Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2026
NAME OF PROVIDER OR SUPPLIER Cherry Blossom Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3520 Kenneth Drive Macon, GA 31206	

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 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. Based on observations, staff interviews, and a review of the facility's policy titled, Storage Area, the facility failed to ensure food safety protocols and maintain sanitary conditions, specifically concerning the disposal of expired food. Additionally, food items opened in the walk-in refrigerator and dry storage area lacked proper labeling or dates. The deficient practices had the potential to place 54 residents who received an oral diet from the kitchen at risk of contracting a foodborne illness. Findings include:Review of facility's policy titled Storage Area reviewed dated 12/27/2025, revealed in Guideline items should be covered, sealed, labeled, and dated appropriately. Cleaning procedures should be a part of the routine cleaning schedules. First in first out (FIFO) should be followed. During the initial tour on 03/20/2026, at 7:43 am, the kitchen inspection revealed food in the dry storage area including one opened 4 lb. (pound) container of creamy peanut butter that was not labeled or dated and was improperly stored. Additionally, there was one opened 12 oz. (ounce) jar of grape jelly that also lacked labeling and dating, as well as one opened 25 lb. bag of brown rice that was similarly unlabeled and undated. Furthermore, two opened 32 oz. bags of light brown sugar were present, along with a 5 lb. cake mix that was missing both labeling and dating and was not stored correctly. The inspection also noted (16) 12 fl. (fluid) oz cans of evaporated milk, which had an expiration date of 12/13/2025. One box contained four 2 lb. bags of sweetened snowflakes coconut, with an expiration date of 06/4/2025. In addition, there was one 2 lb. package of sweetened snowflakes coconut that displayed multiple labels and dates, with the manufacturer's best by date marked as 02/24/2026.The walk-in refrigerator disclosed a serving pan identified by [NAME] FF as chicken gravy and opened turkey slice meat lacked proper labeling and dating. Additionally, there was a 0.58 lb. ham with an expiration date indicating it should be used by or frozen by 03/19/2026. A review of the emergency preparedness dry storage pantry revealed the Certified Dietary Manager (CDM) and Assistant Dietary Manager (ADM) oversaw the monitoring of food expiration dates; (24) 12 fl oz. of evaporate milk canned items was identified with an expiration date of 10/19/2025.On0 3/20/2026, at 10:53 AM, an observation revealed the presence of 57 ceiling tiles exhibiting a brown-orange residue, which varied in size and shape, located throughout the kitchen near the meal preparation area, dishwasher, and steam table. An interview with the CDM conducted on 3/20/2026 at 11:11 AM, the CDM explained that the stained ceiling tiles were not a result of any water issues, but rather due to a few food splatters. One splatter occurred while using the puree robot coupe with pasta sauce, and another was located near the prep station and the reach-in refrigerator resulting from pudding. DM noted that this concern had been raised several months prior.An interview with the Maintenance Director on 03/20/2026, at 11:21 AM revealed that he had recently been made aware of the ceiling tiles, as this information was not entered into TELS (maintenance order system) and was not categorized as a routine task to be performed. The Maintenance Director elaborated that the facility was experiencing some concerns regarding leaks, as condensation was evident on the tiles. However, following his recent review yesterday, he determined that these issues stem from the necessity of overhead cleaning.An interview on 03/21/2026 at 8:50 AM with [NAME] FF confirmed that the night shifts was responsible for the discovery of the open peanut butter and jelly, chicken gravy, and turkey slice meat. [NAME] (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	FF shared that upon her arrival for the morning shift, she frequently had to correct issues left from the night shift. [NAME] FF explained that she discarded the items because she was uncertain about how long the food items had been exposed and whether anything had contaminated them. [NAME] FF revealed the potential risks to residents from consuming unlabeled, undated, expired, or improperly stored items, which could lead to illness.An interview was held with CDM on 03/21/2026 at 8:58 AM concerning kitchen observation. She confirmed that there was previously a different labeling process, where the guideline was solely used to identify the expiration date. However, the current practice involved marking the received date and then using the manufacturer date, and if the manufacturer date was unavailable, they referred to the guideline date. The CDM confirmed that the items found opened, unlabeled, undated, and improperly stored originated from the night shift snack tray preparation. The CDM explained that the ADM typically checked the refrigerator and kitchen for expired items, labeling, and dating, but he was absent due to bereavement.An interview with the Registered Dietitian (RD) conducted on 03/21/2026 at 9:16 AM disclosed that she was present the previous week and noted similar issues concerning labeling, dating, and expired food products. The RD clarified that the food items observed in the kitchen, particularly the one with three labels and varying dates, expired and posed a risk of illness to the residents.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and the review of the facility policy titled, Abuse Prohibition, the facility failed to protect residents from verbal and physical abuse by a staff member for one of three sampled residents (R) (R10). The deficient practice placed R10 and other residents at risk for potential verbal and physical abuse by a staff member. Findings include:Review of the facility policy titled Abuse Prohibition documented INTENT-It is the intent of this center to actively preserve each patient's right to be free from mistreatment, neglect, abuse or misappropriation of patient property. We believe that each patient has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. The purpose of these identified procedures is to assure that we are doing all that is within our control to create a standard of intolerance and to prevent any occurrences of any form of mistreatment, neglect, abuse or misappropriation of any patient and/or their property. The procedures herein establish standards of practice for protection of patients and for identification and prevention of abuse. This policy applies to anyone subjecting a patient to abuse including, but not limited to, center staff, other patients, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals. GUIDELINE: Definitions: For purposes of this policy, the following definitions apply: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caregiver, of goods or services that are necessary to obtain or maintain physical, mental and psychological well-being. Instances of abuse of all patients, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. WILLFUL, as used in this definition of abuse means the individual must have acted deliberately, not the individual must have intended to inflict injury or harm.Review of the electronic medical record (EMR) revealed R10 was admitted on [DATE] with pertinent diagnoses including but not limited to: chronic respiratory failure with hypercapnia, hypertension, dementia, psychotic disturbance, mood disturbance, and anxiety.Review of R10's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicates R10 was cognitively intact. Section GG, functional status, revealed R10 uses a wheelchair. Section J. Health Conditions- No pain regimen and Section O. Special Treatments, Procedures, and Programs- Non-Invasive Mechanical Ventilator.Review of disciplinary action dated 11/14/2025 involving CNA CC revealed inappropriate resident interaction during care. The behavior was categorized as a conduct infraction. A final written warning was issued. The incident involved the CNA failing to disengage and seek assistance when the situation became confrontational. The nurse instructed the CNA to leave, but the CNA reˆentered the room and continued the confrontation. Interview on 03/20/2026 at 9:18 AM with R10 revealed that Certified Nursing Assistant (CNA) CC was nasty to her. R10 reported that during care, CNA CC was aggressive, balled her fist, and pushed it up against her private area, causing pain. R10 stated she did not want CNA CC to provide care. R10 reported that she wrote a letter describing her concerns and provided it to Wound Care Nurse BB. R10 gave her permission to follow up with the Administrator regarding her concerns.Interview on 03/20/2026 at 9:45 AM during the entrance conference it was revealed to the Administrator that R10 filed an abuse complaint against CNA CC and stated it had not been resolved. The Administrator stated this was his first time hearing about the incident and that he would follow up with the resident and proceed with an investigation.Interview on 03/21/2026 at 10:30 AM with R10 confirmed that CNA CC was very nasty, treated her poorly, and that she was scared of her. R10 stated she did not want CNA CC in her room anymore. R10 stated that during care she told CNA CC (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she was hurting her, but CNA CC continued to push her hand outward toward the resident's private area, causing pain. The resident asked her to stop, and she refused. R10 stated she provided a written letter to Wound Nurse BB. R10 stated she feels safe in the facility but does not want CNA CC to provide any care for her.Interview on 03/21/2026 at 10:40 AM with CNA EE revealed that she provided care to R10. She stated that approximately two weeks ago, R10 told her that CNA CC was being rough with her. CNA EE reported that R10 told her she had written a twoˆpage letter regarding the incident. When asked whether she reported the alleged abuse, CNA EE stated she did not. She explained that she did not think she needed to report it because R10 had already written a letter, and she assumed the issue would be addressed. CNA EE also identified R38 as another resident who stated that CNA CC was aggressive with him. CNA EE stated this is just CNA CC's style, describing her as very drill sergeant like when interacting with residents.Interview on 03/21/2026 at 11:29 AM with R38 revealed that CNA CC was nasty and that he had reported concerns to management in the past but did not know the outcome. R38 described CNA CC as bossy and like a drill sergeant. He stated he and CNA CC had verbal disagreements on multiple occasions. R38 stated he is able to advocate for himself and did not feel afraid during interactions with her.Interview on 03/21/2026 at 12:25 PM with Wound Nurse BB confirmed that R10 did not want CNA CC providing her Activities of Daily Living (ADL) care. She confirmed that R10 gave her a letter, but she did not read it or allow R10 to read it to her. She placed the letter in the Director of Nursing's (DON's) mailbox and believed that was sufficient for reporting the abuse. She confirmed that R38 also had concerns with CNA CC. She stated he said, Y'all need to get some better CNAs, because this girl right here. while gesturing toward CNA CC as she walked out of the room. She stated she asked him what he meant, but he did not elaborate. She stated he appeared focused on going to an activity and may not have wanted to miss it.Interview on 03/20/2026 at 12:45 PM with the Administrator and DON revealed the DON was not aware of any letter placed in her mailbox by Wound Nurse BB, nor was she aware of any abuse concerns involving R38. The Administrator reported that the first time he heard about the incident was when it was brought to his attention during the entrance conference yesterday.Interview on 03/21/2026 at 1:18 PM with CNA CC revealed she was assigned to R10 and had worked with her without issues but was later told that R10 requested she not work with her. She stated this request had been in place for over a month. She stated nurses continued to assign her to the resident at times despite the request. She stated she informed the nurse each time that the resident did not want her providing care. She stated she did not provide care to R10 alone after being told the resident refused her. She stated the ADON made room assignments and that CNA DD was present in the room with her.Interview on 03/21/2026 at 2:35 PM with CNA DD revealed R10 was a twoˆperson assist and someone would always be in the room with her. She reported receiving abuseˆprevention training upon hire and that CNA CC was the person who trained her. CNA DD did not recall any issues between CNA CC and R10 but was aware that R10 did not want CNA CC to provide care. She stated CNA CC assisted her one time with pulling the R10 up in bed because no other CNA was available.Interview on 03/22/2026 at 9:30 AM with the Assistant Director of Nursing (ADON), he confirmed that CNA CC worked with R10 on March 15, 2026. He reported that no one informed him that R10 did not want CNA CC providing care, and R10 did not tell him directly. He stated he heard it from another staff member. ADON stated he expected staff to ensure residentswere safe and treated with dignity and respect and to notify the Abuse Coordinator of any suspected abuse.Interview on 03/22/2026 at 1:40 PM with the DON revealed her expectation was that staff report any suspected abuse immediately to their supervisor, who would then report it to the Abuse Coordinator/Administrator. She confirmed that Wound Nurse BB should have followed up on the letter placed in her mailbox.interview on 3/22/2025 at 2:29 PM with the Administrator confirmed that his expectation was for staff to report abuse immediately.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of the facility policy titled, Abuse Prohibition Reporting and Investigating, the facility failed to report abuse for one of three residents (R10) reviewed for abuse. This deficient practice placed R10 and other facility residents at risk of potentially being abused by a staff member.Findings include:Revived of the policy titled Abuse Prohibition- Reporting and Investigating with a review date of [DATE] revealed: INTENT-It is the intent of this center to establish standards of practice for investigation and reporting of abuse, neglect, mistreatment, exploitation, and misappropriation of property. GUIDELINE-Reporting: -Any person hearing a complaint of abuse, corporal punishment, involuntary seclusion, neglect, mistreatment, misappropriation of patient property, or exploitation must immediately tell the Administrator, the Director of Nursing, the Social Services Director, any specific department leader, or the nurse in charge.-Any person identifying any signs and symptoms of abuse as listed in the Abuse Prohibition policy related to a specific patient is responsible to immediately inform the Administrator, the Director of Nursing, the Social Services Director, any specific department leader, or the nurse in charge.-It will be the responsibility of any department leader receiving the complaint of alleged abuse, corporal punishment, involuntary seclusion, neglect, mistreatment, misappropriation of patient property, or exploitation should inform the Administrator or designee immediately.-All allegations of abuse or allegations involving serious bodily injury must be reported immediately but no later than 2 hours.-Allegations that do not involve abuse or allegations with serious bodily injury must be reported immediately but no later than 24 hours. In addition:- The administrator or designee will take immediate action to prevent further potential occurrences while the alleged occurrence is being investigated.Review of the electronic medical record (EMR) revealed R10 was admitted on [DATE] with pertinent diagnoses including but not limited to: chronic respiratory failure with hypercapnia, hypertension, dementia, psychotic disturbance, mood disturbance, and anxiety.Review of R10's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicates R10 was cognitively intact. Section GG, functional status, revealed R10 uses a wheelchair. Section J. Health Conditions- No pain regimen and Section O. Special Treatments, Procedures, and Programs- Non-Invasive Mechanical Ventilator.Interview on [DATE] at 9:18 AM with R10 revealed that CNA CC was nasty to her. R10 reported that during care. R10 reported that she wrote a letter describing her concerns and provided it to Wound Care Nurse BB.Interview on [DATE] at 9:45 AM during the entrance conference it was revealed to the Administrator that R10 filed an abuse complaint against CNA CC and stated it had not been resolved. The Administrator stated this was his first time hearing about the incident and that he would follow up with the resident and proceed with an investigation.Interview on [DATE] at 12:45 PM with the Administrator and DON revealed the DON was not aware of any letter placed in her mailbox by Wound Nurse BB, nor was she aware of any abuse concerns involving R38. The Administrator reported that the first time he heard about the incident was when it was brought to his attention during the entrance conference yesterday.Interview on [DATE] at 1:40 PM with the DON revealed her expectation is that staff report any suspected abuse immediately to their supervisor, who will then report it to the Abuse Coordinator/Administrator.interview on [DATE] at 2:29 PM with Administrator confirmed that his expectation was for staff to report abuse immediately.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on staff interviews, record review, and review of the facility policy titled, Best Practices for PASRR, the facility failed to perform a Level II PASRR (Preadmission Screening and Resident Review) for evaluation and determination of specialized services for one of 14 sampled residents (R) (R5). This failure had the potential for residents with mental disorders not to receive identified specialized services.Findings include:A review of the facility policy titled Best Practices for PASRR, no date, revealed that all residents must be evaluated to determine their PASRR status. The Social Services Director (SSD) is responsible for maintaining an active, ongoing, and up-to-date list of PASRR patients. This list should indicate whether each resident requires services, and a Level 2 screening tool should be used to assess whether a resident qualifies for the PASRR population.A review of the electronic medical record (EMR) revealed that R5 had a history of anxiety disorder (11/29/2024), Major Depressive Disorder (1/19/2024), Post-Traumatic Stress Disorder (9/15/2023), and unspecified intellectual disabilities (9/13/2024).A review of the Minimum Data Set (MDS) OBRA Quarterly Assessment, dated 01/25/2026 revealed in Section C-Cognition, R5 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Section I-Diagnoses revealed diagnoses for anxiety disorder, depression, and PTSD. Section N-Medications revealed that R5 received an antipsychotic, antianxiety, and antidepressant medication.A review of the physician's orders indicated that R5 was prescribed Aricept 10 mg (milligrams) by mouth daily, Abilify 30 mg by mouth daily, buspirone 15 mg by mouth three times a day, and sertraline 150 mg by mouth daily.During an interview with the Social Services Director (SSD) on 3/21/2026 at 01:59 PM, she indicated that R5 was experiencing some psychological and behavioral issues. According to the SW, R5 was prescribed multiple psychiatric medications and received psychological services through the facility. The SSD noted that she had not applied for Level II PASRR for R5 because he had access to the necessary services. However, she acknowledged that an application should have been submitted for R5 and that it was an oversight.

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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. Based on observations, staff interviews, and review of the facility policy titled, Enhanced Barrier Precautions (Contact, Enhanced Barrier, Droplet, Airborne), the facility failed to use Personal Protection Equipment (PPE) for one of 41 sampled residents (R) (R4). The deficient practice had the potential to spread infection.Findings include:Review of the facility policy titled Enhanced Barrier Precautions (Contact, Enhanced Barrier, Droplet, Airborne) reviewed 12/27/2024, indicated under Implementing Contact Versus Enhanced Barrier Precautions: . EBP (enhanced barrier precautions) would be applied during care for residents with indwelling medical devices. A review of the physician's orders dated 01/21/2026 revealed R4 received tube feedings via the gastrostomy tube.During an observation of LPN AA, on 03/21/2026 at 9:41 AM, LPN AA entered R4's room to administer a tube feeding bolus (feeding method allows formula to flow directly into the stomach using a syringe or reusable squeeze pouch). R4 was sitting in his wheelchair. LPN AA washed her hands and put on gloves but did not don (put on) a gown. She lifted R4's shirt and took the tubing from inside his waistband. Using a stethoscope, she auscultated (listened to) R4's abdomen to check the proper placement of the tube. After confirming its placement, she attached a syringe to the tube to assess residuals (how much left in stomach). Once this was confirmed, she poured Isosource 1.5 into the syringe and began administering the feeding. When the Isosource did not enter the tubing, LPN AA applied pressure to various areas of R4's abdomen, near the stoma (entrance to stomach for feeding tube), to reposition the tubing and keep it patent; this occurred approximately three times. After the feeding was completed, LPN AA flushed the tube with 150 mL (milliliters) of water as per the physician's orders, again applying pressure to R4's abdomen. She then clamped the tubing, reinserted it into R4's waistband, and pulled his shirt down over it. At the end of the observation, the Assistant Director of Nursing (ADON) entered the room, holding a gown, and instructed LPN AA to put it on. LPN AA responded that she had already completed the tube feeding.During an interview with LPN AA on 03/21/2026 at 10:01 AM, she confirmed that the resident was under EBP. She acknowledged that she had handled the clothing of R4 and palpated the abdomen near the PEG (gastrostomy) tube site. LPN AA stated that she should have worn a gown before providing care and administering a tube feed bolus to R4.During an interview with the Assistant Director of Nursing (ADON) on 03/21/2026 at 10:04 AM, he stated that LPN AA should have worn a gown before administering a tube feeding and care to R4. He added that PPE was necessary because R4 was EBP due to his PEG tube.