STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425095	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peachtree Centre	1434 N Limestone St Gaffney, SC 29340

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, document review and record review, the facility failed to ensure that the planned menu was followed to meet the nutritional needs of five of five residents (R)2, R151, R108, R168, and R37) reviewed for nutrition. Specifically, the Dietary Aide (DA)2 served smaller portions to R2, R151, R108, R168 and R37 than the portion size the menu indicated. In addition, the residents on one of four floors (third floor) were served a different vegetable that what was indicated on the menu.Findings include:Review of the facility's menu titled Optima Solutions Ahava 2026 s/s Menus Week:1 revealed the baked chicken portion size should be three ounces. 1.Review of R2' electronic medical record (EMR) admission Record located under the Profile tab revealed R2 was admitted on [DATE] with diagnoses of paraplegia, stage IV pressure ulcer, and malnutrition. Review of R2's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/26/26 indicated a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated R2' cognition was moderately impaired. Review of R2' Nutrition/Dietary Note dated 4/21/26 in the EMR under the –Progress Note tab revealed R2 had a history of significant weight loss and multiple wounds. The Registered Dietitian (RD) noted that weight gain was beneficial until multiple wounds are healed and adjusted supplements (Med Pass and fortified juice) to improve intake.During an interview on 04/29/26 at 9:46 AM, R2 stated he did not get enough food and that he only received a chicken leg portion for the lunch meal yesterday. During an interview on 05/01/26 at 2:29 PM, the Registered Dietitian (RD) confirmed R2 was ordered to have a regular diet with double portions at all meals due to significant weight loss and high protein needs for wound healing. The RD stated, I would have been hungry too if I only received one chicken leg for lunch. 2. During an interview and observation on 04/28/26 at 12:45 PM, R151's lunch plate had one chicken leg. Her meal ticket read Diet: regular texture, regular liquids. R151 stated she was still hungry. At the time of the observation, Licensed Practical Nurse 1/Unit Manager (LPN1/UM) validated R151 received only one small chicken leg, while other residents at her table received chicken breasts. During an interview on 05/01/26 at 2:34 PM, the RD stated one small chicken leg was not an adequate portion of protein. The RD stated that R151 should get three ounces of protein, which would be a thigh and leg. There was not enough protein in only a wing or a leg. Depending on the size of the chicken leg, residents should have gotten two chicken legs. (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During an interview and observation on 04/28/26 at 12:47 PM, R108's lunch plate had one chicken wing. Her diet ticket read, Diet Regular low concentrated sweets/no added salt (LCS/NAS). R108 stated that he was still hungry. During an interview on 05/01/26 at 2:41 PM, the RD stated that one chicken wing did not meet her nutritional needs. There was no resident in the building on a small portion diet. 4. During an interview and observation on 04/28/26 at 12:49 PM, R168's lunch plate had one chicken thigh. Her diet ticket read Diet- regular low concentrated sweets. R168 stated that she was still hungry. During an interview on 05/01/26 at 2:42 PM, the RD stated [R168] was on a low concentrated sweet, regular texture diet, with no supplements. She was not on a small portion diet. 5. During an interview and observation on 04/28/26 at 12:52 PM, R37's lunch plate had one small chicken leg. Her diet ticket read Diet regular texture, regular liquids. At the time of the observation, R37 stated that she was still hungry. During an interview on 04/28/26 at 1:06 PM, with DA2, who had served during the lunch meal the chicken to R2, R151, R108, and R168, stated for portion sizes, I know my residents. If I give them a big piece, they aren't going to eat it., I give them a smaller piece instead and they will eat it. During an interview on 05/01/26 at 9:15 AM, the Dietary Manager (DM) stated, we do not serve the same portion size for each person when serving chicken. I can't control that some people get a breast and some only receive a wing or a thigh. All other portions I can control, but not chicken portions. 6. Review of a document provided by the facility titled Optima Solutions.Menus.Week 1. indicated the menu for the lunch meal included: chicken with lemon and pepper, fluffy steamed rice, peas and carrots, dinner roll, fruited Jello, and margarine. Review of a document provided by the facility without a titled and date indicated a Main Course and Alternate which was referred to as an alternate menu items failed to contain information on the substitutions that were to be posted on 04/28/26. During an observation on 04/28/26 at 12:13 PM, the steam table on the third floor, residents were served corn instead of peas and carrots. The menu for the week was posted and did not indicate alternative menu items. During an interview on 05/01/26 at 9:18 AM, the DM stated that kitchen staff were to post the alternates for menu items, so the residents were aware of the substitution.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, document review and policy review, the facility failed to ensure personal protective equipment (PPE) was available for laundry staff in one of one laundry rooms to use while sorting soiled resident clothing and bed linens. This failure had the potential to infect the staff and/or all residents with pathogens which could potentially lead to the development of infectious diseases.Findings include: Review of an undated document by the American Healthcare Association indicated, . Use Personal Protective Equipment (PPE) when handling linens.To protect all staff including nursing and housekeeping from contaminants during laundry operations, they must use PPE.Wear tear-resistant gloves when handling and laundering soiled linens. If there is risk of splashing (e.g., if laundry is washed by hand) when laundering soiled linens, staff should in addition to gowns and gloves always wear face protection (e.g., face shield, goggles) . Review of a facility's policy titled Laundry undated indicated .The facility launders and clothing in accordance with current CDC [Centers for Disease Control] guidelines to prevent transmission of pathogens .The facility's laundry area will provide .PPE Interview and observation of the facility's laundry room on 05/01/26 at 9:09 AM, Laundry Aide (LA)1 stated that she did not have access to PPE (gowns and industrial strength gauntlet gloves) when handling soiled facility linens and residents' clothing. LA1 stated she only had access to disposable gloves. During this interview, the Infection Preventionist (IP) stated she did not come to the laundry room area very often. LA1 walked into the soiled laundry shoot area and again there was no PPE available. LA1 and the IP verified this. During an interview on 05/01/26 at 9:33 AM, the Director of Nursing (DON) stated her expectations were for the laundry staff to have access to PPE to prevent cross contamination.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and policy review, the facility failed to maintain a safe, clean, comfortable, and homelike environment on two of the four floors (first and third floors). Specifically, the floor in the dining/activity area and hallways on the third floor were observed to be sticky. Additionally, four tables on the third-floor dining/activity area were chipped and exposed the wood underneath. The sticky floor posed a potential risk for residents who ambulate, as it could contribute to loss of balance of falls. The chipped condition of the tables had the potential to create an infection control issue. Findings include:Review of the facility's undated policy titled Safe and Homelike Environment indicated, .In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment.The facility will create and maintain, to the extent possible, a homelike environment that de-emphasizes the institutional character of the setting.Report any furniture in disrepair to Maintenance promptly.Report any unresolved environmental concerns to the Administrator. 1. During an observation on 04/28/26 at 12:13 PM, staff were passing out meals for the residents present in the dining/activity area on the third floor. The staff present had their shoes sticking to the floor which also made squeaking sounds. During an observation on 04/29/26 at 6:55 AM, the main dining/activity area, on the third floor, had four dining tables pushed together. Each table had heavy chipping of the paint. The floor was sticky and made a squeaky sound. During an observation on 04/29/26 at 8:02 AM, there were multiple staff present and as each staff member walked this area, their shoes would get stuck on the floor, in the dining/activity area of the third floor. 2. Observation on 04/28/26 at 10:00 AM and 12:15 PM; on 04/29/26 at 8:00 AM; 04/30/26 at 9:15 AM; on 05/01/26 at 9:40 AM and 1:40 PM, revealed the first-floor hallways, dining room, and activity room floors were sticky and squeaked when staff and residents walked on the floors. During an interview on 04/29/26 at 8:39 AM, the Housekeeping Supervisor (HS) stated that she spoke with the chemical company's Sales Representative last week regarding the condition of the floor on the third floor. The HS stated that the sticky floors have been an on-going issue and the facility was aware of this issue. During an interview on 04/30/26 at 2:59 PM, the Licensed Practical Nurse/Unit Manager (LPN3/UM) said she did not know why the floors were sticky. During an interview on 04/29/26 at 8:53 AM, the Sales Representative stated that he was unaware that the floors were sticky and no one from the facility contacted him in an attempt to get the sticky floor issue resolved. During an interview on 04/29/26 at 8:58 AM, the Administrator stated that they had an older machine to clean the floors. The Administrator stated she contacted the chemical vender in the last few months and would look for the work orders. The Administrator did not provide any work orders prior to survey exit. During an observation on 04/29/26 at 11:48 AM, staff were entering the third-floor dining/activity area, and the staff present had their shoes making sticky/squeaking sounds.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to develop person-centered, comprehensive care plans with measurable goals and interventions for two residents (Resident (R) 110 and R73) of two residents reviewed for care plans out of a sample of 54 residents. Specifically, the failure placed R110 at risk for unmet nutritional needs and for R73's unmet mental health treatment needs. These failures placed the residents at risk for unmet care needs, and the inability meet their maximum practicable level of functioning. Findings include:Findings include: Review of the facility's undated Comprehensive Care Plans policy, provided by the DON, noted It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 1. Review of R110's electronic medical record (EMR) admission Record located under the Profile tab indicated that the facility admitted the resident on 02/15/22 with a diagnosis of a vitamin deficiency. Review of a document titled Care Plan dated 02/16/22 provided by the facility indicated that the resident was at nutritional risk due to a vitamin deficiency, gastroesophageal reflux, and hyperlipidemia. The care plan failed to address that the resident had a recent significant weight loss with registered dietitian (RD) recommendations. Review of R110's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/02/26 located in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of six out of 15 which revealed the resident was severely cognitively impaired. The MDS indicated that the resident did not sustain a significant weight loss/gain. Under the Care Area Assessment (CAA) indicated that the resident triggered nutrition and directed the clinical staff to develop a care plan. Review of R110's EMR Nutrition/Dietary Note located under the Prog (Progress) notes dated 02/02/26 indicated the resident was identified with a significant weight loss from 118 to 98 pounds. The Nutrition/Dietary Note indicated that the resident was on a regular diet and would eat 26 to 50 percent of her meals and would snack throughout the day. The note indicated that the resident was provided with a nutritional treat at each lunch and dinner meal. The goal was to halt weight loss with a secondary goal to regain some weight. The note indicated that staff were to continue to monitor the resident's weight along with monitoring her meal and fluid intake. During an interview conducted on 04/30/26 at 10:37 AM, the MDS Coordinator (MDSC)2 stated that the Registered Dietician (RD) does not create the care plans for the residents who were at risk of weight loss. R110's care plan dated 02/16/22 was reviewed during this interview. The MDSC2 stated the resident typically will eat her dessert instead of the main meal and she needs lots of encouragement. MDSC2 stated none of the current recommendations were present in the resident's nutritional care plan. 2.Review of R73's admission Record located under the Profile tab in the EMR revealed the resident was admitted on [DATE] with diagnoses that included anxiety disorder; bipolar disorder, current (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	episode depressed, severe, without psychotic features. Review of R73's quarterly MDS assessment, with an ARD of 02/18/26 and located under the MDS tab in the EMR with a BIMS score of 12 out of 15 which indicated R73's had moderate cognitive impairment. Review of R73's EMR Orders under the Orders tab revealed Topiramate 25 milligram (mg) (an anti-convulsant medication, used off label to treat binge eating), ordered 12/04/25. Review of R73's Care Plan dated 07/28/25 and located in the Care Plan tab of the EMR did not address the behavior of gorging on food and the use of the medication Topiramate as a treatment for the behavior. During an interview on 04/30/26 at 3:00 PM, the Licensed Practical Nurse/Unit Manager (LPN1/UM) stated that R73 had significant issues with gorging on food and drinking four or more energy drinks in a day. LPN1/UM confirmed that R73's behavior of gorging on food had not been entered on the care plan with specific interventions. During an interview on 05/01/26 at 12:31 PM, the Director of Nursing (DON) stated that her expectation for the development of a resident's care plan was to direct the staff on how to provide care to a resident. The DON stated that R110's care plan should have been updated and more individualized to address the resident being at risk for weight loss. During an interview on 05/01/26 at 2:52 PM, the DON stated that we should have had R73's specific behaviors and interventions identified on the care plan.

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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** Based on observation, interview, and record review, the facility failed to ensure that a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain good grooming. Specifically, the facility failed to provide nail care for one of one resident (R)109) in the sample of 54 residents who was observed with long, dirty fingernails. This deficient practice has the potential to affect the resident's quality of life Findings include: Review of R109's electronic medical record (EMR) admission Record under the Profile tab revealed resident was admitted on [DATE] and readmitted on [DATE] with diagnoses of cerebrovascular disease and diabetes mellitus. Review of the Medicare 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/05/26 with a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated R109's cognition was moderately impaired. The MDS indicated that R109 required the assistance of another person to complete ADLs. Review of R109's care plan in the EMR under the Care Plan tab revealed that R109 required maximum assistance of one for personal hygiene due to a stroke and right hip fracture dated 01/02/26. On 04/28/26 at 1:15 PM, R109 was observed to have long fingernails on both hands with visible dark substance underneath. On 05/01/26 at 10:31 AM, the resident was observed in bed with long fingernails. Interview at the time of this observation, revealed R109 stated that he wanted his finger nails cut. During an interview on 05/01/26 at 11:03 AM, Licensed Practical Nurse/Unit 4 Mgr. (LPN8/UM) validated that the resident's nails were approximately 0.5 inches long on both hands. LPN8/UM stated that because the resident was diabetic, a nurse must perform nail care on shower days. During an interview on 05/01/26 at 11:06 AM, Certified Nurse Aide (CNA)7 stated that R109 does not refuse care and that his shower days are Tuesdays and Fridays. During an interview on 05/01/26 at 11:32 AM, the Director of Nursing (DON) stated her expectation was that nails should be cut on shower days or whenever needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to ensure one out seven residents (Resident (R) 46) out of a survey sample 54, by failing to cover a heavily scraped painted wall by R46's bed, who had a history of putting non-food items in her mouth. The resident had the potential for choking, gastrointestinal issues, and toxic exposure.Findings include:Review of a facility policy titled Accidents and Supervision undated indicated . The resident environment remains as free of accident hazards as is possible; and each resident receives supervision and assistive devices to prevent accidents. The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. Review of R46's electronic medical record (EMR) admission Record located under the Profile tab indicated that the facility admitted the resident on 03/14/25 with a diagnosis of late onset of Alzheimer's disease. Review of a document provided by the facility for R46 titled Care Plan dated 06/11/25 indicated that the resident had a history of intentionally placing non-food items in her mouth such as blankets, socks, and clothing. Review of a document provided by the facility titled Safety Data Sheet 06/16/22 indicated . PRO[DATE] Zero VOC Interior Latex Flat.Liquid. Was to be kept out of reach of children. Review of R46's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/25 located under the MDS tab indicated that the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated that the resident had no impairments of her bi-lateral extremities. During an interview conducted on 04/28/26 at 1:59 PM, Certified Nurse Aide (CNA)2 and CNA3 entered R46's room and when asked about the large, scratched wall (which exposed the dry wall under the blue paint) at the head of the resident's bed, both staff stated that the resident would peel and then eat the paint off the wall. Both CNA2 and CNA3 stated that they have reported this to the nurses on the floor. During an interview on 04/28/26 at 2:22 PM, Licensed Practical Nurse (LPN)4 stated she was not aware that R46 did peel and eat the paint off the wall in her room. LPN4 stated that the CNA staff have not reported this to her. During an interview on 04/28/26 at 2:27 PM, LPN5 stated she was not aware that R46 peeled and ate the paint off the wall in her room. LPN5 stated that the resident had a history of placing all sorts of items in her mouth and would chew on anything, such as the socks off her feet. During an interview conducted on 04/28/26 at 2:28 PM LPN1 who was also a Unit Manager (LPN1/UM) stated that she was aware that R46 would peel the paint off the wall in her room but was unaware that the resident would eat the paint. During an interview conducted on 04/28/26 at 2:38 PM, LPN4 stated that she had heard R46 would peel the paint off the wall in her room and stated that the resident did place items in her mouth. LPN4 stated that the staff keep the resident on the outside of her room to keep an eye on her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 04/29/26 at 6:18 AM, CNA1 stated that she was aware that R46 would peel and eat the paint off of her wall in her room. CNA1 entered the resident's room and there was now a plexiglass cover over the heavily peeled area located on the wall close to the resident's head of her bed. CNA1 stated that this cover must have been recently placed there since she had not seen it on previous occasions. During an interview conducted on 04/29/26 at 7:37 AM, the Maintenance Director stated he was asked to place the plexiglass cover over the peeled paint area on R46's wall yesterday. The Maintenance Director stated no one had mentioned this area of disrepair prior to 04/28/26. During an interview conducted on 04/29/26 at 10:43 AM, the Clinical Consultant, Director of Nursing (DON), and the Administrator all stated that they were unaware of R46's behavior of peeling and then eating the paint. The Clinical Consultant stated that R46 does have a history of placing non-food items in her mouth. The Administrator stated that there was a current system in place for staff to reports environmental issues and this was not done.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews and policy review, the facility failed to ensure a medication error rate of less than five percent (5%). Two errors out of a total of 28 opportunities for error related to two (Residents (R) 18 and R82) of six residents observed during medication administration, resulting in a medication error rate of 7.14%. The facility's failure to ensure a medication error rate of less than five percent created the potential for residents to experience negative physical and/or psychosocial effects related to medication errors. Findings include: Review of the facility's undated policy titled, Medication Administration indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.Administer medications as ordered and in accordance with manufacturer's specifications. b. Provide appropriate amount of fluid. Review of R18's admission Record dated 05/01/26 in the Electronic Medical Record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of dementia, congestive heart failure (CHF) and protein-calorie malnutrition. Review of R18's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/25/26 in the EMR under the MDS tab with a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated the resident was severely cognitively impaired. Review of R18's Physician's Order Set dated 04/29/26 in the EMR under the Orders tab revealed an order with an original order date of 04/29/26, for the resident to receive Enteric Coated Aspirin 81 milligrams (MG) daily for CHF. R18 was observed receiving his medication from Licensed Practical Nurse (LPN)7 on 04/30/26 at 9:32 AM. LPN7 administered chewable aspirin 81 MG to the resident instead of the ordered enteric coated aspirin. During an interview with LPN7 on 04/30/26 at 10:29 AM, she confirmed she was aware of the difference between chewable and Enteric Coated aspirin and stated she missed the designation for enteric coated on the resident's Medication Administration Record (MAR). Review of R82's admission Record dated 05/01/26 in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of left radius (arm) fracture, bipolar disorder and malnutrition. Review of R82's admission MDS with an ARD of 04/11/26 in the EMR under the MDS tab revealed a BIMS score of 10 out of 15, which indicated the resident was moderately cognitively impaired. Review of R82's Physician's Order Set dated 04/30/26 in the EMR under the Orders tab revealed an order with an original order date of 04/02/26, for the resident to receive Miralax (a stool softener) 17 grams mixed in 4 – 6 ounces of fluid one time per day every other day. R82 was observed receiving his medication from Registered (RN)3 on 04/29/26 at 8:42 AM. The resident's Miralax powder was poured into a five-ounce cup, and two to three ounces of water was then added to the cup to mix the Miralax. RN3 then administered the Miralax to R82. No additional fluid (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425095	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peachtree Centre	1434 N Limestone St Gaffney, SC 29340

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was provided during the medication pass. During an interview with RN3 on 04/29/26 at 8:59 AM, she stated she thought Miralax needed to be mixed with eight ounces of water. She stated she thought the cup used to add fluid and mix the medication for administration held eight ounces of water. During an interview with Licensed Practical Nurse/Unit Manager (LPN8/UM) on 04/29/26 at 9:11 AM, she stated Miralax needed to be given in at least four ounces of fluid and confirmed the cups available on the medication carts were not big enough to accommodate that much liquid. She stated larger cups were available in the facility. During an interview with the Director of Nursing (DON) on 05/01/26 at 12:30 PM, she confirmed her expectation was correct medication, correct dose and correct route should be verified prior to administration and Miralax, we expect to be administered in at least four to six ounces of water to ensure effectiveness of the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425095	A. Building B. Wing	05/01/2026

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to store and dispense food and ice under sanitary conditions for one of four nourishments rooms (second-floor nourishment room). This failure had the potential to cause residents' food borne illness. Findings include: Observation on 04/28/26 at 11:29 AM revealed an ice scoop was stored directly inside the ice chest, in the second-floor nourishment room. Certified Nursing Assistant (CNA)9 validated the observation at 11:30 AM, stating the scoop was not supposed to be stored inside the chest. Observation on 04/28/26 at 11:33 AM revealed inside the second-floor nourishment room refrigerator, was a broken thermometer. The refrigerator contained several expired and unlabeled items, including a plastic-wrapped salad dated 04/15/26, one opened carton of 2% milk, and a water bottle containing an unidentified milky white substance with no name, label, or date. Further inspection revealed an egg carton with four eggs remaining that had a best by date of [DATE], and a box of renal supplement with a use by date of 02/18/26. The second shelf of the refrigerator was covered in red, blue, and white food debris. The door to the refrigerator was observed to be gouged. Observation and interview on 05/01/26 at 11:47 AM, Licensed Practical Nurse (LPN)9 used the broken thermometer and stated the temperature of the refrigerator was 48 degrees Fahrenheit (F). LPN9 noted that the thermometer was broken. LPN9 stated that the eggs should be thrown away because residents could get food poisoning. The Licensed Practical Nurse 1/Unit Manager (LPN1/UM) stated at this time that it was dietary's job to clean the bottom of the fridge. During an interview on 04/28/26 at 12:35 PM, the Dietary Manager stated the fridge door shelf was gouged and could cause cross contamination; the ice scoop should not be stored inside the machine; food should be labeled and dated and thrown out after three days.