STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115294	A. Building B. Wing	09/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stevens Park Health and Rehabilitation	820 Stevens Creek Road Augusta, GA 30907

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 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. Based on medical record review, staff interviews, and review of the facility policy titled Patient's Plan of Care, the facility failed to develop a comprehensive, person-centered care plan for diuretic use for one resident (R21) of 23 residents receiving a diuretic. This deficient practice had the potential to place R21 at increased risk of medical complications and a diminished quality of life. Findings included:Review of the facility policy titled Patient's Plan of Care, reviewed 12/27/2024, revealed that each resident should have a comprehensive, person-centered care plan designed to address their medical, physical, mental, and psychosocial needs. A further review revealed that the resident's care plan was to be updated as clinical assessments changed over time.Review of the Quarterly Minimum Data Set (MDS) assessment for R21, dated 7/8/2025, revealed Section N (Medications) documented the resident received a diuretic in the seven-day lookback period.Review of R21's care plan revealed that no care plan had been developed for the resident's use of diuretics.Review of the physician's orders for R21, revealed an order dated 12/23/2024 for furosemide 20 milligrams (mg) [a diuretic medication] to be taken orally once per day.During an interview with the Minimum Data Set (MDS) Coordinator on 9/13/2025 at 2:56 pm, she explained that she was responsible for updating and developing resident care plans based on their diagnoses, changes in care, and MDS assessments. She acknowledged that a care plan had not been developed for R21's use of diuretics, attributing this to an oversight.During an interview with the Director of Nursing (DON) on 9/13/2025 at 3:10 pm, she stated that she expected the MDS Coordinator to develop and update care plans for every resident in the facility.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, review of the manufacturer's guidelines, and review of the facility policy titled Cleaning and Sanitizing, the facility failed to store stacked pans free from wet nesting to prevent bacteria, and failed to properly demonstrate the usage of the three-compartment sink to prevent foodborne illness. The facility census was 40, and all residents were receiving an oral diet.Findings include: Review of the facility policy titled Cleaning and Sanitizing revealed that all smallware equipment should be stored in a self-draining position that allows it to air dry.Review of the facility policy titled Cleaning and Sanitizing revealed that the manufacturer's guidelines for the three-compartment sink should be followed. Items should be fully submerged in the sanitizer solution per manufacturer guidelines.Review of Product Specification Document for Multi Quat Sanitizer revealed expose all surfaces to the sanitizing solution for a period of not less than 1 minute. Allow equipment to drain thoroughly and air dry.1. Observation on 9/12/2025 at 8:10 am of the dish room revealed a store rack with stacks of steam table pans. A stack of three small square steam table pans was pulled apart, and the inside of the top and middle pans had moisture.During an interview on 9/12/2025 at 8:47 am, the Certified Dietary Manager (CDM) verified that the inside of the two small steam pans were stacked and stored with moisture inside. The CDM revealed that she expects dietary staff to stack and store pans after they are dry inside. 2. Observation on 9/13/2025 at 11:50 am of Dietary [NAME] AA using the three-compartment sink to wash and sanitize the food processor bowl and lid revealed he washed the dishware items with soapy water. Dietary [NAME] AA then rinsed the items with water, placed the food processor bowl in the sanitizing solution for four seconds, placed it on the drying rack, placed the food processor lid in the sanitizing solution for two seconds, then placed it on the drying rack. Continued observation revealed that Dietary [NAME] AA re-washed and sanitized the food processor bowl and lid, and placed it on a drying rack. Dietary [NAME] AA then took three pieces of paper towel and dried the inside of the food processor bowl and lid. Further observation revealed that the facility was using a quaternary sanitizing chemical for sanitizing in the three-compartment sink. There was a poster hung on the wall above the three-compartment sink that stated, towel free zone, air dry only, no wet nesting.During an interview on 9/13/2025 at 11:50 am, Dietary [NAME] AA confirmed that the food processor bowl and lid were not placed in the sanitizing solution for one minute. Dietary [NAME] AA revealed that he did not have the dishware in the sanitary solution for one minute because he forgot. The dietary cook also confirmed that he dried the dishware items with a paper towel to speed up the drying process. Dietary Aide AA confirmed that there were posters around the three-compartment sink to provide guidance on the proper procedure, and he did not follow them.During an interview on 9/13/2025 at 11:55 am, the CDM revealed that she expected dietary staff to follow proper procedure when washing dishware in the three-compartment sink and expected staff to place dishware in sanitizing solution for at least one minute. Continued interview with the CDM revealed that dietary staff should air-dry dishware sanitized in the three-compartment sink and not use paper towels to dry.