STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115716	A. Building B. Wing	11/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Harbor at Green Island	200 Spring Harbor Drive Columbus, GA 31904

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35180 Based on record review, staff interview, and review of the facility's policy titled, Use of Psychotropic Medication, the facility failed to ensure a stop date was implemented, not to exceed 14 days, for psychotropic medications for three residents (R) (R1, R29, and R7) of six residents reviewed for unnecessary medications. Findings included: Review of the facility's policy titled Use of Psychotropic Medication, revised 1/1/2024, revealed that if the attending physician or prescribing practitioner believed that it was appropriate for PRN (as needed) order to be extended beyond the 14 days, he or she shall document their rationale in the resident's medication and indicate the duration for the PRN order. 1. Review of Physician Orders dated 9/23/2024 for R1 revealed an order for Valium 1 mg by mouth (PO) daily as needed (PRN) for anxiety. The order had no end date. Review of Note to Attending Physician/Prescriber dated 5/1/2024 revealed the pharmacist sent a note to the prescriber regarding R1's diazepam 2 mg PRN for anxiety; indicated the CMS limitation of PRN psychoactive medications. The note stated all PRN psychotropic medication orders, even for Hospice patients, had a 14-day limit. The physician indicated he agreed and changed the order to 180 days, however, the order was not changed. A review of the Medication Administration Record (MAR) revealed R1 was administered Valium 1 mg PO on 9/15/2024 at 7:14 pm, 9/20/2024 at 10:17 am, 10/1/2024 at 10:00 pm, 10/2/2024 at 9:15 pm, 10/3/2024 at 9:18 pm, 10/4/2024 at 9:41pm, 10/7/2024 at 8:25 pm, 10/8/2024 at 8:53 pm, 10/9/2024 at 8:12 pm, 10/10/2024 at 9:36 pm, 10/12/2024 at 8:51 pm, 10/13/2024 at 9:00 pm, 10/14/2024 at 9:30 am, 10/16/2024 at 7:29 pm, 10/17/2024 at 8:30 pm, 10/18/2024 at 7:50 pm, 10/19/2024 at 2:05 pm, 10/20/2024 at 9:09 am, 10/21/2024 at 7:20 pm, 10/22/2024 at 8:12 pm, 10/23/2024 at 8:00 am, 10/24/2024 at 5:42 pm, 10/27/2024 at 8:00 pm, 10/28/2024 at 9:34 am, 10/30/2024 at 7:30 pm, 10/31/2024 at 7:30 pm, 11/4/2024 at 8:00 pm, 11/5/2024 at 8:00 pm, 11/6/2024 at 8:10 pm, and 11/7/2024 at 7:30 pm. 2. Review of Physician Orders dated 9/16/2024 for R29 revealed an order for Xanax 1 mg by mouth (PO) every eight hours as needed for anxiety. The order had no end date. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Note to Attending Physician/Prescriber dated 10/3/2024 revealed the pharmacist sent a note to the prescriber regarding R29's alprazolam 1 mg PRN for anxiety; indicated the CMS limitation of PRN psychoactive medications. The note stated all PRN psychotropic medication orders, even for Hospice patients had a 14-day limit. The physician indicated other and did not make a change to the medication on the form. Review of the Medication Administration Record (MAR) revealed R29 was administered Xanax 1 mg PO on 9/19/2024 at 9:15 pm, 9/20/2024 at 2:15 pm, 9/25/2024 at 7:05 pm, 9/27/2024 at 6:52 pm, 9/28/2024 at 8:16 pm, and 9/30/2024 at 8:28 pm, 10/2/2024 at 8:23 pm, 10/3/2024 at 8:56 pm, 10/4/2024 at 9:35 pm, 10/7/2024 at 8:27 pm, 10/8/2024 at 8:28 pm, 10/9/2024 at 4:18 pm, 10/10/2024 at 8:17 pm. 10/11/24 at 7:29 pm. 10/12/2024 at 8:00 pm, 10/13/2024 at 3:30 pm, 10/14/2024 at 10:09 pm, 10/15/2024 at 9:37 pm. 10/16/2024 at 8:00 pm, 10/17/2024 at 8:00 pm, 10/18/2024 at 8:54 pm, 10/20/2024 at 5:06 pm, 10/21/2024 at 8:36 pm, 10/22/2024 at 11:13 pm, 10/24/2024 at 5:00 pm, 10/26/2024 at 8:42 pm, 10/27/2024 at 8:00 pm, 10/28/2024 at 8:37 pm, 10/29/2024 at 8:00 pm, 10/30/2024 at 8:00 pm, 10/31/2024 at 8:00 pm, 11/4/2024 at 7:27 pm, 11/5/2024 at 8:00 pm, 11/6/2024 at 8:00 pm, and 11/7/2024 at 8:00 pm. 35062 3. Review of Physician Orders dated 8/18/2024 for R7 revealed an order for Xanax 0.5 mg by mouth twice per day as needed for anxiety disorder due to known physiological condition. The order had no end date, and no duration indicated. Review of Note to Attending Physician/Prescriber dated 10/15/2024 revealed the pharmacist sent a note to the prescriber regarding R7's Xanax 0.5 mg PRN for anxiety. The note documented all PRN psychotropic medication orders, even for Hospice patients, had a 14-day limit. The physician indicated he agreed and changed the order to 120 days, however, the order was not changed and indicated no new orders. A review of the MAR revealed R7 was administered Xanax 0.5 mg by mouth PRN on 8/12/2024, 8/14/2024, 8/15/2024, 8/18/2024, 8/21/2024, 8/23/2024, 8/25/2024, 8/27/2024, 8/29/2024, 8/30/2024, 9/1/2024, 9/2/2024, 9/6/2024, 9/9/2024, 9/10/2024, 9/13/2024, 9/15/2024, 9/17/2024, 9/19/2024, 9/23/2024, 9/25/2024, 9/26/2024, 9/29/2024, 9/30/2024, 10/1/2024, 10/2/2024, 10/3/2024, 10/4/2024, 10/7/2024, 10/8/2024, and 10/10/2024. Interview with the Director of Nursing (DON) on 11/9/2024 at 9:00 am revealed that all psychotropic medications were supposed to have a 14-day stop date. If the medical doctor (MD) determined there was a clinical rationale to extend the medication beyond 14 days, the MD would write a progress note noting the clinical indication, and the note would be added to the resident's chart. Per the DON, she or the unit manager would add the indicated duration date to the orders and the MAR. The DON acknowledged there was no stop date for R1's, R29's, and R7's psychotropic medications.

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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. 35180 Based on observations, interviews, and review of the facility's policy titled, Labeling Food Product, the facility failed to ensure that opened food items were labeled, dated, and secured from open air. The deficient practice had the potential to affect 34 residents who received an oral diet and were served food from the kitchen. Findings included: Review of the facility policy, Labeling Food Product, revised 1/3/2024, revealed that all prepared foods, leftovers and opened products stored for later use would be labeled according to food safety standards along with local and state regulations. All labels would contain the complete name of the product, the date the product was prepared or opened, and the date the product must be utilized by. Observation on 11/8/2024 at 8:16 am of the stand-alone freezer revealed the following: One box of [brand name] pork patties not secured, and the food was open to the air; one box of [brand name] pork links not secured and open to the air. Observation on 11/8/2024 at 8:20 am of the walk-in refrigerator revealed the following: One cinnamon spice cake opened and not labeled or dated; two boxes of chicken tenders open to the air and not labeled or dated; one open tray of tres leches cake covered in clear plastic wrap not labeled or dated. Observation on 11/8/2024 at 8:25 am of the walk-in freezer revealed the following: One package of bratwurst was opened, unlabeled, and undated; one box of [brand name] pork chops was opened and not labeled or dated; one clear plastic bag of grit balls was opened and not labeled or dated; one clear plastic bag of tortellini was opened and not labeled; one large plastic bag of pepperoni was opened and not labeled; one 9 round cheesecake covered in plastic wrap was not labeled or dated; one plastic bag of green beans was opened and not labeled or dated; one bag of battered okra was opened and not labeled or dated; and one bag of wheat rolls was opened and not labeled or dated. Observation on 11/8/2024 at 8:31 am of the stand-alone freezer in the main kitchen revealed the following: One clear plastic bag of French fries was opened and not labeled or dated; one clear plastic bag of broccoli was opened and not labeled or dated; one clear plastic bag of okra was opened and not labeled and dated; one clear plastic bag of hashbrown patties was opened and not labeled or dated; and one clear plastic bag of grit balls was opened and not labeled or dated. Observation on 11/8/2024 at 8:34 am of the stand-alone refrigerator on the front line revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	One bag of [brand name] Bread was opened and not labeled or dated; opened salmon dip covered in clear plastic wrap was not labeled or dated; and one small pan of chutney covered in a clear plastic wrap was not labeled or dated. Interview on 11/8/2024 at 8:40 am, with the Executive Chef (EC) revealed that dietary staff were supposed to label and date all opened and prepared food items stored in the refrigerators and freezers. Interview on 11/8/2024 at 10:43 am the Dietary Manager (DM) revealed that he expected dietary staff to ensure all items stored in the freezers and refrigerators were covered and secured from the open air. Additionally, he said all staff was supposed to make sure all prepared and opened foods stored in the freezers and refrigerators were labeled and dated.

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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. 38997 Based on observations, staff interviews, and review of the facility's policy titled, Glucometer Disinfection, the facility failed to ensure proper infection control measures were followed for cleaning and disinfecting a glucometer (a device used to measure blood glucose) on one of one resident (R) (25) reviewed during a glucometer test. In addition, the nurse did not use a barrier before placing the glucometer on the surface of the medication cart. The deficient practices placed residents at risk of potential exposure to infections due to cross-contamination. Findings included: Review of the facility policy titled Glucometer Disinfection dated 9/28/2010 indicated Procedures: Disinfecting Instructions: To disinfect, use a germicidal disposable cloth to remove heavy soil, unfold a second clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full two minutes. Use additional wipes if needed to assure continuous two minutes. Use additional wipes if needed to assure continuous two minutes wet contact time. Let air dry. Glucometer must be disinfected before and after each using new wipes every time. Observation on 11/9/2024 at 12:05 pm of Licensed Practical Nurse (LPN) AA perform a blood sugar check and glucometer reading on R25. The LPN removed the glucometer from the medication cart and placed the glucometer on top of the medication cart without a barrier. The LPN gathered additional supplies and carried the supplies to the resident's room. After obtaining the residents blood sugar the LPN exited the room and placed the glucometer on the top of the medication cart without a barrier. The LPN wipe the glucometer with one alcohol pad and placed the glucometer in the top drawer of the medication cart. The LPN stated that is how the glucometer was cleaned after each use. Interview on 11/9/2024 at 12:10 pm the Director of Nursing Service (DNS) revealed the glucometer device should be cleaned with a germicidal disposable wipe. She also revealed a barrier must be used when placing the glucometer and supplies on any surface. The DNS revealed she would start educating staff on the proper way to disinfect the glucometer and use a barrier. Interview on 11/9/2024 at 2:35 pm the DNS revealed that the facility had five residents with a physician order for blood sugar reading. She revealed R25 had an order for a fingerstick blood sugar check. Four of the residents' blood sugar was obtained by using the continuous glucose monitor system (a wearable device that tracks blood sugar levels in real time). She revealed if the readings appeared to be inaccurate, or the sensor was not scanning, the alternative was to use the glucometer device to obtain the residents blood sugar.