STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115638	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Manor, Incorporated	2455 Oak Grove Church Road Carrollton, GA 30117

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49289 Based on observations, staff interviews, and review of the facility's policies, the facility failed to provide services that meet professional standards for one of six residents observed for medication administration (Resident #41). Specifically, blood pressure monitoring was not provided following physician's orders before administering a medication. Findings include: Review of the undated facility policy titled, Administering Medications, noted: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions . 4. Medications are administered in accordance with prescriber orders, including any required time frame . 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary. [sic] Review of the medical record for Resident (R) #41, showed that the resident was admitted to the facility on [DATE] with diagnoses that included diabetes, major depressive disorder, cerebrovascular disease, and edema. Review of the Physician ' s orders for R#41 for April 2025 included, Furosemide [a diuretic used to treat fluid retention] Tablet 20 MG [milligram]. Give 40mg by mouth one time a day for Edema. Hold for SBP [systolic blood pressure] < [less than] 100, SBP <60. [sic] During a medication administration observation on the 300 Hall, on 4/23/25 at 8:38 a.m., Licensed Practical Nurse (LPN) AA prepared medications for R#41. The LPN reviewed the Physician ' s order from R#41 ' s electronic medical record for each medication, as she retrieved each of R#41 ' s individual blister packet from the 200-300 Hall medication cart, and poured each of the nine medications, which included furosemide 40mg, into a medicine cup. The LPN then locked the cart, performed hand hygiene, and brought the medications to R#41. The LPN observed the resident while the resident swallowed the medications. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/23/25 at 8:45 a.m., LPN AA stated, I didn't check [R#41 ' s name] BP [blood pressure] before giving the medication [furosemide]. It [blood pressure monitoring] was last done with a BP of 124/70 on 4/17/25 at 0354 [3:54 a.m.] according to the chart. [sic]The LPN confirmed that the BP should have been taken before administering the furosemide medication following the physician ' s orders, to ensure that the BP parameters were met before administering the medication. During an interview, on 4/24/25 at 10:45 a.m., the Director of Nursing (DON) stated, I expect the nurse to check the blood pressure within an hour before administering the medication if it requires a blood pressure check. [sic]The DON confirmed that the blood pressure needed to be obtained, following physician ' s orders, prior to administering the furosemide medication to R#41. During a telephone interview, on 4/24/25 at 12:32 p.m., with R#41 ' s primary care physician for the facility, the physician stated, Giving the medication [furosemide 40mg] could lower the blood pressure a little bit. I don't think giving the medication without checking the blood pressure first, would cause major harm for this resident [R#41]. Her blood pressures have been stable, the medication might not work as well for her edema if her blood pressure is low. They [nurses] should be checking the blood pressure routinely before giving the medication though. I have not been notified of any lower blood pressure issues that the resident has had recently. [sic]

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49289 Based on observations, staff interviews, and review of the facility's policies, the facility failed to appropriately store medications in three of three medication storage carts (200-300 Hall cart, 400 Hall cart, and 500 Hall cart). Findings include: Review of the undated facility policy titled, Medication Labeling and Storage, noted: Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy Interpretation and Implementation. Medication Storage: 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. [sic] During a medication storage observation of the 500 Hall medication cart, on 4/23/25 at 2:40 p.m., with Licensed Practical Nurse (LPN) CC, the second and third drawer of the medication cart contained individually sealed and labeled resident medication blister packets [packaging used to keep the medication safe from damage, moisture, and contamination]. Further observation revealed there were five loose pills of various sizes, shapes, and colors lying on the bottom of the second drawer, and four loose pills of various sizes, shapes, and colors lying on the bottom of the third drawer of the cart. During an interview on 4/23/25 at 2:47 p.m., Nurse Supervisor DD stated, I think that the night nurses clean out the [medication cart] drawers. They have more time on their shift. I don't know if they do it every night. It's every nurse's responsibility to keep the cart clean and make sure there are no loose medications in the drawer. During a medication storage observation of the 400 Hall medication cart, on 4/23/25 at 2:50 p.m., with LPN BB, the second drawer of the medication cart contained sealed and individually labeled resident medication blister packets. Further observation revealed there were two loose pills of various sizes, shapes, and colors lying on the bottom of the second drawer of the cart. During a medication storage observation of the 200-300 Hall medication cart, on 4/23/25 at 2:58 p.m., with LPN AA, the third drawer of the medication cart contained sealed and individually labeled resident medication blister packets. Further observation revealed there were 14 and one-half loose pills of various sizes, shapes, and colors lying on the bottom of the third drawer of the cart. During an interview on 4/24/25 at 10:45 a.m., the Director of Nursing (DON) stated, The medication storage carts should be cleaned routinely. All nurses are responsible for checking the medication cart. I expect there might be one or two pills in the bottom of the drawer during a shift, because the medications come out of the packs easily, but there should not be several pills in each drawer found. [sic]

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33363 Based on observations, staff interviews, record review, and review of the facilities policy, the facility failed to accommodate resident's food allergies, intolerances, and preferences for seven (7) residents that had been identified to have a latex allergy to include sampled residents. [Residents (R) #7, R#13, R#27, R#39, R#49, R#51and R#247]. Specifically, the facility failed to provide an appropriate alternative as evident by dietary staff plating food from the tray line using their hands donning latex gloves. The deficient practice had the potential to affect all residents who receive an oral diet from the kitchen. Findings include: Review of the facility policy titled, Food Allergies, undated, revealed: Procedure 4, The facility must determine a practice for patient/resident identification for food allergy. The policy does not specifically identify latex allergies. Review of the facility policy titled, Bare Hand Contact with Food and Use of Plastic Gloves, not dated, revealed, Procedure 2, staff will use clean barriers such as single use gloves, tongs, deli paper and spatulas when handling food. Procedure 3, gloves are considered a food contact surface that can become contaminated or soiled. If used, single use gloves shall be used for only one task such as working with ready-to-eat (RTE) food or with raw animal food, used for no other purpose and discarded when damaged or soiled, or when interruptions occur in the operation. Procedure 5 (f), clean gloves are to be used anytime hands would otherwise touch food directly. Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed. Review of the facility policy titled, Employee Hygiene for Food Safety, not dated, revealed Procedure 6, Use utensils to handle food, avoiding bare hand contact with food. Disposable gloves are a single use item and should be discarded after each use. Hands must be washed prior to using gloves and after removing gloves. A review of the best practice statement provided the Mayo Clinic, titled Latex Allergy, dated November 6, 2024, revealed a latex allergy, the immune system identifies latex as a harmful substance and triggers certain antibodies to fight it off. The next time there is a latex exposure, these antibodies tell the immune system to release histamine and other chemicals into the bloodstream. This process produces a range of allergy symptoms. The more times someone is exposed to latex, the more strongly their immune system is likely to respond. This is called sensitization. Latex allergy can happen by direct contact. The most common cause of latex allergy involves touching latex-containing products, including latex gloves . A review of the electronic medical record (EMR) for R#7 revealed, she was admitted on [DATE] and was diagnosed with a latex allergy at admission. A review of the EMR for R#13 revealed, she was admitted on [DATE] and was diagnosed with a latex allergy at admission. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the EMR for R#27 revealed, she was admitted on [DATE] and was diagnosed with a latex allergy at admission. A review of the EMR for R#39 revealed, she was admitted on [DATE] and was diagnosed with a latex allergy at admission. A review of the EMR for R#49 revealed, she was admitted on [DATE] and was diagnosed with a latex allergy at admission. A review of the EMR for R#51 revealed, she was admitted on [DATE] and was diagnosed with a latex allergy at admission. A review of the EMR for R#247 revealed, she was admitted on [DATE] and was diagnosed with a latex allergy at admission. During the dietary tray line observation on 4/23/25, at 11:15 a.m., food service [NAME] #FF was observed serving dinner biscuits from the steamtable for 85 residents using a latex gloved hand. During an interview, on 4/23/25, at 11:15 a.m., [NAME] FF revealed she prefered to use the latex gloves rather than the vinyl or nitril based gloves. She stated she should have used a tong to plate the rolls and was not aware of any residents with latex allergies. During an interview, on 4/23/25 at 11:20 a.m., the Dietary Manager revealed her staff can use their preference of type gloves, either vinyl or rubber latex. She stated it had never been brought to her attention that there were residents in the facility with latex allergies. She confirmed that [NAME] FF should have used tongs to serve the rolls than her gloved hand. During an interview, on 4/23/25 at 12:33 p.m., the Director of Nursing (DON) revealed the facility did not have a policy restricting the use of latex gloves. He stated he was not aware that latex gloves were being used in dietary services. He confirmed he had learned this was the only area of the facility that was using latex gloves. He identified the serious risk of anaphylactic reaction if anyone in the facility was exposed to latex that had a noted allergy and stated they should not be used anywhere in the facility. He confirmed that the facility identified there were seven (7) residents with documented latex allergies. During an interview, on 4/25/25 at 8:26 a.m., the Infection Control Nurse revealed she was not aware of any residents with latex allergies, but she was aware the dietary staff were using latex gloves. She revealed she was not aware of a policy restricting the use of latex but if the facility had residents that had a latex allergy, anyone caring for them should not use latex as it could cause a serious allergic reaction. During an interview, on 4/25/25 at 8:55 a.m., the Administrator revealed he was not aware of the use of latex being used in the facility. He stated that with residents in the facility being identified to have latex allergies, the facility should not be stocking latex gloves for use. He stated his concerns include the possibility of a resident that had a latex allergy could have a serious allergic reaction if exposed to latex products.

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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. 33363 Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure that proper sanitation and food handling practices to prevent the outbreak of foodborne illness were followed and safe food handling for the prevention of foodborne illnesses throughout the facility's food handling processes, and failed to ensure proper hand hygiene or donning (putting on) of a protective apron during meal service tray line. Specifically, two freezers, one walk in refrigerator, three juice coolers, and one front and back ice cream cooler failed to have documentation verifying the temperatures of each. The deficient practice had the potential to affect all residents who receive an oral diet from the kitchen. Findings include: Review of the facility policy for reference cold and warm temperatures was requested, however the facility failed to provide the requested policy. Review of the facility policy titled, Employee Hygiene for Food Safety, not dated, revealed all food and nutrition service employees will practice personal hygiene and safe food handling procedures. Procedure 2, wash hands before handling food using posted handwashing procedures. Procedure 6, Use utensils to handle food, avoiding bare hand contact with food . Review of the facility policy titled Sample Freezer and Refrigerator Temperatures Form 1, stated Record both internal and external temperatures of freezers and refrigerators at least twice a day (approximately 6:00 a.m. and 7:00 p.m.). Any unit not at the proper temperature must be reported to the supervisor at once for corrective action. Refrigeration/freezer units may include milk or ice cream coolers, or any unit used to keep foods cold or frozen. All units must be monitored daily. Review of the facility policy titled Sample Freezer and Refrigerator Temperature Form 2, stated Take AM and PM Temperatures and document corrective action, which is to be initialed by the staff performing the check. Review of the facility policy titled Sample Food Temperatures Form to be dated weekly, revealed record food temperatures prior to service and again after half of the meal has been served for each meal service daily. Hot foods should be equal to or greater than 165 degrees Fahrenheit prior to tray line and 135 degrees Fahrenheit through end of tray line. Cold foods must be maintained at equal to or less than 41 degrees Fahrenheit. Report any foods that are in the temperature danger zone of greater (>) 41 degrees Fahrenheit to less than (<) 135 degrees Fahrenheit to the supervisor immediately for corrective action. An observation on 4/22/25 at 11:17 a.m., revealed a walk-in refrigerator temperature revealed an external thermometer to read at 36? with an internal temperature reading at 32 degrees Fahrenheit. A review of the Sample Freezer and Refrigerator Temperature Form 1, dated April 2025 revealed, from 4/1/25 to 4/21/25, no temperatures had been documented. On 4/21/25 and 4/22/25, a negative (-10 degrees Fahrenheit) was documented. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 4/22/25 at 11:25 a.m., of a walk-in freezer temperature to read at +10 degrees Fahrenheit. A review of the Sample Freezer and Refrigerator Temperature Form 1, dated 4/1/25 to 4/22/25 revealed no temperatures had been documented per policy of twice a day, every day. An observation on 2/22/25 at 11:35 a.m., of the front and back ice cream freezers failed to have an internal thermometer. A review of the temperature log from 4/1/25 to 4/22/25 for both freezers revealed no documentation of the temperatures being checked on either AM or PM shift. An observation on 4/22/25 at 11:45 a.m., of juice cooler #1, #2, and #3 revealed an internal thermometer located inside of each cooler and all reading +32 degrees Fahrenheit. A review of the Sample Freezer and Refrigerator Temperature Form 2, for cooler #1, cooler #2 and cooler#3 from 4/1/25 to 4/21/25 for day shift (AM) and evening shift (PM) revealed no temperatures had been documented for either shift. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, of the walk-in refrigerator temperature revealed the Sample Freezer and Refrigerator Temperature Form 1, dated 3/1/25 to 3/30/25 revealed no temperatures had been documented twice a day on each shift daily. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, of the walk-in freezer temperature revealed the Sample Freezer and Refrigerator Temperature Form 1, dated 3/1/25 to 3/30/25 revealed no temperature documented twice a day on each shift daily. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, of the Sample Freezer and Refrigerator Temperature Form 1, dated March 2025 for the front and back ice cream freezer revealed, from 3/1/25 to 3/30/25, no temperatures were documented on the AM shift. From 3/28/25 to 3/30/25, no temperatures were documented from the PM shift twice a day on each shift daily. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, a review of the sample food temperature form revealed food temperatures were not documented prior to service and again after half of the meal service for 3/1/25 on the dinner meal, on 3/2/25 on the breakfast and lunch meals and on 3/7/25 for the breakfast and lunch meals. On 3/10/25 there was no food temperature documented for the dinner meal. On 3/16/25 and 3/19/25, there were no food temperatures documented on the dinner meal. On 3/25/25, no food temperatures were documented on the breakfast and lunch meals. On 4/2/25 there were no food temperatures documented for the breakfast and lunch meals. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, of the sample freezer and refrigerator temperature form 2, dated March 2025 of juice cooler #1, #2, and #3 revealed from 3/1/25 to 3/30/25 revealed no temperatures had been documented for the AM shift and 3/28/25 to 3/30/35, no temperatures documented on PM shift of twice a day on each shift daily. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, of the walk-in refrigerator temperature revealed the sample freezer and refrigerator temperature form 1, dated 2/23/25 to 2/28/25 revealed no temperatures had been documented on the AM shift. No temperatures from 2/20/25 to 2/28/25 were documented on the PM shift twice on each shift daily. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, of the walk-in freezer temperature revealed the sample freezer and refrigerator temperature form 1, dated 2/20/25 to 2/28/25 revealed no temperatures had been documented on the AM shift twice on each shift daily. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, of the sample freezer and refrigerator temperature form 1, dated February 2025 for the front and back ice cream freezer revealed, from 2/23/25 to 2/28/25, no temperatures were documented on the AM shift. From 2/23/25 to 2/28/25, no temperatures were documented from the PM shift twice a day on each shift daily. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, of the sample freezer and refrigerator temperature form 2, dated February 2025, juice cooler #1, #2, and #3 revealed from 2/24/25 to 2/28/25 revealed no temperatures had been documented for the AM shift twice a day on each shift daily. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, a review of the sample food temperature form revealed food temperatures were not documented prior to service and again after half of the meal service for each meal. On 2/3/25 at the lunch meal, on 2/5/25 at the breakfast and lunch, and on 2/25/25, at the dinner meal, there were no food temperatures documented. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, of the sample freezer and refrigerator temperature form 1, dated January 2025 for the back ice cream freezer revealed, from 1/13/25 to 1/31/25, no temperatures were documented on the AM shift twice a day on each shift daily. An observation on 4/22/25 at 11:45 a.m., with the Dietary Manager, a review of the sample food temperature form revealed food temperatures were not documented prior to service and again after half of the meal service for each meal. On 1/5/25 at the breakfast and lunch meal, on 1/17/25 and 1/18/25 at the breakfast and lunch, on 1/24/25 and 1/25/25 at the dinner meal, and on 1/29/25 at the breakfast and lunch meal, there were no food temperatures documented. An observation on 4/23/25 at 11:15 a.m. with [NAME] FF revealed multiple observations during meal service, of her leaving the steamtable area with gloves and apron on and returning to the steamtable without proper hand hygiene or glove change. These observations included contact with surfaces that were outside of the work duty that were transported by other food service staff, then she continued to serve dinner biscuits with the same gloved hands. An observation on 4/23/25 at 12:30 p.m. of a dietary aid receiving the plated food from the cook to drop 3 warming covers into the floor. She picked them up with gloved hands and placed them to the side and continued to serve resident food trays without changing gloves after performing proper hand hygiene. During an interview, on 4/25/25 at 8:51 a.m., the Dietary Manager revealed she expected her staff to check all temperatures of the cold and hot units in the kitchen and document their findings. She stated she had been doing ongoing in-services with the staff on the checking of temperatures, but the staff just don't follow the policy. Her concerns included the risk of food born illness and the residents getting sick. She stated that all staff were expected to follow good hand hygiene during meal preparation and services to reduce the risk of cross contamination. During an interview, on 4/25/25 at 9:05 a.m. with the DON, stated he expected the dietary staff to follow the policy on checking storage temperatures and food temperatures and to document their findings. Failure to ensure temperatures were within the normal range could cause food born illness and residents to become ill. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview, on 4/25/25 at 9:09 a.m. with the Administrator he revealed he expected the dietary staff to follow safe food service policies to eliminate the risk of resident illness.