the wound . 1. Review of R45's Census tab of the electronic medication record (EMR) revealed R45 was admitted to the facility on [DATE]. Review of R45's Diagnosis tab of the EMR revealed R45 had diagnoses that type 2 diabetes with neuropathy (nerve pain) and left leg below the knee amputation. Review of R45's Care Plan, dated 11/26/24 and located under the Care Plan tab of the EMR, revealed, . Resident has potential/actual impairment to skin integrity related to fragile skin, impaired mobility causing sheering, and unstable DM [diabetes mellitus]. The goal was, Resident will maintain or develop clean and intact skin by the review. Review of R45's Braden Scale for Predicting Pressure Sore Risk, dated 12/10/24 and located under the Assessment tab in the EMR, revealed R45 scored an 18, which was indicative of being at low risk for the development of pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R45's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/21/24 and located under the MDS tab of the EMR, revealed R45 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. It was recorded R45 required supervision or touching assistance for upper and lower body dressing and personal hygiene, was independent with repositioning in bed and from going from sitting to lying, lying to sitting, and transferring from his wheelchair to bed and to the toilet. It was recorded that R45 did not have pressure or stasis ulcers present. Review of R45's Progress Note, dated 02/11/25 at 8:23 PM, written by Licensed Practical Nurse (LPN)3, and located under the Progress Notes tab in his EMR revealed a Certified Nursing Assistant (CNA) had assisted R45 with his shower and noticed a red area to his right heel, and the CNA reported the area to LPN3. It was recorded LPN3 assessed, cleaned, and applied a dressing to his right heel. It was recorded that R45's physician had been notified at 8:30 PM. Review of the DON's logs of non-pressure wounds, dated 02/11/25 and provided by the DON, included R45's wound listed as diabetic. The wound to his right heel had initial measurements of 2.8 centimeters (cm) by 2.5 cm. The depth could not be measured. There was tissue present described as slough. The treatment was Medi-honey/Island ointment covered with a dressing to be changed daily. Review of R45's Care Plan, revised 02/12/25 and located under the Care Plan tab of the EMR, revealed, . Resident has open area noted to right lower extremity. MD notified with treatment in progress, float heel while in bed, in house wound care, MD to eval [evaluate] on next visit and treat till healed. Review of R45's clinical record, dated 02/11/25 through 02/16/25, revealed no documented evidence that R45 was encouraged to elevate his right foot while in bed. There was no documentation that pressure relieving devices for the foot were provided or used while the resident was up in his wheelchair. During an observation and interview on 02/16/25 at 3:00 PM, R45 was observed in his wheelchair in the dining room. His wheelchair only had one pedal on the right. His right foot rested on the pedal in a slanted way which put pressure on the outside area and bottom of his right heel. There was a surgical shoe protector on his right foot. There were areas on the shoe protector that had stains of what appeared to be light-colored blood. R45 stated he had a sore on his right heel, and he did not know how he got it. He stated he had been instructed to keep his foot on a pillow when he was in bed, but no one had helped him, and he did not have an extra pillow in his room. During an observation on 02/17/25 at 10:55 AM, Licensed Practical Nurse (LPN)2 completed a dressing change for R45's right heel wound. There were dried drainage spots on his sheets and on the surgical shoe cover he had over the dressing. The old dressing was wet with a bloody appearing drainage. The wound was open with a large amount of thick stringy tissue hanging out of the wound. There was a foul odor from the wound. A wound cleanser was used on a gauze pad and only the area around the wound was cleansed before the new dressing was applied. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the dressing change observation, there were no extra pillows observed in the room to elevate his right foot on, he had a regular mattress, and there were no heel protector boots noted in his room. When R45 laid down in bed so that his dressing change could be completed, his right foot was turned so that pressure was applied in the location of the room. R45 stated this was how his right foot rested on his mattress when he was sleeping. During an interview on 02/19/25 at 8:45 AM, the DON stated she did not think R45's wound was a pressure ulcer because he had a diagnosis of diabetes. She stated she had not thought of it as a pressure ulcer because of the diabetes diagnosis. The DON stated the wound had declined rapidly and the wound care doctor was supposed to see the resident on 02/18/25 but was unable to make it The DON confirmed she had not assessed whether R45 put pressure on the heel area when he was in bed or in the wheelchair. The DON stated she had provided R45 a Prevalon boot (padded knee high boot which provides pressure relief to the heel) last night. During an interview on 02/19/25 at 10:34 AM, CNA3 stated she did not have access to R45's care plan to see what interventions she was supposed to provide for the resident. She stated she was not aware of what assistance R45 needed to help with the healing of his right heel wound. She stated the CNAs documentation only focused on how much assistance a resident needed. During a phone interview on 02/19/25 at 2:40 PM, LPN3 stated the CNA had reported to her on the evening shift on 02/11/25 that R45 had a wound on his right heel. She stated when she assessed his right heel, it felt squishy to touch. LPN3 stated there was not a blister as it was not clear fluid but infection looking fluid. She stated it had a smell to it but no drainage. LPN3 stated she placed a non-stick gauze pad and a folded over ABD (thick abdominal dressing) pad on the wound and wrapped it in gauze. She stated she had let the staff on duty that evening know R45 should keep his right foot elevated, but she had not written it down so all the staff would know. She stated she had instructed R45 to elevate his leg, and she thought he had an extra pillow to put his leg on. 36190 2. Review of R48's annual MDS, with an ARD of 11/13/24 and located in the EMR under the MDS tab, revealed an admitted [DATE]. R48 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R48 was cognitively intact. It was recorded R48 had impairment on both sides of the lower extremities, required supervision or touching assistance to roll left and right, required substantial/maximal assistance for chair/bed-to-chair transfer, was always incontinent of bowel and bladder, had a stage four pressures ulcer, and had diagnoses of type 2 diabetes mellitus without complications, peripheral vascular disease, and a fracture of the tibia or fibula in the left leg after an orthopedic implant is inserted. Review of R48's Health Status note, dated 08/08/24 and located in the EMR under the Progress Note tab, revealed, When applying zinc to areas noted active bright red bleeding. New order was received to D/C [discontinue] zinc to areas and do Vaseline dressing daily to area or as needed until healed. Measurements to right upper buttocks 1cm [centimeter] X 1cm x 0 . Resident is aware of areas and treatment orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R48's Skin/Wound note, dated 08/27/24 and located in the EMR under the Progress Note tab, revealed, . [Medical Doctor (MD) 2] in facility and eval [evaluated] wounds, new order as following . Wound to upper right buttocks, clean with wound cleanser, pat dry, apply medi honey to area, cover with island dressing secure with tape, change daily and as needed until resolved. Measurements: 5.2 x 4 x 0.2cm area is unstageable due to necrosis, resident is aware of new orders and measurements. Review of R48's Care Plan, dated 08/27/24 and located in the EMR under the Care Plan tab revealed, . Resident has potential/actual impairment to skin integrity r/t [related to] incontinence and impaired mobility . Interventions included, . In house wound care MD to follow weekly until healed, enablers placed on both sides of bed to assist with turning and repositioning, supplements per MD orders and . Res. [resident] refused wound care Encouraged to allow nurse to change dressing . The care plan did not address repositioning or limiting time in the wheelchair. Review of R48's Wound Physician notes, located in the EMR under the Miscellaneous tab revealed on 09/17/24, 12/17/24 01/21/25, and 02/11/25, the wound physician had recommended to limit sitting to 60 minutes, to off-load wound, and to reposition per facility protocol: Review of R48's Progress Notes, dated from 02/17/24 to 02/17/25 and located in the EMR under the Progress Note tab, revealed the only entry mentioning repositioning was on 11/01/24. Only four entries of R48 refusing wound care were on 09/02/24, 09/10/2024, 12/03/24, and 01/07/25. No entry was found encouraging R48 to limit his time in the wheelchair. During an interview on 02/18/25 at 3:50 PM, the Director of Nursing (DON) was asked about R48's pressure sore. The DON stated R48's wound was in-house acquired, and R48 was seen weekly by the wound doctor and measures were taken then. The DON stated R48 had a gel cushion in his wheelchair and a pressure-reducing mattress on his bed, but the mattress was not an air mattress. The DON stated the events that had led to R48's pressure sores began with R48 gaining weight after he fractured his foot in 2023. The DON stated R48 underwent surgery and had become less mobile. On 02/19/25 at 9:25 AM, R48 was awake in bed lying on his back playing a game on his cell phone. R48 was asked if his pressure sores hurt and R48 stated, No. R48 was asked if staff helped reposition him and he said, Yes sometimes but he could reposition himself. During an interview on 02/19/25 at 9:30 AM, Licensed Practical Nurse (LPN)2 was asked what interventions were in place for R48's pressure sores. LPN2 stated, We try to get [R48] to reposition, and he refuses, we try to use pillows and a cushion, but he takes them off. LPN2 stated R48 did not have any feeling in his lower extremities. During an interview on 02/19/25 at 10:23 AM, Certified Nurse Aide (CNA)2 was asked if R48 needed to be repositioned. CNA2 stated, No, he does that himself. CNA2 was asked if she had to remind him to reposition and CNA stated, No. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 02/19/25 at 10:56 AM, the DON was asked what pressure sore interventions were in place since R48's mobility was reduced. The DON stated [R48] needed to be repositioned by staff and more staff help mostly because of his size. The DON was asked if R48 needed more help, why did his CNA say he did not need to be repositioned or reminded to change positions in bed. The DON stated, That's because [R48] knows already when he needs to be repositioned but R48 does refuse to be repositioned and wound treatments at times. The DON stated R48 did not need to be reminded because he knew when to be repositioned and had enablers on his bed. The DON was asked if R48 needed help, how does he get repositioned. The DON stated R48 needed to be encouraged to reposition. The DON stated R48 should be repositioned every two hours. The DON was asked how CNAs knew what kind of care R48 should receive as the care plan or the Kardex did not include repositioning. The DON stated she did not know what the Kardex was, and the CNAs did not have access to the care plan. The DON was asked if there were any recommendations from the wound doctor. The DON stated, To offload. The DON was asked if she was aware of the recommendation to limit time in the wheelchair. The DON stated, Yes but she was unaware of the time limit. The DON was informed that the recommendation was for 60 minutes. During a telephone interview on 02/19/25 at 2:51 PM, LPN3 was asked if R48 needed to be repositioned in bed. LPN3 stated, Yes, but [R48] can do it himself but he does need assistance. LPN3 went on to say [R48] will do it himself and he has not asked to be repositioned. LPN3 stated [R48] is always sitting up in his bed playing video games and he needs a donut to sit on. LPN3 stated she encourages him to get out of bed. LPN3 was asked if there was a time-limit for R48 to be in his wheelchair. LPN3 stated, No, [R48] will let someone know when he wants to get in bed. During a telephone interview on 02/19/25 at 3:37 PM, Medical Director (MD)1 was asked about R48's pressure sore. MD1 stated [R48] was up and about the home and is paraplegic. MD1 was asked what his expectation was for repositioning R48. MD1 stated that R48 could move about in his wheelchair and would be able to move in his bed but needed to be checked on. MD1 stated R48 was somewhat non-compliant. MD1 stated it was his right to refuse treatment, and he did refuse. MD1 stated R48 should not need to be in the wheelchair more than two hours at a time. MD1 stated R48 should be encouraged to get off his pressure sore and he needed to be encouraged to be off his back in bed and off his buttocks. During a telephone interview on 02/19/25 at 3:52 PM, Wound Care Physician (MD)2 was asked about R48's pressure sore interventions. MD2 stated, To offload but [R48] was non-compliant and wet constantly. MD2 stated he wanted [R48] to stay off his bottom but doesn't. MD2 stated he has tried stem cell and ultrasound treatment. MD2 was informed staff were not aware of the 60-minute limit in the wheelchair. MD2 stated R48 was cognitive intact, and he knew the 60-minute limit in his wheelchair. MD2 was asked if he expected staff to read his recommendations in his notes. MD2 stated he I think so, I have them for a reason. On 02/19/25 at 10:21 AM to 4:19 PM, R48 was observed in his wheelchair, dressed, and groomed and wheeling himself about the facility.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on interview and record review, the facility failed to report abnormal blood sugar levels to the physician for one of two residents reviewed for laboratory services (Resident (R)32). This deficient practice could lead to serious health complications for R32 such as nerve damage, kidney disease, vision problems, heart disease, and even diabetic coma. Findings include: Review of the facility policy titled Obtaining a Fingerstick Glucose Level, dated 10/11, provided by the facility, revealed 1. Report results promptly to the supervisor and the Attending Physician. Review of the facility policy titled Lab and Diagnostic Test Results- Clinical Protocol, revised 11/18, provided by the facility revealed 3. A nurse will identify the urgency of communicating with the Attending Physician based on the physician request, the seriousness of any abnormality, and the individual's current condition. 1. Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: Whether the physician has requested to be notified as soon as a result is received. Whether the results should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). Review of R32's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/03/24 and located in the resident's Electronic Medical Record (EMR) under the MDS tab, revealed an admitted [DATE]. R32 had a Brief Interview for Mental Status (BIMS) score of nine out of 15 indicating R32's cognition was moderately impaired. The MDS also indicated the resident received insulin, and had diagnoses of type 2 diabetes mellitus with other specified complication and dementia. Review of R32's Care Plan, undated, located in the EMR under the Care Plan tab revealed Resident is at risk for alterations in FSBS [finger-stick blood sugar] due to DX [diagnosis] of DM [diabetes mellitus]. Resident is noncompliant with diet. Interventions included FSBS as indicated, medications as ordered, and notify MD [physician] as needed. Review of R32's Physician Order, dated 08/09/22, located in the EMR under the Order tab revealed Check blood sugar BID [twice daily] & as needed two times a day for DM and Notify MD for blood sugar less than 60 or greater than 500. Review of R32's Physician's Order, dated 10/29/23, located in the EMR under the Order tab revealed Gvoke Kit Subcutaneous Solution 1 MG [milligram]/0.2ML [milliliter] (Glucagon) Inject 1 mg subcutaneously every 6 hours as needed for Give for BS [blood sugar] 60 or less related to type 2 diabetes mellitus with other specified complication. Review of R32's Blood Sugar located in the EMR under the Weights & Vitals tab revealed R32's blood sugar was measured on 09/22/24 at 50.0 mg/dL[milligrams per deciliter], on 10/12/24 at 46.0 mg/dL, on 10/22/24 at 46.0 mg/dL, and on 02/11/24 at 561.0 mg/dL. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R32's Progress Notes, located in the EMR under the Progress Note tab revealed on 09/22/24, 10/12/24, 10/22/24, and 02/11/25, there was no entry or documentation notifying the physician of the abnormal blood sugar levels, whether R32 was displaying signs/symptoms of hyperglycemia/hypoglycemia, or if treatment was provided. Review of R32's September and October 2024 Medication Administration Record (MAR) located in the EMR under the Order tab revealed Glucagon was not administered on 09/22/24 for a blood sugar of 50.0 mg/dL, on 10/12/24 for blood sugar of 46.0 mg/dL, and on 10/22/24 for a blood sugar of 46.0 mg/dL. During an interview on 02/17/25 at 1:08 PM, the Director of Nursing (DON) was asked if the physician should have been notified for the blood sugar of 561 on 02/11/25. The DON checked the EMR and confirmed there was no note the physician was notified. The DON then stated, Yes, the doctor was most likely called. The DON went on to say Medical Director usually wants to know if R32 was symptomatic and R32 wasn't. Otherwise, it would be documented that the Medical Director was called. DON confirmed there was no documentation of signs/symptoms or that the physician was call/notified. During an interview on 02/18/25 at 8:36 AM, the DON was asked about the September and October 2024 MAR for R32's blood sugar. The DON acknowledged the nurse didn't document her interventions for the low blood sugars of 46 and 50.0 mg/dL. The DON reviewed the EMR and confirmed the glucagon should have been documented as given and acknowledged it wasn't. The DON was asked if the nurse didn't document the glucagon, how do you know the physician was notify of the abnormal BS. The DON stated, The nurse said she gave a snack but again it wasn't documented. The DON stated, The nurse called the physician, but she didn't document it. The DON was asked if the blood sugar was out of range, should the nurse have rechecked it. The DON said, Yes. The DON stated the nurse said she documented the blood sugar of 561 in error. During a telephone interview on 02/19/25 at 2:39 PM, LPN3 was asked about R32's blood sugar of 561 on 02/11/25. LPN3 stated she thought she tapped it in wrong as R32 doesn't normally get up that high. LPN3 was asked about the low blood sugars on 9/22/24 and 10/12/24. LPN3 stated she would have contacted the physician, but she forgot to document it. LPN3 was asked why the glucagon order wasn't utilized as there was no document in the September and October 2024 MAR. LPN3 stated because she gave R32 orange juice and chocolate pudding. LPN was asked if she rechecked R32's blood sugar after the orange juice and pudding. LPN3 stated, Yes, but she did not document it. LPN3 was asked when she would utilize the glucagon order if she gave food and beverage first. LPN3 stated, If the orange juice didn't work. During a telephone interview on 02/19/25 at 3:43 PM, MD1 was asked what his expectation was when R32's blood sugar was out of range and was he notified about R32's recent blood sugars. Medical Director stated staff should notify him and they have been good about that. The Medical Director stated he had only been the Medical Director since November 2024 and would have to review his notes. The Medical Director stated staff should document the physician had been notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115607	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Nursing Center	433 North McGriff Street Whigham, GA 39897

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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	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, interview, and facility policy review, the facility failed to date, label, and/or cover food in refrigeration and freezer storage, failed to discard food in refrigeration storage with expired use by dates or signs of spoilage, and ensure scoops were not stored in containers of sugar, flour, and corn meal. The facility also failed to keep the kitchen's oven, large manual can opener, and metal exhaust hood vents clean. This failure had the potential to create an environment for food-borne illnesses which could affect 57 of 57 residents who consumed food prepared from the facility's kitchen. Findings include: Review of the facility's policy titled, Food Receiving and Storage, with a revision date of ,d+[DATE], indicated, . Food shall be received and stored in a manner that complies with safe food handling practices . 7. All food stored in the refrigerator or freezer will be covered, labeled, and dated (use by date) . Review of the facility's undated policy titled, Leftover Food, indicated, . 3. Leftover foods will be stored in approved containers and labeled with the name of the item and the date prepared. 4. Refrigerated leftover food items must be used within 48 hours of original preparation and frozen leftover food items must be used within two months. 5. All refrigerated or frozen leftover food items that are improperly stored, stored for a time period longer than allowed, or appear spoiled or of poor quality, will be discarded . Review of the facility's undated policy titled, Food Storage, indicated, . 6. Scoops must be provided for flour, sugar, cereals, dried vegetables, and spices. Scoops are not to be stored in the food containers, but are kept covered in a protected area near the containers . Review of the facility's undated policy titled, Sanitation/Infection Control, indicated, . 4. To maintain high environmental sanitation standards, the following practices are suggested, but are not all-inclusive: . d. Hoods and ducts are cleaned at least monthly to prevent grease build up, which creates a fire hazard as well as a sanitation problem. Ducts are professionally cleaned every six months . f. All cooking equipment, door seals, and surfaces of grills, burners, and ovens are wiped off daily and thoroughly cleaned regularly . 1. Observation of kitchen food storage areas on [DATE] from 8:15 AM to 8:45 AM, during the initial kitchen inspection, with Dietary [NAME] (DC)1 present, revealed the following concerns: a. Observation of food stored in the kitchen's walk-in refrigerator revealed three large packages of cole slaw mix, which contained cabbage, purple cabbage and carrots, with expired use by dates of [DATE], one undated opened 128 ounce container of buttermilk dressing, one unlabeled and undated plastic bag of Swiss cheese slices, 20 undated loaves of thawed bread, 27 half pint cartons of whole milk with expired use by dates of [DATE], 12 tomatoes stored in a box that were very mushy and appeared rotten, three undated and unlabeled wrapped peanut butter and jelly sandwiches that had very hard bread, and four undated and unlabeled dishes of left over peach crisp. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Observation of food stored in the kitchen's walk-in freezer revealed one 9.75-pound box of dinner rolls, one 20-pound box of cookie dough, and one 13.5-pound box of French toast that were not closed, and the food stored inside each box was unprotected from possible contamination. c. Observation of food stored in the kitchen's dry storage room revealed three large plastic containers which contained sugar, flour, and corn meal that had scoops stored inside each of these containers. The scoops were in direct contact with the food and the handles of the scoops were embedded in the flour, sugar, and corn meal stored in these containers. During an interview on [DATE] at 8:45 AM, DC1 confirmed the above observed concerns with food stored in the kitchen's walk-in refrigerator, walk-in freezer, and dry storage room. DC1 stated scoops should not be stored in food bins, food should be dated and labeled when opened and completely covered when stored, and any food with expired use by dates or signs of spoilage should be discarded. During an interview on [DATE] at 11:15 AM the Dietary Manager (DM) stated bread products should be dated by staff when taken out of freezer storage and placed in refrigeration storage to thaw and should be discarded if not used within 14 days after they were thawed. 2. Observation on [DATE] from 8:15 AM to 8:45 AM, during the initial kitchen inspection, with DC1 present, revealed the kitchen's only oven was unclean with heavy accumulated blackened and dried food spills on its interior cooking compartment, the large manual can opener's blade and table base attachment were unclean with accumulated dried and sticky substances, and the kitchen's metal exhaust hood vents, located directly above the kitchen's stove top where food was prepared, were unclean with a greasy residue and black dust. During an interview on [DATE] at 8:45 AM, DC1 confirmed the kitchen's oven, manual can opener and its' base attachment, and the kitchen's exhaust hood vents were unclean. DC1 stated the kitchen's oven and manual can opener was on the kitchen's weekly cleaning schedule. DC1 was unsure when the kitchen's metal exhaust hood vents were last cleaned. During an interview on [DATE] at 2:15 PM, the DM stated the kitchen's metal exhaust hood vents should be cleaned weekly or as needed. The DM stated she had worked at the facility since the end of [DATE] and to her knowledge the kitchen's exhaust hood vents had not been cleaned since she started working at the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, and record review, the facility failed to accurately document in the medical record that insulin was not administered when blood sugars were 250 ml/dl (milligrams per deciliter) or less for one (Resident (R)32) of one resident reviewed for resident records. The failure had the potential to result in overlooking proper care and diabetic complications. Findings include: Review of the facility policy titled Charting and Documentation, dated 07/2017, provided by the facility revealed All services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. l. Documentation in the medical record may be electronic, manual or a combination 2. The following information is be documented in the resident medical record: Objective observations; Medications administered; Treatments or services performed; Changes in the resident's condition; . Review of the facility's policy titled Obtaining a Fingerstick Glucose Level, dated 10/2011, provided by the facility, revealed The person performing this procedure should record the following information in the resident's medical record: . 6. The blood sugar results. Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results (if resident is on sliding scale coverage and/or physician intervention is needed to adjust insulin or medication dosages), etc. Review of R32's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/03/24, in the Electronic Medical Record (EMR) under the MDS tab revealed an admitted [DATE]. R32 had a Brief Interview for Mental Status (BIMS) score of nine out of 15 indicating R32's cognition was moderately impaired. The MDS also indicated the resident received insulin, and had diagnoses of type 2 diabetes mellitus with other specified complication and dementia. Review of R32's Physician Order, dated 07/26/24, located in the EMR under the Order tab revealed Novolog Injection Solution 100 unit/ml [millimeter] (Insulin Aspart) Inject 10 unit subcutaneously in the morning for uncontrolled blood sugar related to type 2 diabetes mellitus with other specified complication (E11.69) Hold insulin if blood sugar is 250 or below. Review of R32's Care Plan, undated, located in the EMR under the Care Plan tab revealed Resident is at risk for alterations in FSBS [finger-stick blood sugar] due to DX [diagnosis] of DM [diabetes mellitus]. Resident is noncompliant with diet. Interventions included FSBS as indicated, medications as ordered, and notify MD [physician] as needed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R32's January and February 2025 Medication Administration Record (MAR) located in the EMR under the Order tab revealed an order to hold the Novolog insulin if R32's blood sugar (BS) was 250 or below. Check marks were present that indicated 10 units was administered on 01/02/25 with a BS of 147, 01/05/25 with a BS of 116, on 01/08/25 with a BS of 121, 01/16/25 with a BS of 225, 01/18/25 with a BS of 162, 01/25/25 with a BS of 136, 01/27/25 with a BS of 168, on 02/01/25 with a BS of 196, on 02/08/25 with a BS of NA [not applicable], and on 02/13/25 with a BS of 102. During an interview and record review on 02/17/25 at 3:32 PM, Licensed Practical Nurse (LPN) 4 was asked if a check mark was present on the MAR for R32's Novolog insulin, did that indicate the insulin was administered. LPN4 stated she was not sure because the insulin should not be administered if his BS was 250 or below. LPN4 was shown the January 2025 MAR and that she had coded the 01/27/25 MAR with a check mark when the BS was 168. LPN4 reviewed the MAR ledger, and the check mark indicated the medication was administered. LPN4 was then asked if the check mark meant she administered the insulin. LPN4 stated she wasn't sure about the meaning of the check mark, but she did not administer the Novolog insulin, and the Director of Nursing (DON) would need to be asked about the codes. During an interview on 02/17/25 at 4:56 PM, the DON was asked about the February 2025 MAR that included check marks on 02/01/25, 02/02/25, 02/08/25, and 02/13/25, indicating Novolog was given and X marks on 02/15/25 and 02/16/25, in the spaces for BS. The DON stated the nurse probably checked it by mistake. The DON was asked if mistakes should occur multiple times. The DON had no comment. The DON was also asked about the X marks in the space instead of BS. The DON stated the check and X marks meant the BS was done. The DON was asked if the insulin was administered at these times that were checked. The DON stated, No but understands how it looks unclear. During an interview on 02/17/25 at 6:03 PM, the DON provided a detailed printout of the insulin administration for January and February 2025. The DON was asked about the 0coding that indicated 10 units of Novolog insulin were administered for blood sugars less than 250 for the days of 01/05/25, 01/08/25, 01/16/25, 01/18/25, 01/25/25, 01/27/25, 02/01/25, 02/02/25, 02/08/25, and 02/13/25. DON stated she did the blood sugar on 02/13/25 and she documented the wrong code indicating she administered insulin but she in fact did not. The DON was asked about the other days. DON stated, I can't dispute that it appears it was administered but it wasn't. During a follow up interview on 02/18/25 at 8:36 AM, the DON provided more clarification on the check marks on the January and February 2025 MAR. The DON stated the nurse checked, Yes, in the drop-down box so as to say, I see the order. The DON stated, there is confusion among the staff with the [EMR program] and they don't know what the 'yes or no' means. During an interview on 02/18/25 at 8:53 AM, LPN1 was asked about R32's morning order for Novolog and to hold if the BS was below 250. LPN1 was asked about the N/A [not applicable] she documented instead of listing a BS on 02/08/25 MAR and documented a check mark indicating 10 units of insulin was given. LPN1 reviewed the EMR and stated she used N/A because she didn't give the insulin. LPN1 stated she documented for the injection location/site also as N/A because she didn't give it. LPN1 then crossed checked the BS for 02/08/25 and confirmed it was 92 and she didn't give the insulin. LPN1 dropped down the menu in the EMR and confirmed there was confusion as how to code the MAR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 02/19/25 at 3:43 PM, the Medical Director stated he had only been the Medical Director since November 2024. The Medical Director was asked about his expectation in documenting in the EMR for R32's morning insulin order. The Medical Director stated if the order says to give the insulin, it should be documented according to the order.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, and record review, the facility failed to include in the binding arbitration agreement that it was not a requirement to sign the agreement to continue to receive care at the facility and be allowed to communicate with federal, state, local officials and the ombudsman for two of three residents (Resident (R)32 and R42) reviewed for arbitration out of 21 sampled residents. This placed residents at risk of unknowingly giving up their constitutional rights. Findings include: Review of the facility's arbitration agreement, undated, provided by the facility revealed no statement that it was not a requirement to sign the agreement to continue to receive care at the facility and residents and their representatives were allowed to communicate with federal, state, local officials and the ombudsman. 1. Review of R32's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/03/24, in the Electronic Medical Record (EMR) located in the MDS tab, revealed an admitted [DATE]. Review of R32's Binding Arbitration Agreement, provided by the facility, revealed R32's name and signature, dated 08/09/22. R32's arbitration agreement did not include in the agreement that it was not required to receive care by the facility and the resident, or their representative were allowed to communicate with federal, state, local officials, and the ombudsman. 2. Review of R42's quarterly MDS with an ARD date of 12/18/24, located in the MDS tab of the EMR, revealed an admitted [DATE]. Review of R42's Binding Arbitration Agreement, provided by the facility, revealed R42's name and signature, dated 09/07/22. R42's arbitration agreement did not include in the agreement that it was not required to receive care by the facility and the resident, or their representative were allowed to communicate with federal, state, local officials and the ombudsman. During an interview on 02/19/25 at 8:34 AM, the SSD stated she was aware of the items included in the agreement and explained the agreement as written. The SSD stated she had not received any education regarding the regulatory requirements related to arbitration agreements.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interviews, and record review, the facility failed to ensure the arbitration agreement provided for the selection of a neutral arbitrator and a venue without stipulations for two (Residents (R)32 and R42) of three residents in a sample of 21 reviewed for arbitration. This placed residents at risk of an unfair advantage in the selections of venues and arbitrators. Findings include: Review of the facility's undated arbitration agreement, provided by the facility, revealed . The parties shall agree upon an arbitrator who must either be a retired circuit court, [State] court of Appeals, [State] Supreme Court or Federal Judge or a member of the [State] State Bar with at least (20) years of experience as an attorney and or judge and The Arbitration will be conducted with seventy (70) miles of this facility and in accordance with the Federal Arbitration Act . 1. Review of R32's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 11/03/24 and located in the electronic medical record (EMR) located under the MDS tab, revealed an admitted [DATE]. It was recorded that R32 had a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated R32' was moderately cognitively impaired. Review of R32's binding arbitration agreement, provided by the facility, revealed R32's name and signature, dated 08/09/22. R32's arbitration agreement included, The parties shall agree upon an arbitrator who must either be a retired circuit court, [State] court of Appeals, [State] Supreme Court or Federal Judge or a member of the [State] State Bar with at least (20) years of experience as an attorney and or judge and The Arbitration will be conducted with seventy (70) miles of this facility and in accordance with the Federal Arbitration Act. During an interview on 02/19/25 at 4:25 PM, R32 stated he did not know what arbitration was. During an interview on 02/19/25 at 12:09 PM, the Social Service Director (SSD) was asked about R32's BIMS of nine, which indicated he was cognitively impaired and that he signed the agreement. SSD confirmed R32's BIMS was nine. The SSD stated she broke down the explanation of the arbitration agreement and believed he understood what he was signing. The SSD stated R32 would not remember now and would not know how to utilize the process. The SSD stated that R32 did not have family. 2. Review of R42's quarterly MDS, with an ARD date of 12/18/24 and located under the MDS tab of the EMR, revealed an admitted [DATE]. It was recorded that R42 had a BIMS score of 15 out of 15, which indicated R42 was cognitively intact. Review of R42's binding arbitration agreement, provided by the facility, revealed R42's name and signature, dated 09/07/22. R42's arbitration agreement included, The parties shall agree upon an arbitrator who must either be a retired circuit court, [State] court of Appeals, [State] Supreme Court or Federal Judge or a member of the [State] State Bar with at least (20) years of experience as an attorney and or judge and The Arbitration will be conducted with seventy (70) miles of this facility and in accordance with the Federal Arbitration Act. (continued on next page)

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/16/25 at 9:01 AM, R42 stated he had no complaints and if he signed an arbitration agreement, he would be okay with it. During an interview on 02/19/25 at 8:34 AM, the SSD was asked if she was the person responsible for having residents sign the binding arbitration agreement. The SSD stated, Yes. She stated the agreement was in the admission packet. The SSD stated she explained to the residents or their representative if a dispute arises, the facility can use the arbitration process, by passing the court. The SSD stated she let them know it was voluntary to sign but all the residents have signed the agreement. The SSD stated she explained that no court would be involved. The SSD was asked about the stipulations placed on the arbitration location and the qualifications of the arbitrator. The SSD stated she was aware the agreement mentioned the arbitration had to be within 70 miles of this facility and that the qualification of the neutral arbitrator had to be a retired [State] judge with years of experience. The SSD stated she was aware of the items included in the agreement and explained the agreement as written. The SSD stated she had not received any education regarding the regulatory requirements related to arbitration agreements.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on interview, record review, policy review, and review of the Centers for Disease Control website, the facility failed to offer pneumococcal vaccinations to two of five residents (Resident (R)1 and R45) reviewed for immunizations out of a total sample of 21. This placed the residents at risk of acquiring pneumonia/pneumococcal infections. Findings include: Review of the facility's policy titled, Pneumococcal Vaccine, dated March 2022, revealed, . All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections . Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series and when indicated, are offered the vaccine within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Pneumococcal vaccines [NAME] administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol . Review of the CDC website revealed, . On October 23, 2024, the Advisory Committee on Immunization Practices recommended a single dose of PCV for all adults aged ?[AGE] years who are PCV-naive or who have unknown vaccination history . 1. Review of R1's Census tab of the electronic medical record revealed R1 was admitted to the facility on [DATE]. Review of R1's Immunizations tab of the EMR revealed no documentation of pneumococcal vaccinations. There was a note that recorded that she was not eligible. There was no reason listed why she was not eligible 2. Review of R45's Census tab of the electronic medical record revealed R1 was admitted to the facility on [DATE]. Review of R45's Immunizations tab of the EMR revealed no documentation of pneumococcal vaccinations. There was a note that recorded that he was not eligible. There was no reason listed why he was not eligible During an interview on 02/18/25 at 2:00 PM, the Infection Preventionist (IP) stated when a resident was admitted to the facility, she would check the state's data base to see if the resident had received a pneumococcal vaccination prior to admission. The IP confirmed she had not assessed the pneumococcal vaccine status for R1 and R45. The IP stated R1 and R45 were below the age of 65 when they had been admitted , and she was not aware of the residents' risk factors. The IP stated she was not aware of the pneumococcal recommendations by the CDC. During an interview on 02/18/25 at 4:00 PM, with the Director of Nursing confirmed the residents had not been offered the pneumococcal vaccination as indicated in the policy and CDC recommendations.