STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER: Harborview Tifton		STREET ADDRESS, CITY, STATE, ZIP CODE: 1451 Newton Drive Tifton, GA 31794	

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 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. Based on record review, staff interviews, and facility policy review, the facility failed to ensure residents were free of verbal and physical abuse for two of two residents (R) (R13 and R 45) reviewed for resident-to-resident altercations from a sample of 34. These failures had the potential to place residents at risk of physical injury and psychosocial harm. Findings include:Review of R13's undated admission Record, located in the EMR under the Profile tab showed an admission date of 06/25/25 with diagnoses which included congestive heart failure (CHF), confusional arousals, and chronic kidney disease.Review of R13's quarterly MDS with an ARD of 09/25/25 and located in the EMR under the MDS tab, showed a BIMS score of 14 out of 15 which indicated R13 was cognitively intact.Review of R13's Nurses Note, dated 11/03/25 and located in the EMR under the Progress Notes tab, documented Writer made aware of altercation between resident and roommate during morning rounds by staff. Staff made aware to keep residents separated, room change initiated. DON [director of nursing] notified, police called to make a report.Review of R13's Care Plan, located in the EMR under the Care Plan tab, documented a focus area of psychosocial well-being related to roommate scratching him and resident slapping roommate on 11/03/25 with interventions to allow the resident time to answer questions and to verbalize feelings, perceptions, and fears, and when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings.Review of the paper Facility Reported Incident Report, dated 11/03/25, and provided by the DON, revealed the resident-to-resident abuse was substantiated due to R12 scratching R13 on his left leg in their shared room and then R13 slapped R12 on the right side of his face in response at 8:30 AM. Certified Nursing Assistant (CNA) 1 heard the slap in the hallway, entered the room, saw two scratches on R13's left leg and R12's face was red, removed R12 from the room, and reported the incident to the DON.During an interview on 11/30/25 at 12:45 pm, R13 stated his former roommate, R12, scratched him on his leg because he was mad at him for talking to the nurse while they were sitting in their wheelchairs in the doorway of their shared room, so he slapped R12 on the face on 11/03/25. R13 stated R12 made grunting noises and would try to scratch staff when he did not want to be bothered or was angry about something. R13 stated R12 was removed from the room by the nurse aide and moved to another room the same day. R13 stated the Social Worker checked on him after the incident and he felt safe in the facility.During an interview on 12/03/25 at 8:39 AM, the DON confirmed CNA1 reported the physical altercation between R13 and R12 on 11/03/25 after she separated the residents. The DON reported the abuse to the state survey agency (SSA) on 11/03/25 at 9:26 am and submitted the follow-up report to the SSA on 11/10/25. The DON stated skin assessments were performed after the residents were separated and the right side of R12's face was red and swollen and R13 had two scratches on his left knee. The DON indicated social services saw them to ensure they had not suffered any ill effects from the incident, the police came and took their statements, and the residents were seen by the behavioral health provider. The DON also indicated no incidents had occurred prior to or after the incident on (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/03/25.During an interview on 12/03/25 at 9:07 am, CNA1 confirmed she heard R13 slap R12 from the hallway as she was picking up meal trays around 8:30 AM on 11/03/25. CNA1 stated she entered the room, R13 stated R12 scratched him on his leg so he slapped him on the face. CNA1 stated she moved R12 out of the room in his wheelchair and reported the incident to the nurse and DON at 8:36 Aam. CNA1 indicated all nurse staff were trained on de-escalation techniques that week. CNA1 also stated there were no witnesses to the incident.3. Review of R45's undated admission Record, located in the EMR under the Profile tab documented an admission date of 08/12/25 with diagnoses which included encephalopathy, heart failure, and chronic kidney disease, stage 3.Review of R45's admission MDS with an ARD of 08/21/25 and located in the EMR under the MDS tab, showed a BIMS score of five out of 15 which indicated R45 was cognitively impaired.Review of R45's Incident Note, dated 10/08/25 and located in the EMR under the Prog Notes tab, showed Called to the room by CNAs after staff noted the door was closed and heard the resident's roommate yelling at him, stating, I'm going to beat your ass. The resident was immediately assisted outside via wheelchair to the front porch with staff supervision. Upon assessment, the resident stated he was okay and was not afraid. He reported that he no longer wished to share a room with his current roommate because the roommate does not sleep, walks around the room throughout the night, and talks to himself, which prevents him from resting. The resident also stated that the strong scent of cologne his roommate frequently sprays makes the room stink. The resident explained that he told his roommate, Open the damn door, it stinks in here, after which the roommate began yelling . Police were called and interviewed both parties. Ombudsman notified and NP [nurse practitioner] in house evaluated both residents. The resident agreed to relocate to a different room on the opposite hall. Staff assisted in moving his belongings. After the transfer, the resident voiced satisfaction with his new room and roommate, stating he was happy with the change.Review of the paper Facility Reported Incident Report, dated 10/08/25 and provided by the DON, showed the resident-to-resident abuse was substantiated due to R17 threatening to physically hurt R45 in their shared room on 10/08/25 at 2:20 PM. Restorative Aide (RA) 2 heard R17 yelling you need to get out of here with your bullshit before I beat your ass at R45 in the hallway outside of their shared room. RA2 entered the room, removed R45 from the room, took R45 outside, and then a room change was made for R45. The NP initiated inpatient psychiatric stabilization at the hospital for R17, and behavioral health services were rendered after R17's return to the facility. The police were called on the same day as the incident. R45 admitted he yelled at R45 for closing the door and then R17 threatened to beat him up as he stood over him while lying in his bed.During an interview on 11/30/25 at 9:10 am, R17 stated he had a verbal altercation with R45 in October when they were roommates, and he was sent to the hospital for treatment. R17 also stated his medications were adjusted and R45 was moved to another room, and he had not talked to him since the incident. During an interview on 12/03/25 at 8:50 am, the DON confirmed RA2 notified her that she heard R17 threaten to hurt R45 in their shared room on 10/08/25 at 2:20 PM. The DON stated RA2 took R45 outside on the front porch. R45 was afraid to go back inside due to R17's threat, a room change was made for R45, and then R17 was sent to the hospital for evaluation and treatment. The DON also stated the social worker checked on R45 and he had not suffered any ill effects. The DON indicated she sent the initial report to the SSA on 10/08/25 at 3:10 PM and the follow-up report on 10/13/25 in which verbal abuse was substantiated.During an interview on 12/03/25 at 9:50 am, RA2 stated she heard R17 yelling at R45 in their shared room on 10/8/25 at 2:20 PM as she was walking down the hallway. RA2 stated when she entered the room, R17 was leaning over and yelling at R45, and R45 looked scared and stated he was not staying in the room with R17. RA2 escorted R45 out of the room and R45 said R17 threatened to beat him up and kill him and he (continued on next page)

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	115412	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Tifton	1451 Newton Drive Tifton, GA 31794

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was going to return to the room with him. RA2 indicated she reported the verbal abuse to the DON after she ensured R45 was safe.During an interview on 12/03/25 at 10:21 am, R45 stated R17 was his roommate in the past and R17 got mad at him and threatened to beat and kill him because he told him to leave the door open. R17 stated a nurse aide intervened and moved him to another room, and he felt safe in the building now. Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 07/15/25, provided by the facility revealed It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident alterations . Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment . Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure an appropriate discharge plan for one of four residents (R) (R86) reviewed for transfer and discharge. The facility issued an Against Medical Advice (AMA) discharge but failed to arrange for necessary care and services to include post discharge follow-up. The failure had the potential to affect the well-being and safety of R86.Findings include:Review of the Hospital Discharge Summary located under Documents in the electronic medical record (EMR) revealed R86 was originally admitted to the facility on [DATE] following a hospitalization related to a cardiac arrest. The EMR also revealed the residents' diagnoses included congestive heart failure, chronic obstructive pulmonary disease (COPD), acute respiratory failure, and alcohol and cocaine use. Review of a Progress Note dated 09/16/25 at 5:08PM, found under the Prog Note tab of the EMR revealed, Spoke with resident's significant other.about taking the resident out past midnight. The resident had already signed out and was in the car. I explained that she would need to be back in the facility by midnight per insurance regulations and that if she was not, it would be a DC against medical advice, without meds.Further review of the Progress Note found under the Prog Note tab of the EMT, dated 09/17/25 at 8:33AM, revealed a call from the facility's Social Services Director (SSD) to the residents' significant other, Resident Representative (RR) 1, in which he confirmed R86, who had stayed outside of the facility overnight, stated that she needed to get back, but that since the resident was outside of the facility after midnight she would have to be discharged . Per the note, SSD explained that due to her insurance, we actually have to discharge her. SSD also explained that R86 was told yesterday before she left that she had to be back before midnight last night due to her insurance by the DON [Director of Nursing]. The note continued, stating we cannot give her medications, cannot arrange home health and have to contact APS [Adult Protective Services]. [R86] understood and asked if she was allowed to come and get her belongings. SSD stated that she is able to come and get her belongings.During an interview with the DON and the Regional Clinical Consultant (RCC) on 12/02/25 at 1:33PM, the DON stated that she recalled the resident was discharged from the facility AMA as per her understanding of the resident's managed care insurer required the resident to be discharged , if outside of the facility after midnight. The RCC also concurred with this understanding. When asked if they understood the resident must be given the chance to return, they expressed that they were not aware of that requirement. During an interview with the SSD on 12/02/25 at 4:13PM, and she confirmed that she did contact the resident the day of discharge and per her understanding of the regulation, the facility would not be covered for charges for R86 if she did not arrive prior to midnight. She also stated that she believed the resident was to be discharged from the facility AMA. When asked if the resident was given an opportunity to return, she stated that she was not. She also confirmed that the resident never returned to pick up her belongings. During a follow up interview with the DON and the RCC on 12/03/25 at 11:09AM, and the DON stated that she believed the facility followed their policy. She was asked where they documented the discussion related to the advising the resident of the risks and their right to return to the facility and she advised that the provider, who she could not name, called R86 later the day of the discharge to invite the resident back but the resident declined. On 12/03/25 at 12:22PM the DON provided a Progress Note, dated 09/17/25 at 1:21PM, written by Nurse Practitioner (NP) 2. The note read, [R86] left last night with her boyfriend and did not return. I spoke with her, and she does not plan on coming back. I told her she would be discharged AMA.A review of the facility's Transfer and Discharge (including AMA) policy, with an effective date of 01/01/23, states that the purpose of the policy is (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to permit each resident to remain in the facility and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. The policy specifically states that for a discharge against medical advice (AMA), The resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. Under no circumstances will the facility force, pressure, or intimidate a resident into leaving AMA.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, record review, review of facility policy, the facility failed to ensure two of 32 sampled residents (R) (R16 and R40) were invited to their care plan meeting to review their care plans. This failure created the potential that residents will not obtain their highest practicable level of functioning. Findings include:1.Review of R16's admission Record, found in the Electronic Medical Record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included infection and inflammation reaction due to other internal joint prosthesis and idiopathic necrosis of the right femur. The record revealed the resident was her own medical decision-maker. Review of R16's admission Minimum Data Set (MDS) Assessment, with an assessment reference date (ARD) of 10/30/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15, which indicated the resident was cognitively intact. Review of a R16's Comprehensive Care Plan, dated 10/31/25 and found in the EMR under the Care Plan tab, revealed a comprehensive care plan with associated problems, goals and interventions, such as infection control and antibiotic administration, Activities of Daily Living (ADL) status, Nutritional Status, etc. had been issued on that date. Review of R16's comprehensive record revealed nothing to indicate an interdisciplinary team care planning meeting had been held for R16 since her admission to the facility on [DATE] or that R16 was invited to a care planning meeting since admission. During an interview with R16 on 11/30/25 at 3:12 pm, she indicated she was aware of what a care planning meeting was, but stated she had not been invited to, or attended, one since her admission to the facility on [DATE]. 2. Review of R40's admission Record, found in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included heart failure and recent fracture of her left fibula. The record revealed the resident was her own medical decision-maker. Review of R40's admission MDS Assessment, with an ARD of 11/03/25 and found in the EMR under the MDS tab, revealed a BIMS assessment score of 15 out of 15, which indicated the resident was cognitively intact. Review of a R40's Comprehensive Care Plan, dated 11/03/25 and found in the EMR under the Care Plan tab, revealed a comprehensive care plan with associated problems, goals and interventions, such as Activities of Daily Living (ADL) status, Physical Therapy Services, Nutritional Status, etc. had been issued on that date. Review of R40's comprehensive record revealed nothing to indicate an interdisciplinary team care planning meeting had been held for R40 since her admission to the facility on [DATE] or that R40 was invited to a care planning meeting since admission. During an interview with R40 on 11/30/25 at 9:19 AM, she indicated she was aware of what a care planning meeting was but stated she had not been invited to or attended one since her admission to the facility on [DATE]. During an interview with the Social Services Director (SSD) on 12/01/25 at 2:20 pm, she indicated she was responsible for scheduling care planning meetings for residents as well as for inviting residents to each meeting. The SSD confirmed she could not locate anything in R16 or R40's record to show either resident had ever been invited to an initial care planning meeting or that such a meeting had ever been held for either resident since their admission to the facility. The SSD indicated each resident was expected to have an initial care planning meeting within 72 hours of their initial admission to the facility. During an interview with the Director of Nursing (DON) on 12/03/25 at 10:52 am, she confirmed her expectation was an initial care planning meeting should be held for each resident admitted to the facility within 72 hours of their admission and each resident was expected to be invited to the meeting.Review of the facility's Care Planning-Resident Participation (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy last reviewed 03/01/25 documented, This facility supports the resident's right to be informed of, and participate in their care planning and treatment (implementation of care); and The facility will honor the resident's right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care; and The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes.

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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 observation, interview, record review, and review of the facility's policies, the facility failed to ensure residents were free of accidents and hazards for two of three sampled residents (R) (R45 and R11) reviewed for smoking at the facility, out of 32 sampled residents. These failures had the potential to cause serious adverse outcomes, including significant injury to all 80 residents residing in the facility.Findings include:1. Review of R45's Face Sheet, located under the Profile tab of the electronic medical record (EMR), revealed R45 was admitted to the facility on [DATE] with diagnoses which included encephalopathy, heart failure, and atherosclerotic heart disease.Review of R45's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/21/25, located under the MDS tab, showed a Brief Interview for Mental Status (BIMS) score of nine out of 15 indicating R45 had moderate cognitive impairment. The resident was revealed to not reject care, had no behavior, and no delirium. R45 was documented to be independent with mobility.Record review revealed that the Hospital Discharge summary, dated [DATE], located under the Miscellaneous tab of the EMR, revealed the resident was nicotine dependent, prior to admission.Record review of R45's admission Data Collection, dated 08/12/25, and located under the Assessments tab of the EMR, revealed the resident regularly used tobacco, about three cigarettes a day.Review of R45's Care Plan initiated on 08/25/25 and located in the EMR under the Care Plan tab revealed the residents had displayed behaviors which included smoking inside and outside the facility. The care plan documented that the resident had been observed smoking in his bathroom on 08/20/25. The care plan was revised on 11/17/25 to include that R45 was observed smoking on facility grounds. Interventions included to educate R45 on not smoking in the facility, to attempt interventions before behaviors begin, offer the resident something they like as a diversion, and to inform the physician of any resident behaviors that interfere with daily living. An intervention, dated 08/20/25, stated that R45 was educated on not smoking in the facility, the resident verbalized understanding, and that a lighter was found and removed from his room. Additionally, on 11/17/25, R45 was again educated on not smoking on the facility property.Record review revealed a Progress Note, dated 08/13/25, and located under the Progress Note tab of the EMR, .nicotine dependence.Provide information on tobacco cessation. Record review revealed a Progress Note, dated 08/22/25, . R45 adamantly denied smoking in his room last night. SSD [Social Service Director] explained that smoking in the building is prohibited and dangerous. SSD explained the dangers inside the facility. SSD also explained that if [resident name] wants to smoke, he needs to sign out and leave the property. Additional progress notes identified non-compliance with smoking inside and outside the facility.Record review of R45's 30-day notice of discharge, dated 11/19/25, and located under the Miscellaneous tab of the EMR, revealed, As you are aware from out (sic) previous meetings on unacceptable conducts of behaviors, we have discussed R45] continuing to violate the facilities smoking policy. This discharge notice was provided to the resident after multiple warnings. Record review on 11/23/25 revealed a Progress Note in the EMR that R45 was alert and oriented x 3 (person, place, and time).Record review revealed that although there were numerous documents prior to and during the admission process to identify R45 as a regular cigarette smoker, he was nevertheless admitted to a non-smoking facility. There was no documentation in the EMR for R45 that revealed the residents were provided with any education on tobacco cessation programs.Record review revealed there was no assessment documented in the EMR to identify that the resident was evaluated for smoking safety, after observing the resident consistently smoking.During an observation on 11/30/25 at 8:20 AM, R45 was observed standing independently outside the facility, with a door ajar, smoking a cigarette.During an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 11/30/25 at 4:07 PM, R45 stated that residents were not allowed to smoke in the facility, so he signed out at the front reception desk, and then went to the side of the facility building to smoke. He said that the facility had residents who used oxygen, so he knew how to follow the rules, and smoked outside.During an interview on 12/02/25 at 8:50 am, the Facility Receptionist (FR) stated that when residents left the facility they were supposed to sign out and then sign back in. FR said that if a resident was going to leave the facility to smoke, they were supposed to go outside off the property, to the dirt road south of the building. She said that when they noticed the R45 was going outside to smoke, they told him he had to sign in and out, and smoke off property at the dirt road. She confirmed he did not always sign in and out and may sometimes wait until she was busy to exit. FR said that the sign out logs were kept at the nurse stations and brought to her the following morning for review.During an interview on 12/02/25 at 9:40 am, Registered Nurse/Unit Manager (RN/UM) stated that there had been some issues with residents that smoked and were not following the rules. She stated that residents were supposed to sign out and go off property to smoke because the facility was non-smoking. There was to be no smoking in the building. She added that off the facility property was like across the street. RN/UM said they had a handful of residents who would go across the street. She said they offered residents nicotine patches. She said R45 was non-compliant with smoking but would go outside to the right location. She said he had been educated, as well. She confirmed that R45 had received a 30-day discharge notice for non-compliant smoking. She said she had not seen him smoke in his room. She added that the facility gave a warning, and then upper management would give a warning. The facility would document the issue and then follow the process to give the 30-day notice. During an additional interview on 12/02/25 at 10:43 am, R45 stated that he was required to sign out to smoke, and that the facility smokers were required to go to the south side of the building, onto the dirt road to smoke. He stated that this was the guidance he was given when he wanted to smoke.During an interview on 12/02/25 at 11:07 am, the facility Ombudsman stated that she was aware that the facility had some residents that were non-compliant with smoking, and most of them had received a 30-day notice to discharge. She said that the last Administrator had been lax, and residents had become used to it. The Ombudsman said that the new Administrator had been trying cessation programs but was not successful with some areas of concerns that included drugs, alcohol, and smoking. She was not aware of any negative outcomes.During an interview on 12/02/25 at 1:23 pm, the Director of Nursing (DON) stated that the facility had a consulting team that assisted with resident referrals. She stated that R45 had received a 30-day notice of discharge due to violations that included smoking in his room, bathroom, the facility premise, and had possession of cigarettes and lighters. She said that the facility did not allow smoking in the facility. She said that if a resident that smoked was admitted to the facility, they could offer cessation products and could offer nicotine patches. She said the resident could use the behavioral group they consult with, if the resident wanted to stop smoking. If the residents violated the policy they would have care plan meetings, and if they continued to violate it, they would then give the discharge notice to the resident, Ombudsman, and the physician. The DON said residents could sign out and leave the building to smoke, but they could not have banned paraphernalia inside the facility. She was not aware of who would do a smoking assessment for residents that were non-compliant with smoking, and that she was not aware of a facility policy regarding smoking in the facility. During an interview on 12/02/25 at 4:28 pm, the SSD stated that if a resident had a concern with substance abuse, they would offer them the mental health practitioner. She said that if a resident was a non-compliant smoker, there would be a verbal warning to tell them the facility was non-smoking and that they could not have banned items, we would set (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115412	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Tifton	1451 Newton Drive Tifton, GA 31794

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up two separate care plan meetings, then give them the 30-day notice. The SSD said that the former Administrator was more lax with the smoking process. She said the facility had been trying to get the process under control since September 2025 and were trying to go by the non-smoking policy.2. Review of R11's admission Record, found in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included paraplegia and history of spinal cord injury. Review of R11's Quarterly MDS Assessment, with an ARD of 09/22/25 and found in the EMR under the MDS tab, revealed a BIMS assessment score of 15 out of 15, which indicated the resident was cognitively intact. Review of R11's Smoking Care Plan, dated 08/25/25 and found in the EMR under the Care Plan tab, revealed the resident was a daily smoker and indicated the resident was to be reminded the facility was a smoke free facility and reminded he needed to leave the facility property to smoke. The care plan indicated R11 had displayed behaviors (throughout his admission to the facility) which included smoking marijuana in his room and smoking cigarettes in front of facility despite numerous reminders of (the facility) being a nonsmoking facility. The plan indicated staff was to inform the charge nurse immediately if the resident was suspected to be breaking the facility's smoking policy and the resident's clothing and skin was to be observed for signs of cigarette burns. Review of R11's comprehensive record revealed nothing to indicate a smoking assessment had ever been completed for the resident to determine the resident's ability to smoke safely and follow the facility's smoking rules. Review of R11's Progress Notes, dated 08/23/25 and found in the EMR under the Notes tab, revealed, During medication pass, I (the nurse who entered the note) entered the resident room to give him his medication and cigarette smoke came from his mouth. He stated that he was sorry and didn't deny he was smoking. I explained to him he can't smoke in the room and that he has to respect his roommate. He stated he wouldn't do it again.Review of R11's Progress Notes, dated 09/30/25 and found in the EMR under the Notes tab, revealed, R11 smoking in room. Educated resident about not smoking in room and that he has to respected (sic) his roommate. Resident said he didn't feel like going out the door and that's why he smoked in his room.Review of the facility's Accident and Incident Logs, dated 06/01/25 through 12/01/25 and provided directly to the survey team, revealed nothing to indicate an incident had been initiated or investigated related to R11's 08/23/25 or 09/30/25 smoking incidents. Further review of the EMR revealed nothing could be located indicating there had been any follow-up by the facility related to R11's 08/23/25 or 09/30/25 smoking infractions.R11 was observed leaving the facility property to smoke after lunchtime and until suppertime on 11/30/25, 12/01/25 and 12/02/25. The resident was not observed smoking in the facility or on facility property during the survey.During an interview with R11 on 12/01/25 at 10:47 am, he confirmed he was a daily smoker and stated he usually left the facility property to smoke. During an interview with the DON on 12/02/25 at 1:25 pm, she confirmed awareness of R11 having a history of smoking in his room. She confirmed the facility did not initiate or investigate smoking events as incidents and stated the facility was expected to hold a care planning meeting after each incident of violating the facility's smoking rules. The DON confirmed residents were not allowed to smoke on the facility property and were not allowed to have smoking materials in the facility. The DON also confirmed smoking assessments were not completed for residents to ensure safe smoking practices and smoking rules were being followed in the facility because the facility was a non-smoking facility. During a follow-up interview with the DON on 12/03/25 at 10:54 am, she confirmed the facility's process related to smoking infractions was expected to be followed for any resident living in the facility who smoked. The DON could not clearly verbalize, however, what the facility's procedure was related to residents who were found repeatedly violating the facility's smoking rules.

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NAME OF PROVIDER OR SUPPLIER Harborview Tifton		STREET ADDRESS, CITY, STATE, ZIP CODE 1451 Newton Drive Tifton, GA 31794	

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to ensure a physician's order was obtained for the use of an indwelling urinary catheter device for one of three residents (R) (R69) reviewed for urinary catheter devices. This failure created the potential for R69 to go without appropriate care and services.Findings include:Review of R69's admission Record, found in the Electronic Medical Record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included type 2 diabetes and urinary retention. Review of R69's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 11/13/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12 out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident had an indwelling urinary catheter placed in his bladder. Review of R69's Physician Order Set, dated 12/02/25 and found in the EMR under the Orders tab, revealed there was no physician's order related to the use or care of the resident's urinary catheter.Review of a R69's Catheter Care Plan, dated 11/13/25 and found in the EMR under the Care Plan tab, revealed the resident had an indwelling urinary catheter in place and indicated the resident's intake and output was to be monitored and the resident was to be monitored for potential signs and symptoms of Urinary Tract Infection (UTI) and pain and/or discomfort related to the use of the catheter.During an interview with the Director of Nursing (DON) on 12/03/25 at 11:00 am, she confirmed her expectation was all physician orders related to the use and care of a resident's urinary catheter were to be in place and up to date in the resident's record.The facility's policies and procedures related to the implementation and ongoing use of indwelling urinary catheters were requested by the survey team on 12/02/25 at 2:00 pm and again on 12/02/25 at 5:00 pm, however the policies were not received prior to survey exit on 12/03/25 at 2:30 pm.

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NAME OF PROVIDER OR SUPPLIER Harborview Tifton		STREET ADDRESS, CITY, STATE, ZIP CODE 1451 Newton Drive Tifton, GA 31794	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to properly assess and initiate side rails before alternatives were attempted for three of three residents (R) (R10, R25 and R66) reviewed for accidents/hazards out of 34 sampled residents. This failure had the potential to increase their risk of accidents.Findings include:1.Review of R10's undated admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed she was admitted to the facility on [DATE] with diagnoses that included end stage renal failure, major depressive disorder, and generalized anxiety disorder.Review of R10's significant change in status Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 07/04/25 and located in the EMR under the MDS tab, showed a Brief Interview for Mental Status (BIMS) score of 99. The facility assessed R10 as modified independence in cognitive skills for decision making with no upper and lower extremity impairments. R10 was not coded for side rail use on the MDS.Review of R10's Physician's Orders, dated 03/24/25, and located in the EMR under the Orders tab, revealed an order for mobility bars for repositioning and increased mobility per family request.Review of R10's initial Side Rail/Entrapment Risk Evaluation, dated 03/24/25, and located in the EMR under the Assessments tab, revealed R10 was currently using the side rails for support or positioning, wants the bed rails raised, 1/4 side rail bilaterally initiated, and no alternatives were attempted prior to initiating the side rails. The quarterly Side Rail/Entrapment Risk Evaluation assessment conducted on 08/17/25 showed R10 requested the use of the side rails.Review of R10's Care Plan, revised on 12/02/25, and located in the EMR under the Care Plan tab, revealed a focus area of risk for falls and that R10 requested to have her bed rails in the down position at times.Review of R10's Nurses Note, dated 12/01/25, and located in the EMR under the Prog Notes tab, revealed During rounds, writer adjusted bed rails to an upward assisting position, resident refused to keep bed rails up, stating that she wanted these to be down. Writer lowered the bed rails down to the requested position.Observation on 11/30/25 at 8:39 AM, 12/01/25 at 4:30 PM, and 12/02/25 at 2:45 PM, revealed R10 laying in the bed with bilateral 1/2 side rails raised from her abdomen to her upper thighs.During an interview on 12/01/25 at 4:20 PM, Unit Manager (UM) 1 confirmed side rail assessments were completed on 03/24/25 and 08/17/25 with no alternative attempts prior to initiating them. UM1 stated R10 would not let the staff raise them towards the head of her bed, she preferred them down near her waist and legs.During an interview on 12/03/25 at 9:24 AM, the Director of Nursing (DON) stated the bed rails were applied when R10 was admitted to the facility and a consent was signed by R10's family. The DON also stated the position of the side rails was not optimal, but she preferred them in the down position instead of by her head. 2. Review of R25's undated admission Record, located in the EMR under the Profile tab, revealed she was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, Alzheimer's Disease, gastrostomy status, and other seizures.Review of R25's quarterly MDS assessment with an ARD of 09/26/25 and located in the EMR under the MDS tab, showed a BIMS score of 99. The facility assessed R25 as moderately impaired in decision making with upper and lower extremity impairments. R25 was not coded for bedrail use on the MDS.Review of R25's Physician's Orders, dated 08/01/25, and located in the EMR under the Orders tab, revealed an order for Resident may have mobility bars for repositioning and increased mobility per family request.Review of R25's initial Side Rail/Entrapment Risk Evaluation, dated 08/01/25, and located in the EMR under the Assessments tab, revealed R25 was currently using the side rails for support or (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Harborview Tifton		STREET ADDRESS, CITY, STATE, ZIP CODE 1451 Newton Drive Tifton, GA 31794	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positioning, wants the bed rails raised, 3/4 side rail bilaterally initiated, and no alternatives were attempted prior to initiating the side rails. It was documented on the quarterly Side Rail/Entrapment Risk Evaluation assessment conducted on 11/01/25 that a low bed and call light were tried before use of the side rails began.Review of R25's Care Plan, revised on 12/02/25, and located in the EMR under the Care Plan tab, revealed a focus area of at risk for falls and that R25 requested to have her bed rails in the down position at times.Observations on 11/30/25 at 9:23 AM and 3:25 PM, and 12/01/25 at 11:49 AM revealed R25 lying in bed with the bed rails raised bilaterally which extended from her abdomen to her thighs with blue bed bolsters located inside of the bed rails. R25's arms were contracted, and a brace was on the right arm. R25 could not use the bedrails, and the rails were in the wrong position. The rails should be positioned near the head of the bed and not in the middle.During an interview on 12/01/25 at 12:03 PM, Licensed Practical Nurse (LPN) 6 stated she was not certain why the half bed rails were on the bed because the resident could not reach them.During an interview on 12/01/25 at 2:39 PM, Certified Nursing Assistant (CNA) 1 stated R25's family member wanted the bed rails raised for her safety.During an interview on 12/01/25 at 2:52 PM, Restorative Aide (RA) 1 stated R25 could not reach the bed rails because her arms were contracted, and the bed rails were raised because she scooted down in the bed, and they prevented her from falling out of the bed.During an interview on 12/01/25 at 4:18 PM, UM1 confirmed side rail assessments were completed on 08/01/25 with no alternative attempts before raising them until the 11/01/2 assessment. UM1 confirmed the side rails were placed upon admission per family request and alternate interventions were not attempted.During an interview on 12/03/25 at 9:24 AM, the DON stated the bed rails were applied when R25 was admitted to the facility and a consent was signed by the family for her to have them. The DON also stated the position of the side rails was not optimal, but she preferred them in the down position instead of by her head. The DON indicated the Maintenance Director conducted bed rail inspections on the safety of the bed rails and beds on a routine basis.3.Review of R66's admission Record, dated 12/03/25, located in the Electronic Medical Record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a stroke.Review of R66's quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 11/13/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12 out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated bed rails were not in use for the resident.Review of R66's Physician Order Set, dated 12/02/25 and found in the EMR under the Orders tab, revealed an order, with an original order date of 09/20/25, indicating the resident May have mobility bars for repositioning and increased mobility per family request.Review of a R66's Comprehensive Care Plan, dated 11/13/25 and found in the EMR under the Care Plan tab, revealed nothing to indicate the resident's use of bed rails.Review of R66's 09/20/25: Side Rail Assessment in his Admission/readmission Nursing Evaluation, dated 09/20/25 and found in the EMR under the Evaluations Tab, revealed the resident was using quarter rails for mobility bilaterally per the patient and family's request.Review of R66's comprehensive record did not reveal evidence to indicate alternatives to the use of bed rails were assessed for the resident or the reason the alternatives had failed.R66 was observed lying in his bed with 1/3 rails in the raised position in the middle of each side of his bed on 11/30/25 at 10:30 AM, on 12/01/25 at 5:30 PM, on 12/02/25 at 8:44 AM, 9:02 AM, 11:09 AM, and 5:02 PM.During an observation and interview on 12/02/25 at 8:46 AM, R66's bed rails were observed along with Licensed Practical Nurse (LPN1). LPN1 confirmed 1/3 rails were raised bilaterally in the middle of the resident's bed and stated the rails were generally in that position on the resident's bed.During an observation (continued on next page)

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	115412	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Tifton	1451 Newton Drive Tifton, GA 31794

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and interview on 12/02/25 at 9:03 AM, R66's bed rails were observed along with Unit Manager (UM1). UM1 confirmed the rails were in the raised position in the middle of both sides of the resident's bed and stated the rails were raised because that was the way the resident wanted them to be. She stated R66 was able to use the rails as grab bars to move about in his bed.During an interview with the Director of Nursing (DON) on 12/03/25 at 11:00 AM, she confirmed that each resident was expected to have a thorough assessment for the use of bed rails prior to rails being applied to a bed and confirmed her expectation was for the facility policy to be followed regarding the implementation of bed rails.Review of the facility's policy titled, Proper Use of Bed Rails, revised 03/01/25, provided by the facility, revealed Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails . Policy Explanation and Compliance Guidelines: Resident Assessment . 2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs . Appropriate Alternatives 9. The facility will attempt to use appropriate alternatives prior to installing or using bed rails Alternatives include but are not limited to: a. Roll guards b. Foam bumpers c. Lowering the bed . 10. Alternatives that are attempted should be appropriate for the resident, safe and address the medical conditions, symptoms or behavioral patterns for which a bed rail was considered . Ongoing monitoring and Supervision . 16. Responsibilities of going monitoring and supervision . d. the Maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails.

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NAME OF PROVIDER OR SUPPLIER: Harborview Tifton		STREET ADDRESS, CITY, STATE, ZIP CODE: 1451 Newton Drive Tifton, GA 31794	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and facility policy review, the facility failed to ensure overflow medications were secured for one of two medication supply rooms on the south hall. This failure placed 30 residents' medications at risk of diversion. Findings include:An observation on 11/30/25 from 9:30 to 9:40 am, revealed the medication supply room door was held open with a cardboard box placed between the door and door frame behind the nurses' station on the south hall. During this time, three facility staff members walked past the nurses' station while it was unattended, and the door was open.An observation and interview on 11/30/25 at 9:52 am, with Unit Manager (UM) 2 revealed the medication supply room contained 30 residents' overflow medications (medications that would not fit in the medication cart) stacked on the shelves and two packages of expired medications that needed to be returned to the pharmacy were lying on the floor. UM 2 stated there were no scheduled medications in the room and that two nurses had a key to the room which was in their medication carts. UM 2 stated the door should be closed and always locked so that residents and staff would not have access to the residents' medications and supplies.During an interview on 11/30/25 at 10:15 am, the Director of Nursing (DON) stated the medication supply room door should be closed and always locked to prevent staff and residents from removing the residents' medications per the policy.During an interview on 11/30/25 at 12:35 pm, the Maintenance Director stated he was installing a keypad on the medication supply room door because a nurse reported she did not have a key to the medication supply room door. During an interview on 11/30/25 at 5:05 pm, UM 2 stated Licensed Practical Nurse (LPN) 5 left the supply room door propped open because she needed to return to the room to retrieve supplies and did not realize she had a key to the room in the medication cart. An interview was attempted on 11/30/25 at 5:15 pm, 12/02/25 at 9:55 am, and 10:05 am with LPN 5, but the phone call was not returned.Review of the facility's policy titled, Medication Storage, revised 03/01/25, and provided by the facility, revealed Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medications carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments .

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, facility document review and facility policy review, the facility failed to ensure food was monitored and served at appropriate temperatures to prevent food borne illness. This deficient practice had the potential to affect 80 of 80 residents receiving meals prepared in the kitchen. Findings include:Record review of the October 2025, November 2025, and December 2025 Hot/Cold Temperature Logs revealed that only four temperatures were taken at meal service, on average. Only the temperatures of the main items, at regular texture, were documented. Further review of the log procedure revealed the dietary staff failed to document all food items. Additionally, the dietary staff failed to ensure they had functioning thermometers, and knew how to calibrate thermometers correctly, as noted below.During a meal service observation in the kitchen on 12/02/25 from 12:00 pm to 12:40 pm revealed the following:-On the steam table was rice, barbeque chicken, black eyed peas, mashed potatoes, and beef patties.-The Dietary Manager (DM) was asked to calibrate the thermometer before taking temperatures on the steam table. The DM placed the manual probe thermometer into a cup of ice water. The needle on the thermometer was stuck between the high temperature and the 0, pointing at the F. The DM said she was going to wait until the needle pointed at the 0. At 12:06 PM, the DM said the thermometer was getting there (to reach 0 F), but was still pointing straight down at the F, and was not properly functioning. This observation revealed the DM, responsible for the kitchen process, was not aware of the appropriate process to calibrate thermometers.During an interview on 12/02/25 at 12:08 PM, Dietary Aide (DA) 3 stated that the thermometer should be calibrated to 32 F and confirmed the manual probe thermometer was not working correctly and was reading 0 F. DA3 stated that she had another thermometer and removed a digital thermometer from her pocket. The digital thermometer read LL. She confirmed it was broken. The DM said she would go look for another thermometer. This failure revealed the dietary staff failed to have appropriate equipment to ensure food temperatures were accurately and efficiently monitored for all meals.In an attempt to see if the broken manual probe thermometer that was stuck on F and would function at all, at 12:15 pm, the food on the steam table was tested for temperatures. Adjusting for an estimated 32-degree difference, the food on the steam table read:-rice: 142 F-barbeque chicken: 136 F-black eyed peas: 131 F-mechanical barbeque chicken: 101 F-chopped barbeque chicken: 82 F-mashed potatoes: 122 F-pureed barbeque chicken: 84 F-pureed black eyed peas: 102 F-beef patty: 92 FDA 3 placed the items back into the oven to reach appropriate temperatures while the DM continued to look for a functioning thermometer that could provide accurate temperatures.During an interview on 12/02/25 at 12:22 pm, the DM returned to the kitchen with the radar thermometer used by the maintenance department. The thermometer was calibrated with a cup of ice water, to 36 F.During an interview on 12/02/25 at 12:23 pm with Dietary Aides, DA 3 stated that the steam table did not hold temperatures well. This was agreed upon by DA 2 and DA 4. DA 4 stated that the air conditioning vent blew cool air right across the top of the steam table. After removing the food items from the oven, they were rechecked on the steam table 12/02/25 at 12:26 pm with the maintenance department thermometer. The food items recorded were:-rice: 137 F-barbeque chicken: 145 F-black eyed peas: 110 F-mechanical barbeque chicken: 144 F-chopped barbeque chicken: 144 F-mashed potato: 147 F-pureed black-eyed peas: 139 F-beef patty: 155 FThe DM stated after taking the temperatures that she would ensure that a new thermometer was purchased to ensure food was properly recorded before meal was served.During an additional meal service on 12/03/25 at 7:20 am, breakfast was observed on the steam table. The DM stated that the kitchen staff were still using the Maintenance Department thermometer, since a new dietary thermometer had still not been purchased. The breakfast food temperatures (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	recorded by DA 2:-grits: 124 F-scrambled eggs: 136 F-sausage links: 141 F-pureed sausage: 114 F-pureed eggs: 144 F-mechanical sausage: 142 FThe Dietary Manager had the grits, scrambled eggs, and pureed sausage placed back into the oven.An additional temperature on 12/03/25 at 7:35 am revealed:-grits: 134 F-scrambled eggs: 138 F-pureed sausage: 130 FThese items were again placed in the oven to raise temperatures prior to service.During an interview on 12/03/25 at 7:36 am, DA 3 stated the cooks performed and recorded the temperature checks of the main meal items, but they did not record temperatures for any altered textures on the steam table.A test tray was prepared in the kitchen while breakfast was being plated at the steam table, on 12/03/25 at 7:50 am. The plate was taken to the resident hallway by an unheated, covered meal cart. It was removed at 8:10 am, outside resident room [ROOM NUMBER]. The test tray was taken directly to the nurses' station, and the temperatures were taken with the DM present. The temperatures recorded were:-grits: 117 F-mechanical sausage: 108 F-scrambled eggs: 104 F-pureed sausage: 111 FDuring a concurrent interview on 12/03/25 at 8:12 am, the DM confirmed the breakfast food item temperatures were too low, and the temperatures had not held properly from the kitchen. She confirmed the kitchen used the plate warmer, base and cover. She was not aware of any other elements that could assist in keeping the plates warm during transfer to the resident hallways.During an interview on 12/03/25 at 10:38 am with the Regional Clinical Consultant (RCC) and Director of Nursing (DON), both confirmed that they expected residents to be served food that was hot, and at appropriate temperature.During an interview on 12/03/25 at 10:47 am, the DM confirmed that the facility was having problems with food temperatures during meal service, and that it needed to be addressed. She stated that she would be buying numerous thermometers for future use, to have them readily available.During an interview on 12/03/25 at 11:25 am, the Administrator stated that she expected the food to be served to the residents at the right temperatures whether served in the dining room or in the resident rooms. She confirmed that she would not like to eat food that was too cold either.Review of the facility's policy titled, Food Safety Requirements, dated 06/01/24, revealed Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety.When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards.Cooking-foods shall be prepared as directed until recommended temperatures for the specific foods are reached. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed.Holding-staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained.Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone.Review of the facility's Hot/Cold Temperature Log used by the Dietary Department documented that:Hot Food should be 135 F [Fahrenheit] or higher, and that Cold Food should be served at 41 F or lower. This log documented the procedure as:1. Check consistency of all mechanically altered menu items following the IDDSI guidelines.2. Calibrate thermometer prior to checking temperatures-thermometer should read 30-34 degrees F for accuracy.3. Check temperature of each food item on the steam table-thermometer should be sanitized in between each food item.4. Document temperatures and time temperatures were taken.5. Take appropriate action and reheat food items if needed.Best practice:1. Check temperature multiple times during meal service. 2.If temperature drops below the 135-degree [F] threshold for hot items, or above the 41-degree threshold from cold items, pull the item from the line and take corrective action.

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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. Based on observations, staff interviews, and policy review, the facility failed to ensure food was dated, labeled, stored properly, not expired, and that the facility's ice machine was maintained in a sanitary manner. These failures had the potential to increase the prevalence and spread of foodborne illness and infection among all 80 residents' receiving meals from the kitchen.Findings include:1. During initial observations of the kitchen on 11/30/25 at 8:30 am, a full-sized can of lemon-lime soda was observed placed inside the facility ice machine, half deep into the ice. During a concurrent interview and observation on 11/30/25 at 8:33 am, Dietary Aide (DA) 2 confirmed the soda can should not be in the facility ice machine. DA 2 went to the ice machine and with bare hands removed the can of soda without washing her hands, touching the ice in the machine during the process.2.Additional initial kitchen observations revealed on 11/30/25 at 8:36 am, in the walk-in refrigerator revealed the following:-Two thawed vanilla Magic Cups in the walk-in refrigerator without thaw dates recorded. The two cartons stated, Store frozen. Serve cold. Consume within 5 days of thawing (under refrigeration).-A bag of sliced turkey, stating Prep 11/24, with no use by date.-A large stack of sliced ham, half wrapped in aluminum. It was not properly covered nor dated.-A large plastic container of chicken noodle soup with Use by 11/28 on the lid.During a concurrent interview and observation on 11/30/25 at 8:43 am, DA 2 stated that the items in the walk-in refrigerator were not properly dated or labeled. 3. During an additional kitchen observation on 12/03/25 at 8:25 am, sugar was observed in the dry storage pantry stored in a large plastic container. The scoop rested directly on the sugar, including the handle.During a concurrent interview and observation on 12/03/25 at 8:25 am, the Dietary Manager (DM) confirmed that the scoops should be placed inside the container in the holder, and not resting directly on the sugar. The DM stated she had reminded staff about this on multiple occasions.During an additional interview on 12/03/25 at 10:47 am, the DM confirmed that the vanilla Magic Cups should have been dated when they were thawed. She stated that she had not been made aware of the soda can in the facility ice machine, nor that it was removed with bare hands. The DM said the dietary staff knew better than to leave anything inside the ice machine. During an interview on 12/03/25 at 11:25 am, the Administrator stated that there should never be any items stored inside the facility ice machine.Review of the facility's policy titled, Dietary Sanitation, dated 06/01/25, revealed Policy: It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulation.Review of the facility's policy titled, Food Safety Requirements, dated 06/01/24, revealed Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety.Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms.Preparation of food, including thawing.Employee hygienic practices.Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date.Keeping foods covered or in tight containers.Staff shall not touch food with bare hands.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, observation and interviews, the facility failed to ensure their infection control program was followed for two of six residents (R) (R69 and R16) reviewed for infection control. Specifically, personal protective equipment (PPE) was not worn for contact isolation. In addition, a foley catheter bag with tubing was touching the floor. These failures created the potential for cross contamination and spread of infection among residents and staff. Findings include:1. Review of R69's admission Record, dated 12/03/25 and found in the Electronic Medical Record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included type 2 diabetes and urinary retention. Review of R69's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 11/13/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12 out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident had an indwelling urinary catheter in place in his bladder.Review of R69's Physician Order Set, dated 12/02/25 and found in the EMR under the Orders tab, revealed no orders related to the use or care of the resident's urinary catheter. Review of a R69's Catheter Care Plan, dated 11/13/25 and found in the EMR under the Care Plan tab, revealed the resident had an indwelling urinary catheter in place and indicated the resident's intake and output was to be monitored and the resident was to be monitored for potential signs and symptoms of Urinary Tract Infection (UTI) and pain and/or discomfort related to the use of the catheter. R69 was observed on 12/01/25 at 11:07 am, 5:01 pm, and 5:30 pm, and on 12/02/25 at 8:42 am, 10:32 am, 11:07 am and 12:05 am. R69's urinary catheter bag and/or tubing was observed to be either lying or dragging in direct contact with the floor during these observations.An observation and interview on 12/02/25 at 12:10 pm revealed R69 was sitting in his wheelchair in the dining room. UM 1 confirmed the resident's catheter drainage bag was in direct contact with the floor at the time of the observation. UM 1 confirmed the resident's catheter bag and tubing should not be in contact with the floor in order to prevent potential infection. During an interview with the Director of Nursing (DON) on 12/03/25 at 11:00 am, she confirmed her expectation was urinary catheter drainage bags and tubing were to be kept off the floor at all times to prevent potential infection. 2. Review of R16's admission Record, and found in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included infection and Inflammation Reaction Due to Other Internal Joint Prosthesis and idiopathic Necrosis of the Right Femur.Review of R16's admission MDS Assessment, with an ARD of 10/30/25 and found in the EMR under the MDS tab, revealed a BIMS assessment score of 15 out of 15, which indicated the resident was cognitively intact. Review of R16's Physician Order Set, dated 12/02/25 and found in the EMR under the Orders tab, revealed an order, with an original order date of 11/02/25, for R16 to be maintained on Contact Isolation Precautions due to an active infection of her total hip prosthesis. The order indicated R16 was receiving Meropenem Intravenous (IV) Solution (an antibiotic medication) 500 milligrams (MG) per day and Micafungin Sodium IV Solution 50 MG (an antimicrobial medication) per day via her IV to treat the infection to her hip prosthesis. Review of R16's Infection Care Plan, dated 10/30/25 and found in the EMR under the Care Plan tab, revealed the resident was receiving intravenous antibiotics related to a current infection of her right total hip prosthesis. The care plan indicated the resident was to be maintained in contact isolation related to the active infection. On 11/30/25 from 10:38 am until 10:50 am Housekeeper (HK) 1was observed cleaning R16's room. A sign was posted prominently on R16's door indicating the resident was on Contact Isolation Precautions and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating gloves and a gown were to be worn by anyone entering the resident's room. HK 1 swept and mopped the resident's floor, cleaned the surfaces in the resident's bathroom and cleaned the resident's bed frame and overbed table, coming into direct contact with multiple items consistently used by R16 in her room. HK1 did not apply the required PPE (a gown) while cleaning the resident's room and was observed wearing the same pair of gloves throughout the cleaning process while entering and exiting the resident's room to obtain supplies from her housekeeping cart as well as after she finished cleaning the resident's room and headed down the hallway to clean another resident's roomHK1 was not able to be interviewed related to her observed failure to follow the facility's Infection Control/Contact Isolation procedures. On 12/01/25 at 1:35 pm, Physical Therapy Aide (PTA 1) was observed providing therapy services to R16 in the therapy gym. PTA 1 did not wear a gown or gloves while providing services to R16 and did not appropriately sanitize the equipment used by R16 during therapy after services were provided.During an interview with PTA 1 and the Therapy Director on 12/01/25 at 2:35 pm, PTA 1 confirmed he had not worn gloves or a gown while providing treatment to R16 and confirmed the equipment used during R16's treatment had not been appropriately sanitized after her services were provided. He stated he was not aware that R16 was on contact isolation precautions. The Therapy Director stated her expectation was that appropriate PPE (a gown and gloves) should have been worn by PTA 1 while he was providing treatment to R16, and the equipment should have been sanitized after use to treat R16 to prevent potential spread of infection. During an interview with the DON on 12/01/25 at 3:13 pm, she stated her expectation was all staff working directly with R16, or entering R16's room for any reason, were to wear a gown and gloves per the facility's infection control procedures.Review of the facility's Infection Prevention and Control Program Policy updated on 02/01/25 revealed, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines; and All staff are responsible for following all policies and procedures related to the program; and Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC (Center for Disease Control) guidelines.The facility's policies and procedures related to urinary catheter maintenance and infection control were requested by the survey team on 12/02/25 at 2:00 pm and again on 12/02/25 at 5:00 pm, however the policies were not received prior to survey exit on 12/03/25 at 2:30 pm.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review interviews and policy review, the facility failed to ensure antibiotics were used in accordance with current evidence-based antibiotic use indications for one of six residents (R) R27 reviewed for antibiotic stewardship. The failure had the potential to increase the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use.Findings include:Review of the Census tab, located in the electronic medical record (EMR) revealed R27 was originally admitted to the facility on [DATE].A review of R27's medical diagnoses, found under the Med Diag [Diagnosis] tab of the EMR, revealed a diagnosis urinary tract infection (UTI), dated 05/29/25. A review of R27's Physician Orders, under the Orders tab of the EMR, revealed an order for 250 milligrams (MG) of Erythromycin taken every 6 hours for urinary tract infection (UTI), for 28 days starting 11/14/25. A review of the EMR, under the Results tab, revealed the last urine culture was collected 10/14/25 and was Negative. During an interview with the Infection Preventionist (IP) on 12/01/25 at 3:27 pm, she stated that R27 made complaints of pain in his lower abdomen and with the resident's history of UTI's and the use of a Foley catheter due to bladder-neck obstruction, the residents' provider decided to place the resident on the antibiotic as prophylaxis. She was asked if the resident had a positive culture to confirm the presence of an infection and she confirmed there was no positive culture.In a follow-up interview with the IP on 12/03/25 at 11:21 am, she confirmed that she was aware that the R27 had not had a positive culture, and after receiving the order for antibiotics, she did not address the Medical Director with any concerns regarding the use of an antibiotic outside of the facility's antibiotic use parameters. A review of the facility's policy titled, Antibiotic Stewardship Program, with an effective date of 03/01/22, revealed the purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The policy also advises that the Medical Director sets the standards for antibiotic prescribing practices as well as oversees adherence to antibiotic prescribing practices and ensures the best practices are followed. The policy also states that the IP is responsible for tracking and monitoring of antibiotic use and adhering to the evidenced-based published criteria during the evaluation and management of treated infections.