STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115619	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenvue Health & Rehab	721 North Veterans Blvd Glennville, GA 30427

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 52126 Based on staff interviews, and record review, the facility failed to provide staff assistance with activities of daily living for one of four residents (Resident (R) 244) reviewed for activities of daily living out of a total sample of 24 residents. This failure had the potential to lead to a decline in activities of daily living. Findings include: Review of R244's Admission Record located under the Profile tab in the electronic medical record (EMR), revealed R244 was initially admitted on [DATE] with diagnoses including acute respiratory failure, epilepsy, cerebral palsy, cognitive communication deficit, bipolar, and intellectual disabilities. The resident went out to the hospital on 2/28/29, readmitted on [DATE], and discharged on [DATE]. Review of R244's Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 02/28/24 revealed the resident was unable to complete a Brief Interview of Mental Status (BIMS) assessment. A Staff Assessment for Mental Status was conducted and determined that the resident's cognitive skills for daily decision making was severely impaired. The MDS also indicated R244 required substantial/maximal assistance to complete bathing. Review of R244's Baseline Care Plan located in the EMR under the Assessments tab revealed the resident required the assistance of one person for bathing. Review of R244's Documentation Survey Report - Feb-24 located under the Reports tab in the EMR revealed there was no documentation that the resident was bathed from 02/23/24 through 02/28/24. The resident was scheduled to be bathed on 02/27/24 but was not marked as completed. During an interview on 04/17/25 at 4:50 PM, Certified Nursing Assistant (CNA) 6 stated, There is a bath sheet at nurses desk indicating when residents are scheduled to be bathed. We, then, documented in EMR. If a resident refuses their bath/shower, we ask them three times and then notify the nurse. We then document the refusal in the EMR and select refused. If a resident wants to be bathed the next day, then we would bathe them the next day. New admissions would be scheduled on the bath sheet as soon as they are admitted . If a resident was admitted on Tues, then they would be scheduled for one on the next day. Residents are scheduled either Monday, Wednesday, Friday, or Tuesday, Thursday, Saturday. If a resident needs a bath when they are admitted , then they would get one right away. I do not recall a resident by the name of [R244]. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/25 at 5:00 PM, CNA5 stated, A list of the residents' bath schedule is at the nurses' desk. We look at the list when we come in each day. Residents are scheduled either Monday, Wednesday, Friday or Tuesday, Thursday, Saturday. Baths would be scheduled between day, evening, and night shift depending on the resident's preference. Residents who refuse are reapproached three times, then we notify the charge nurse. I document in EMR the refusal. I note it on the bath list and notify the nurse. The nurse also documents the refusal in the chart. New admissions would be scheduled either the same day or the next day. I do not recall a resident by name of [R244]. During an interview on 04/17/25 at 5:10 PM, the DON stated. New admissions are scheduled by the nurse manager for Monday, Wednesday, Friday or Tuesday, Thursday, Saturday and based on the resident's preference for the time of day. The expectation is that residents receive a bath immediately if needed or the next day. [R244] was admitted on [DATE]. The expectation was that [R244] should have been scheduled for a bath on 02/24/24. The CNAs that worked then have retired and no longer work here. The CNA scheduled that day did not document any baths in the chart for the day. There was no documentation that the resident was offered a bath or refused. [R244] was scheduled for baths beginning 02/27/24. The documentation for bathing was blank on 02/27/24. No documentation would mean that the task was not completed.

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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 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** 40824 Based on record reviews, and staff interviews, the facility failed to ensure physician orders were followed related to laboratory monitoring for one of one (Resident (R)45) residents reviewed for laboratory services. Specifically, the facility failed to ensure that R45's HbA1c (blood test measuring average blood sugar levels over the past two to three months) labs were drawn in October 2024 and January 2025. Findings included: Review of R45's Admission Record located in the Electronic Medical Record (EMR) under the Profile tab, showed an admitted [DATE] with a primary medical diagnosis of hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side. Review of R45's Care Plan revised 04/11/25 located in the EMR under the Care Plan tab included diabetic status and .labs as ordered . Review of R45's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Review Date (ARD) of 01/07/25 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating that he was moderately cognitively impaired. Review of R45's Order Summary Report located in the EMR under the Orders tab included an order, dated 03/13/24, for HbA1c to be drawn quarterly in January/April/July/October. Review of R45's HbA1c results located in the EMR under the Results tab revealed the most recent HgA1c was drawn on 03/19/24 at the facility. The resident was hospitalized [DATE] and had HgA1c drawn while hospitalized . No HgA1c was collected for October 2024 or January 2025. Review of Pharmacy Progress Notes, dated 11/05/24, located in the EMR under the Progress Notes tab included a recommendation to update HbA1c lab monitoring. Review of Pharmacy Progress Notes, dated 02/03/25, located in the EMR under the Progress Notes tab included a recommendation to update HbA1c lab monitoring. During an interview on 04/16/25 at 4:07 PM with the Director of Nursing (DON) stated that the expectation was for labs to be drawn as ordered by the physician. The expectation for pharmacist review recommendations was for the physician or the nurse practitioner to bring back any signed recommendations or new orders that resulted from the pharmacist reviews. The DON confirmed that she was unable to locate proof of HgA1c being drawn in October 2024 or January 2025. Additionally, the Unit Managers receive a list of which residents are due for labs from Clinical Laboratory Services (CLS) which generates from standing orders. The DON showed this surveyor an email that she received for October 2024 and January 2025 which did not include R45 for HgA1c. The DON did not know why the order did not trigger with the pharmacy, and the facility had no protocol in place to ensure laboratory monitoring was in place. The DON stated that the facility did not have a policy related to following physician orders or laboratory monitoring. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/25 at 2:28 PM with Corporate Compliance Nurse (CCN) confirmed that R45 had orders for HbA1c to be drawn January/April/July/October. CCN confirmed that lab results could not be located to confirm that HbA1c was drawn in October 2024 or January 2025.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 12273 Based on observations, staff interview, and record review, the facility failed to ensure that the preplanned menu portion serving sizes and standardized recipes were followed. Failure to meet these requirements altered the intended calorie and nutritional content of the meal offered and could place residents at risk for weight loss and health complications associated with malnutrition. The deficient practice had the potential to affect all residents who receive an oral diet from the kitchen. Findings include: On 04/15/25 at 4:45 PM, [NAME] (C) 3 was observed setting up the tray line for the meal service. After removing the main entree from the oven, C3 tested the temperature, and stated the menu included chicken pot pie, and could be served without any alteration to the residents with altered textured diets. C3 then stated he needed to prepare the casserole for puree foods. When asked if a standardized recipe was used to prepare the casserole, C3 explained he had added cheese to the recipe and provided assurance the resident really liked it. It was also noted that biscuits had been placed on the top of the pot pie while baking. C3 then used a gray handled scoop (which held a four (4) ounce serving) to place four scoops of the pot pie into the blender, added a liquid and blended the food to a smooth texture. After placing the puree on the steam table in the pan, C3 began to plate foods for residents sitting in the dining room. After serving approximately 10 plates to residents, the Dietary Manager (DM) was asked about the portion serving size used for the entree. The DM stated the scoop was not the right portion size, and advised C3 the portion size should be six ounces, she then obtained a six-ounce scoop and provided it to C3. Which was the portion serving size identified on the spread sheet for the entree. Review found the standardized recipe, provided by the facility, revealed the recipe did not include any cheese. In addition, the recipe included a pie crust being cooked on top of the casserole, the recipe was not followed and changed the calorie and nutrient value of the meal. During a follow-up interview with the DM on 04/16/25 at 10:30 am the following day, a copy of the diet count was provided. The diet count showed the eight residents had physician orders for puree diet. When asked how 16 ounces (four scoops) of the casserole prepared in a blender with liquid met the nutritional needs for the eight puree diets, she stated she did not know. The menu extension verified a six-ounce portion serving size was intended portion to be served the puree diets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 12273 Based on observations, staff interviews, and record review, the facility failed to ensure food was stored, prepared, and distributed under sanitary conditions; as evidenced by failure to ensure food preparation equipment was stored under sanitary conditions; and ensure food storage areas were kept clean and sanitary. In addition, the facility failed to ensure foods were cooked to the appropriate temperature before placing them in a warmer (a low temperature oven intended to hold hot food), and failure to ensure ready to eat foods were handled in a manner that prevented contamination. The deficient practice increased the risk for all residents residing in the facility who receive a diet from the kitchen could experience a food borne illness. Findings include: On 04/14/25 at 9:20 AM, during the initial tour of the kitchen, the following observations for food preparation equipment, and food storage areas were kept in a clean and sanitary manner. The floor in the kitchen was soiled with food crumbs, and particulate matter, broken linoleum tiles were observed exposing the sub-floor. Food particulate matter was adhered to the cracked and broken edges of the tiles. The doors and handles on the reach in refrigerators were visibly soiled with food splash and spills. A deep fryer had splash guard that was heavily soiled with food spills and crumbs. The Dietary Manager (DM) stated it was used the previous day and should have been cleaned after use. The microwave handle was soiled and the interior had food crumbs inside. A juice dispenser machine was observed on the counter, the DM reported the dispenser spigots are cleaned weekly. The steam table wells had food spills and splash inside the water. When asked how often the water was changed, the DM responded it should have been emptied and cleaned the previous day and appeared that it was not completed. On 04/14/25 at 9:20 AM, the DM stated the cleaning schedule was being revised to meet the facility's needs, and stated a new contractor had just taken over the food service department that week. On 04/15/25, at 4:45 PM, [NAME] (C)3 observed preparing and setting up for meal service. C3 removed a deep steamtable pan from the oven containing chicken pot pie. C3 obtained a blender, prepared the pureed entree, and placed it in the steam table for service. C3 began serving plates using utensils to plate hot foods, and then placed a biscuit on the plate using gloves (which had touched multiple surfaces throughout the kitchen) and could contaminate the ready-to-eat food. C3 served several plates and then obtained a pair of tongs to serve the biscuits, stopped handling them with the gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/16/25 at 10:55 AM, several pans of food were observed in the warming oven (intended for hot holding). The thermometer inside the unit displayed a temperature of 200 degrees Fahrenheit (F). When asked to test the temperature of the pureed meat, the thermometer reading was below 100 F. When asked how long the item had been in the warming oven, the DM asked the staff, who responded it was just prepared and placed in the warmer. When asked about the facilities practice for heating foods, the DM explained food should be heated to 165 F prior to placing the item in the warmer. On 04/16/25 at 2:45 PM, during a follow up interview with the DM, when asked about the manufacturers' recommendations for a clean the juice machine, she revealed the instructions were found on the interior of the door, the recommendation was to clean and sanitize the spigots daily.

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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** 40824 Based on staff interview and record review, the facility failed to maintain a complete and accurate medical record for one of 31 sampled residents (Resident (R) 8). Specifically, the facility failed to include the physician order for metoprolol tartrate 25 milligrams (mg) into the electronic medical record (EMR) following a readmission after hospital discharge. This failure had the potential to cause a medication error that could be harmful to the resident. Findings include: Review of R8's Admission Record located in the EMR under the Profile tab indicated R8 was readmitted to the facility on [DATE] with a primary diagnosis of encounter for surgical aftercare following surgery on the circulatory system. Review of R8's Order Summary Report, dated 04/17/25, did not include orders for metoprolol 25mg tablets. An order for gabapentin 100mg capsule, give 2 capsules by mouth twice daily for neuropathy was ordered 08/01/24 and atorvastatin 20mg tablet, give one tablet by mouth every evening for hyperlipidemia was ordered 02/04/25. Review of R8's .Discharge to Acute/Chronic Medical Facility Medication Orders, dated 04/12/25, included metoprolol 25 mg, one tablet to be given by mouth twice daily. During an observation and interview on 04/16/25 at 4:38 PM with Licensed Practical Nurse (LPN) included administration of metoprolol tartrate 25mg. The medication was delivered by the pharmacy in a packet, dated 04/16/25, which included atorvastatin, gabapentin, and metoprolol. LPN1 stated that the resident was recently hospitalized and was on multiple cardiac medications and she knew that R8 had been on metoprolol for a long time. LPN1 stated she would let her Unit Manager (LPN4) know that the medication order was not in the EMR. LPN1 administered metoprolol 25mg without having active orders for the medication. Administration of the medication was not documented in the EMR due to no order triggering documentation after administration. During an interview on 04/17/25 at 10:55 AM with LPN4 confirmed that R8 was recently hospitalized and that the hospital sends the pharmacy the medication orders for packaging and delivery. The hospital sends Discharge to Acute/Chronic Medical Facility Medication Orders document to the facility. LPN4 stated that the protocol was for the nurse readmitting the resident to review the hospital discharge orders, review with the physician, and then transcribe the orders into the EMR. During an interview on 04/16/25 at 5:48 PM with Director of Nursing (DON) stated that R8 recently went to the hospital and was prescribed metoprolol tartrate 25mg oral tablets, give one tab by mouth twice daily, she was discharged from the hospital 04/12/25. Her expectation was for the Unit Manager to fax the pharmacy the medication orders and then the nurse that re-admits the resident puts the orders in the EMR. The DON stated that it appeared that the nurse that did the re-admission failed to add the metoprolol order but should have. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/25 at 6:06 PM the DON stated the facility did not have a policy related to complete/accurate medical records

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824 Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure infection control was maintained for five of 31 sampled residents (Resident (R) 17, R53, R59, R61, and R84). Specifically, the facility failed to ensure that hand hygiene was completed during medication administration, meal service, and housekeeping tasks. Additionally, a personal drink was on top of the medication cart during medication pass which increased the risk for cross contamination and infections. Findings include: Review of the facility policy titled, Handwashing/Hand Hygiene provided by the facility and revised 08/2019 indicated, This facility considers hand hygiene the primary means to prevent the spread of infections .Use an alcohol-based hand rub .before preparing or handling medications .before handling clean or soiled dressings . after handling used dressings, contaminated equipment .after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident . 1. During an observation and interview of medication administration on 04/16/25 at 4:26 PM Licensed Practical Nurse (LPN1) 1 had an open can of soda on top of the medication cart for D Hall. LPN1 confirmed that the soda was hers and that it should not be on top of the medication cart at any time. She said that she just got braces yesterday and her mouth was very sore and dry and that's why she had her drink on the cart. 2. Observation of medication administration pass on 04/16/25 from 5:20 to 5:30 PM with LPN2 revealed the following: At 5:20 PM, LPN2 provided medication to R59 and did not perform hand hygiene after medication administration. At 5:24 PM, LPN2 prepared and administered medications for R84. LPN2 did not perform hand hygiene after administration of medications to R84. At 5:28 PM LPN2, prepared and administered medications for R53. LPN2 did not perform hand hygiene after administration of medications to R53. During an interview on 04/16/25 at 5:30 PM with LPN2, she confirmed that she had not performed hand hygiene between residents receiving medications and should have. She did not give a reason why hand hygiene was not performed. Review of R53's Admission Record located in the Electronic Medical Record (EMR) under the Profile tab, showed an admitted [DATE] with a primary medical diagnosis of alcohol dependence with alcohol-induced persisting dementia. Review of R53's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Review Date (ARD) of 03/01/25 revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating that he was severely cognitively impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R59's Admission Record located in the EMR under the Profile tab, showed an admitted [DATE] with a primary medical diagnosis of chronic pancreatitis. Review of R59's annual MDS located in the EMR under the MDS tab with an ARD of 15 revealed a BIMS score of 15 out of 15 indicating that he was cognitively intact. Review of R84's Admission Record located in the EMR under the Profile tab, showed an admitted [DATE] with a primary medical diagnosis of urinary tract infection. Review of R45's quarterly MDS located in the EMR under the MDS tab with an ARD of 0/13/25 revealed a BIMS score of nine out of 15 indicating that he was moderately cognitively impaired. During an interview on 04/17/25 at 5:05 PM with the Director of Nursing (DON) stated that her expectation was for the nurse to perform hand hygiene before medication administration, between residents, and at completion of medication pass. Additionally, staff are not allowed to have personal beverages on the medication cart or at the nurses' station. All food and drinks are to be consumed in the staff break room. The DON stated the facility did not have a policy regarding personal beverages on the medication carts. 3. Review of R61's Admission Record found under the Profile tab of EMR revealed R6 was admitted to the facility on [DATE]. Review of the annual MDS assessment with an ARD of 11/10/24, documented R61 had a score of 15 out of 15 on the Brief Interview for Mental Status and had multiple diagnoses on admission, which included an unstageable chronic wound. Review of the Care Plan, dated 01/10/25, indicated the resident was on Enhanced Barrier Precautions. The posting on the door indicated all staff who enter the room should complete hand hygiene when entering and before leaving the room. Review of the R17's Admission Record revealed an admitted [DATE]. Review of the annual MDS assessment with an ARD date of 11/10/24, indicated the resident was admitted to the facility with a progressive neurological disease, and needed assistance from staff with the Activities of Daily Living (ADL's I.e. Dressing, grooming, hygiene, transfers and eating), but had independent mobility after being transferred to a motorized wheelchair. Review of the Care Plan, dated 01/10/25, indicated the resident was on Enhanced Barrier Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/25 at 10:00 AM, Housekeeper (HK) 1, was observed in R61's room cleaning the floor with a floor mop, after completing the task HK1 exited the room, wearing gloves. After placing the mop on the cart, the staff removed the gloves, and obtained another pair of clean gloves, and placed them on. HK1 then obtained a cleaning cloth from a locked cupboard on the cart and a spray bottle. After spraying the cleaning solution on the cloth HK 1 then entered R17's room and begin cleaning the bathroom. Although a sign was hung on R61's door directing any staff that entered the room to complete hand hygiene prior to leaving the room, HK1 did not wash her hands or sanitize them prior to exiting the room. On 04/1625 at 10:10 AM, HK1 was interviewed. When asked about hand hygiene after removing the gloves, she acknowledged the error. On 04/16/25 at 3:20 PM, Licensed Practical Nurse (LPN) 5 was observed preparing to provide wound care for R61. After placing the Personal Protective Equipment (PPE's) on to provide wound care (a gown and gloves), LPN 5 stated he had forgotten supplies. The LPN5 removed the PPE's, exited the room, closed the door, then returned to the room with additional supplies. The staff entered the room, placed a new gown and gloves on without completing hand hygiene, and then completed the dressing change. On 04/16/25 at 5:50 PM, during a follow up interview, LPN5 acknowledged the error and explained hand hygiene should have been completed after reentering R61's room, but it was not.