

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER Eagle Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 405 S College St Statesboro, GA 30458	

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 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33516</p> <p>Based on observations, staff interviews, and record review, the facility failed to ensure each resident received food that was prepared in a form designed to meet individual needs for two residents (R) (R4 and R20) of six residents who required a pureed diet. Specifically, the facility failed to ensure that the consistency of the pureed diet was appropriate to meet the needs of the residents.</p> <p>Findings included:</p> <p>Review of the IDDSI (International Dysphagia Diet Standardization Initiative) dated 2019 read in part:</p> <p>Level 4 Pureed - Have a smooth with no lumps .not sticky .do not require chewing .Food characteristic to AVOID .tough or fibrous foods .food with skins or outer shell, food with husks, bone or gristle .stringy food . visible lumps.</p> <p>Examples of food to AVOID .steak .peas .corn .meat with gristle .lumps in pureed food.</p> <p>Review of the lunch menu for the week of 4/22/2025 through 4/24/2025 included:</p> <p>4/22/2025 Beef stew, white rice, green peas, and frosted spice cake.</p> <p>4/23/2025 BBQ ribs, baked beans, corn, and double chocolate chip cookies.</p> <p>4/24/2025 Ethica fried chicken, roasted sweet potatoes, Key [NAME] vegetable blend, dinner roll, and bread pudding.</p> <p>1. R4 was admitted to the facility on [DATE], and diagnoses included unspecified dementia, hemiplegia and hemiparesis, diverticulitis, gastro-esophageal reflux disease (GERD), cognitive communication deficit, Alzheimer's disease, dysphagia oropharyngeal phase, and dysphagia oral phase.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively impaired and staff identified the resident had short and long-term memory problems, no memory recall, and was severely impaired; never or rarely made decisions. The resident was dependent on staff during meals. She had a mechanically altered diet that required a change in the texture of food or liquids.</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 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the care plan, which was reviewed by facility staff on 3/21/2025, identified the resident needed assistance using utensils and bringing food and liquids to her mouth. The interventions included assisting the resident with meals.</p> <p>Further review of the care plan, which was reviewed by facility staff on 3/21/2025, identified the resident was at risk for altered nutrition related to use of daily diuretics, risk of weight fluctuations, edentulous, and history of dysphagia. Interventions included staff was to observe for worsening swallowing and/or chewing problems; staff was to provide diet as prescribed; the resident required total assistance with feeding; and the resident was on a pureed diet.</p> <p>Review of the current physician orders included:</p> <p>Puree 4 for the diagnosis of dysphagia, oropharyngeal phase. The order was entered on 5/15/2024.</p> <p>Review of the annual nutrition assessment dated [DATE] included the diet order of Puree 4.</p> <p>Review of the nutritional screen dated 3/12/2025 included the diet order of Puree 4.</p> <p>Review of R4's meal tickets from 4/22/2025 to 4/24/2025 identified the resident received a pureed diet.</p> <p>During an observation and interview on 4/22/2025 at 12:33 pm, Certified Medication Aide (CMA) HH was feeding R4 her lunch. The CMA stated the meal was beef stew, rice, and mixed vegetables of peas and carrots. She stated the food was not smooth, but was moderately smooth. She stated the resident was supposed to have a pureed diet, which was smoother. CMA HH stated she was able to feed the resident the consistency and give her drinks in between bites of food. The beef stew appeared stringy, the rice looked like mini tapioca pudding beads, and there was the skin from the peas, and the carrots were in small chunks. CMA HH returned the plate to the kitchen and returned at 12:48 pm with another plate. The consistency was not pureed. CMA HH stated it was smoother, to help the resident swallow more easily, but it still was not the consistency of the dessert, which was pudding consistency.</p> <p>During an observation and interview on 4/23/2025 at 12:16 pm, Registered Nurse, MDS (RN/MDS) Coordinator AA sat down to assist R4. She stated the resident's meal consisted of corn, which had a husk, and the BBQ meat was stringy; neither of the two items was smooth or pudding consistency.</p> <p>2. R20 was admitted to the facility on [DATE] with diagnoses that included dementia and dysphagia, oropharyngeal phase.</p> <p>Review of the quarterly MDS dated [DATE] included the resident's Brief Interview for Mental Status (BIMS) score was seven out of 15, indicating the resident was severely cognitively impaired. The resident was dependent on staff during meals. She had a mechanically altered diet that required a change in the texture of food or liquids.</p> <p>Review of the care plan, which was reviewed by facility staff on 2/24/2025, identified the resident needed assistance using utensils and bringing food and liquids to her mouth. The interventions included assisting the resident with meals.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of the care plan, which was reviewed by facility staff on 3/21/2025, identified the resident was at risk for altered nutrition. Interventions included the resident required total assistance with meals; staff was to provide the diet as prescribed; and the resident was on a pureed diet.</p> <p>Review of the current physician orders included:</p> <p>Puree 4 for the diagnosis of infection and inflammatory reaction due to an indwelling urethral catheter. The order was entered on 10/3/2024.</p> <p>Review of R20's meal tickets from 4/22/2025 to 4/24/2025 identified the resident received a pureed diet.</p> <p>During an observation on 4/22/2025 at 12:59 pm, R20 was in her room being assisted with her meal by CNA II. She stated the resident was supposed to have a pureed diet and provided the meal ticket that identified Puree-4. CNA II stated the resident had to have foods softened, and this was not a pudding or mashed potato consistency. She stated the dessert was a pureed consistency. CNA II stated the food should not have stringy pieces in the meat, the rice was not mashed potato consistency, and it was supposed to be pureed. She stated this was not smooth, the peas and carrots should be smooth, and there were pea skins and little chunks of peas and carrots being served. She further stated the rice was ground and not like the dessert, which was a pudding consistency.</p> <p>During an interview on 4/23/2025 at 1:29 pm, CNA BB stated she assisted R20 at about 12:30 pm for the lunch meal. She stated the resident was on a pureed diet, which should be smooth and not lumpy. She stated the meal was not smooth, and she saw the husks from the corn in the food.</p> <p>During an observation and interview on 4/24/2025 at 12:55 pm, R20 was in her room, and her meal was on a tray on her bedside table. CNA BB was assisting the resident, and she stated the lunch meal looked different today, it's thicker and smoother than yesterday and the day before; there are no lumps.</p> <p>During an interview on 4/23/2025 at 12:26 pm, Registered Dietitian (RD) EE stated they followed the IDDSI. She stated they used the spoon test, which included the placement of the pureed product on a spoon and flicking it. She stated they wanted it to come off easily and not leave a lot of residual on the spoon. She stated that as long as it met the test, then it was okay. RD EE stated she could not supply a copy of the IDDSI and stated, You can search it. She stated, I can only give you a copy of the policy. A copy of the policy was requested. The RD left the building at approximately 12:45 pm and did not provide a copy of the policy, as requested. An email was sent to the Administrator to request a copy of the policy for alternate diet textures, which was not received by the time of the exit.</p> <p>During an interview on 4/23/2025 at 1:08 pm, the RN/MDS AA stated she was in the dining room daily to assist and to make sure there was a nurse in the dining room. She stated she and the Assistant Director of Nursing (ADON) took turns in the front or the back of the dining room. She further stated the pureed diets today were different, and it was normally pretty smooth.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/23/2025 at approximately 3:00 pm, the Nursing Home Administrator (NHA) GG stated they did not have a policy for food that was mechanically altered. He stated it was because they followed the IDDSI. NHA GG stated they had not had a negative outcome with the food not being smooth.</p> <p>During an interview on 4/24/2025 at 1:02 pm, with the Dietary Manager (DM) FF and the RD EE present, DM FF stated that on the first day (of the survey), the pureed food was not right. She stated the cook did not puree the food long enough. She stated she felt the meal was smooth enough on the second day because the cook followed protocol, with the spoon test. DM FF stated she could not disagree that the meat was stringy both days, the rice was not smooth, and the vegetables were not smooth enough. She stated it was important to ensure the food was the proper consistency for the safety of the residents. She further stated they did not want the residents to choke, and to make sure they ate properly and comfortably. RD EE would not describe the food. She stated she glanced at it and it was supposed to be smooth, and that it should not have had lumps or clumps.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33516</p> <p>Based on observations, staff interviews, and record review, the facility failed to provide special eating equipment and utensils and assistance for one of one resident (R) (6) reviewed for the use of adaptive equipment. Specifically, the facility failed to identify the correct position of a plate guard and who was responsible for the correct position of the plate guard on the resident's plate during meals.</p> <p>Findings included;</p> <p>R6 was admitted to the facility on [DATE] with diagnoses that included spastic hemiplegic cerebral palsy, lack of coordination, severe intellectual disabilities, and general weakness.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE], which contained a Brief Interview for Mental Status (BIMS) assessment that the staff completed, identified that the resident had long and short-term memory problems and was severely cognitively impaired and never or rarely made decisions. The resident required setup and/or clean-up assistance with meals, in which a helper set up and/or cleaned up; and the helper assisted only prior to or following the activity. The resident's height was 66 inches (5 feet 6 inches), and weight was 185 pounds. There were no therapies during the assessment period.</p> <p>Review of the care plan, which was reviewed by facility staff on 2/11/2025, identified the resident had a self-care deficit and required assistance with Activities of Daily Living (ADLs), which included the resident needing assistance using utensils and bringing food and liquids to her mouth, as evidenced by an assistive device for meals. The care plan did not identify the assistive device for the problem. The interventions included that the staff were to assist the resident with meals. The interventions did not identify what equipment was needed and did not provide instructions on how or where to position the plate guard on the plate, or who was responsible for ensuring the plate guard was placed properly on the plate.</p> <p>Review of the significant Nutritional Change assessment dated [DATE], identified the use of a plate guard. The assessment did not provide instructions regarding how or where to position the plate guard, the plate, or who was responsible for ensuring the plate guard was placed properly on the plate.</p> <p>Review of the Nutrition Screen completed by the Dietary Manager dated 1/21/2025, revealed the use of a plate guard. The screen did not provide instructions regarding how or where to position the plate guard, the plate, or who was responsible for ensuring the plate guard was placed properly on the plate.</p> <p>Review of the Occupational Therapy (OT) Discharge Summary dated 4/6/2017 read in part:</p> <p>(continued on next page)</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Pt [patient] is discharged from OT services secondary to pt's treatment plan completed, staff have been consistently securing a plate guard in place during meals, with pt independent during feeding task with minimal to no spillage noted. The summary did not provide instructions regarding how or where to position the plate guard, the plate, or who was responsible for ensuring the plate guard was placed properly on the plate.</p> <p>During an observation on 4/22/2025 at 12:44 pm, R6 was sitting in the dining room at a table with her lunch meal. The plate had a plate guard set from 9:00 to 2:00 (positions on a clock), and the bottom half of the plate was open. The resident had food debris on the table and her clothing that came from her spilling food from the unguarded portion of the plate. No staff were assisting or queuing the resident while she ate.</p> <p>During an observation on 4/23/2025 at 12:12 pm, R6 was sitting in the dining room at a table with her lunch meal. The plate had a plate guard on from 6:00 to 12:00 (positions on a clock), which left the right side of the plate open. R6 was eating independently without staff assistance or queuing. Continued observation revealed R6 ate less than half of the serving of corn, and there was corn in between the plate and the plate guard.</p> <p>During an interview on 4/23/2025 at 1:08 pm, Registered Nurse/MDS (RN/MDS) Coordinator AA stated she was in the dining room daily to assist and to make sure there was a nurse in the dining room. She stated she and the Assistant Director of Nursing (ADON) took turns in the front or the back dining room. She identified R6 as the only resident with a plate guard of which she was aware. She said she was not sure where it was supposed to be positioned. RN/MDS AA stated she did not know if R6 had an order for the plate guard or if it had a specific location (how/where to place on the plate) or who was supposed to put the plate guard on the plate.</p> <p>During an interview on 4/24/2025 at 2:40 pm, Certified Nurse Aide (CNA) BB helped in the dining room as needed. She stated the plate guard should have been in position when they (staff) served the tray; she reiterated that it should be on. CNA BB stated that if the plate guard was not on the plate, she would ask the Dietary Department for the plate guard. CNA BB stated they used to have a chart to show staff how to put the plate guard on. CNA BB stated Resident 6 used a plate guard, and she would put the plate guard on in the 3:00-9:00 position, which left the top of the plate open, because the resident was right-handed. She stated the lunch ticket did not include the position of the plate guard, and the plan of care did not say anything about the position. CNA BB stated it was important to have the plate guard in the right position, so the food did not go outside the plate and helped keep the food on the resident's fork and spoon.</p> <p>During an interview on 4/24/2025 at 4:38 pm, Director of Rehabilitation/Physical Therapist Assistant (DOR/PTA) CC stated she had been in her current position since 12/30/2024. She explained the process when a resident required a plate guard with the following steps:</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notification from dietary, nursing, or a therapist (it was a team effort) would occur; if a device was needed, then they sent a referral to OT (Occupational Therapy) or ST (Speech Therapy). She stated that the majority of the referrals went to OT because they provided assistance with feeding. DOR/PTA CC was not sure where the use of a plate guard would be found in the electronic medical record. She was unsure who placed the plate guard on the plate. She stated they did not have a policy for the use of assistive devices for meals. DOR /PTA CC stated R6's plate guard position should have been open at the top. She stated it was also dependent on whether the resident was right or left-handed. DOR/PTA CC stated R6 was right-handed, so the plate guard should be placed at 12:00-6:00 (position on a clock) on the left side of the plate because she is right-handed. DOR/PTA CC stated that if recommended, they would provide education to the staff on where the opening should be. She stated she was unable to find information about the position or who was responsible for placing the plate guard on the plate in the electronic medical record. She reviewed the care plan and was unable to locate the use of the plate guard. She stated she thought it needed to be on the care plan. DOR/PTA CC further stated it was important to know the position of the plate guard and who was responsible for its placement, so when she ate, food did not fall off the plate. The plate guard was used due to visual impairment.</p> <p>During an interview on 4/24/2025 at 4:44 pm, Director of Nursing (DON) DD stated she did not know who was responsible for placing the plate guard on the plate. She stated that during her observations, the plate guard was already on the plate. DON DD stated the plate guard was not listed on the care plan and should have been. She stated the Registered Dietitian told her an order was not needed for a plate guard to be used. DON DD stated it was important to know the correct position to place the plate guard in order to keep the food on the plate, so the resident was able to get the food to her mouth.</p> <p>During an interview on 4/24/2025 at 5:38 pm, Nursing Home Administrator (NHA) GG provided a copy of the plan of care for the physical functioning portion, which included the history of the use of the plate guard beginning on 3/7/2018. The documentation did not include information regarding the positioning of the plate guard.</p>		