STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115619	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GLENVUE HEALTH AND REHAB	721 NORTH VETERANS BLVD GLENNVILLE, GA 30427

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to follow the care plan related to related to [DEVICE] medication administration as ordered for two residents of nine (R) R#8, and R#9 residents receiving medications through a Gastric tube ([DEVICE]). The deficient practice had the potential to affect nine of twelve residents receiving medications through [DEVICE]. Facility census 115 Findings include: 1. Record review of the care plan for R#8 care plan problem on set date of 9/27/2019 last updated 6/18/2020 revealed R#8 is at risk for alteration in nutrition and risk for dehydration, resident receives all nutrition and hydration via [DEVICE], approaches are to administer supplements/nutrition and flushes as ordered at room temperature. Record review of R#8 the Medication Administration Record [REDACTED]. Observation and interview on 8/11/2020 at 9:00 a.m. with LPN EE revealed that LPN EE administered 30 ml of water before medication administration and after completion of medication administration no water was administered between each medication as order specifies. Interview with LPN EE revealed that R#8 was to receive 30 milliters (ml) of water per tube before and after medication administration. Continued interview also revealed that the procedure for [DEVICE] medication administration according to LPN EE was to check for placement before medication administration, then residual is checked and if there was more than 100 ml of stomach contents the medication would be held and she would return later to administer medications after residual was less than 100 ml. 2. Review of the care plans for R#9 revealed a care plan with an onset date of 3/30/2020 that was updated on 7/3/2020 that documented the following: at risk for alteration in nutrition and risk for dehydration. Resident is NPO (nothing orally), receives all nutrition and hydration via [DEVICE]. Approaches for R#9 was to administer medication as ordered. Record review of page three of the MAR for R#9 revealed [MEDICATION NAME] powder mix one scoopful (4mg) with 60 ml water and stir until completely mixed: Give by mouth. Observation of medication given to R#9 revealed that medication was not mixed completely as evidence by medication powder remained in the base of the cup after [DEVICE] administration. Also noted in R#9 record medication was ordered to be given by mouth not by [DEVICE] according to MAR. Cross-reference to F 759
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, observation, and review of the facility policy titled, Administering Medications and facility policy titled Self-Administration of Medications the facility failed to follow physician order to administer medications as ordered for two of four residents observed for medication administration through [DEVICE], Resident (R) R#8, R#9. The deficient practice had the potential to affect nine of twelve residents receiving medications through [DEVICE] administration. Facility census was 115. Findings include: Review of the facility policy titled Administering through an Enteral Tube revised November 2018, revealed under general guidelines number three Administer each medication separately and flush between medications. Continued review of policy located under steps and procedures number thirteen states If administering more than one medication, flush with 15 ml warm purified water (or prescribed amount) between medications. 1. Record review of R#8 Medication Administration Record [REDACTED]. Observation of medicatio admininstration on 8/11/2020 at 8:45 a.m pass revealed LPN EE charge nurse on F Hall preparing medication for R#8 which included the following medications: [REDACTED]. LPN EE prepared R#8 medications for [DEVICE] administration, medication was taken to the residents' room. Observation revealed taht LPN EE checked rthe [DEVICE] for placement and residual which was 20 ml, LPN EE continued with administration of medications in different medication cups with 5ml of water in each cup for medication dilution. First medication was poured into R#8 G- tube via 60 ml syringe. LPN EE continued administering medications one after the other with no flushes between each individual medication administered. After completion of medication administration [DEVICE] was flushed with 30 ml of water. LPN EE administered 30 ml of water before medication administration and after completion of medication administration no water was administered between each medication as order specifies. Interview on 8/11/2020 at 9:00 a.m. with LPN EE revealed that R#8 was to receive 30 ml of water per tube before and after medication administration. Continued interview also revealed that the procedure for [DEVICE] medication administration according to LPN EE was to check for placement before medication administration, then residual is checked and if there was more than 100 ml of stomach contents the medication would be held and she would return later to administer medications after residual was less than 100 ml. 2. Record review of page three the MAR for R#9 revealed [MEDICATION NAME] powder mix one scoopful (4mg) with 60 ml water and stir until completely mixed: Give by mouth. Also noted in R#9 record medication was ordered to be given by mouth not by [DEVICE] according to MAR. Medication observation on 8/12/2020 at 9:35 a.m. with LPN FF revealed LPN FF pulled /prepared the following medication for R#9 : Folic acid 1mg tab (1 tab); Zen pep DR (3 capsules); Vitamin C 500mg (1 tab); Zinc sulfate 220mg (1 tab); [MEDICATION NAME] liquid 15 ml; Potassium Chloride 20MEQ/15ml (15ml); [MEDICATION NAME] Sodium 100mg (1 tab); [MEDICATION NAME] 30mg capsule (1 tab); [MEDICATION NAME] 0.5mg (1 tab); [MEDICATION NAME] 1.5 cal ((1)-8fl oz carton); B-1 100mg (1 tab); [MEDICATION NAME] powder mix 1pk (4GM) in 60ml of water. Observed nurse wash her hands, placed each pill in a separate 30 ml cup. LPN FF then crushed each pill separately and opened capsules and poured into 30 ml cup. LPN FF stated she was pouring 5 ml of water into each cup because it was the facility's policy to add 5 ml to each medication. Residual was checked and medication administration began using [DEVICE] syringe. LPN FF was observed pouring water in syringe after each medication was given without measuring. LPN FF stated she was pouring about 3-5 ml of water between medications to help it (the medications) go down. [MEDICATION NAME] powder was not mixed in a cup, she took the syringe and attempted to mix the powder with syringe just before [DEVICE] administration to R#9. After administration of Zen pep and [MEDICATION NAME], there were some beaded medication left in the cup there was no attempt to extract left over medications from the base of the cup. After administration of the [MEDICATION NAME] powder, most of the medication remained at the base of the cup. LPN FF discarded cups without ensuring that all of the medications were administered. Observation of medication given to R#9 revealed that medication was not mixed completely as evidence by medication powder remained in the base of the cup after [DEVICE] administration.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, observation, and facility policy review entitled Administering Medications and facility policy Self-Administration of Medications the facility failed to ensure the medication error rate was less than 5%. There were 19 errors with 34 opportunities for two of four residents (R#8, R#9) for a medication error rate of 55.88%.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Findings: Review of the facility policy titled Administering through an Enteral Tube revised November 2018, revealed under general guidelines number three Administer each medication separately and flush between medications. Continued review of policy located under steps and procedures number thirteen states If administering more than one medication, flush with 15 ml warm purified water (or prescribed amount) between medications. 1. Record review of R#8 Medication Administration Record [REDACTED]. Observation of medicatio admininstration on 8/11/2020 at 8:45 a.m pass revealed LPN EE charge nurse on F Hall preparing medication for R#8 which included the following medications: [REDACTED]. LPN EE prepared R#8 medications for [DEVICE] administration, medication was taken to the residents' room. Observation revealed taht LPN EE checked rthe [DEVICE] for placement and residual which was 20 ml, LPN EE continued with administration of medications in different medication cups with 5ml of water in each cup for medication dilution. First medication was poured into R#8 G- tube via 60 ml syringe. LPN EE continued administering medications one after the other with no flushes between each individual medication administered. After completion of medication administration [DEVICE] was flushed with 30 ml of water. LPN EE administered 30 ml of water before medication administration and after completion of medication administration no water was administered between each medication as order specifies. Interview on 8/11/2020 at 9:00 a.m. with LPN EE revealed that R#8 was to receive 30 ml of water per tube before and after medication administration. Continued interview also revealed that the procedure for [DEVICE] medication administration according to LPN EE was to check for placement before medication administration, then residual is checked and if there was more than 100 ml of stomach contents the medication would be held and she would return later to administer medications after residual was less than 100 ml. 2. Record review of page three the MAR for R#9 revealed [MEDICATION NAME] powder mix one scoopful (4mg) with 60 ml water and stir until completely mixed: Give by mouth. Also noted in R#9 record medication was ordered to be given by mouth not by [DEVICE] according to MAR. Medication observation on 8/12/2020 at 9:35 a.m. with LPN FF revealed LPN FF pulled /prepared the following medication for R#9 : Folic acid 1mg tab (1 tab); Zen pep DR (3 capsules); Vitamin C 500mg (1 tab); Zinc sulfate 220mg (1 tab); [MEDICATION NAME] liquid 15 ml; Potassium Chloride 20MEQ/15ml (15ml); [MEDICATION NAME] Sodium 100mg (1 tab); [MEDICATION NAME] 30mg capsule (1 tab); [MEDICATION NAME] 0.5mg (1 tab); [MEDICATION NAME] 1.5 cal ((1)-8fl oz carton); B-1 100mg (1 tab); [MEDICATION NAME] powder mix 1pk (4GM) in 60ml of water. Observed nurse wash her hands, placed each pill in a separate 30 ml cup. LPN FF then crushed each pill separately and opened capsules and poured into 30 ml cup. LPN FF stated she was pouring 5 ml of water into each cup because it was the facility's policy to add 5 ml to each medication. Residual was checked and medication administration began using [DEVICE] syringe. LPN FF was observed pouring water in syringe after each medication was given without measuring. LPN FF stated she was pouring about 3-5 ml of water between medications to help it (the medications) go down. [MEDICATION NAME] powder was not mixed in a cup, she took the syringe and attempted to mix the powder with syringe just before [DEVICE] administration to R#9. After administration of Zen pep and [MEDICATION NAME], there were some beaded medication left in the cup. There was no attempt to extract this medications from the base of the cup. After administration of the [MEDICATION NAME] powder, obseervation revealed that most of the medication remained at the base of the cup. LPN FF discarded cups without ensuring that all of the medications were administered. Observation of medication given to R#9 revealed that medication was not mixed completely as evidence by medication powder remained in the base of the cup after [DEVICE] administration and the amount of flush between each medication was not measured. Interview on 8/17/2020 at 5:00 p.m. with the Director of Nursing (DON) revealed that her expectations for medication administration for [DEVICE]s is that the nurses administer the residents' medication in its entirety. Continued interview revealed that the facility has no policy to her knowledge of what to do when there is medication left in the bottom the administration cup.
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, staff interview , and facility policy review titled How to Properly store foodthe facility failed to ensure that expired foods in the dried foods pantry, kitchen up right cooler, and milk cooler, in the main kitchen were discarded. The facility also failed to ensure that kitchen steamer, food warmer, and steam table were clean and maintained. The deficient practice had the potential to affect 106 of 115 residents receiving an oral diet. Findings: Observation on [DATE] at 9:50 a.m. of the facility kitchen revealed the steamer located behind the steam table had noted buildup of white streaks streaming down the front of steamer as well as the stand in which the steamers rested on had debris noted. Further observation of steamer revealed that the inside base had dark brown substance noted as well. Observations were confirmed by Dietary Manager (DM) at the time of observation. Observation on [DATE] at 9:55 a.m. of kitchen steam table revealed the base of the steam table tray is covered with brown substance to all tray inserts. The substance was from the base to the sides of noted trays on all trays observed which was confirmed by DM. Interview on [DATE] at 10:00 a.m. with DM revealed that the substance in question was lime build up and that the staff has not had a chance to clean them. Continued interview with DM revealed that she would have the staff to remove steam table pans and have them to soak them over night to remove the build up that has accumulated. DM was unable to express the last time that steam table pans have been cleaned for lime build-up. Observation on [DATE] at 10:15 a.m. of the milk cooler located in the first room to the right revealed four half gallons (1.89L) of buttermilk with the expiration date noted of [DATE] DM confirmed that milk was expired and still inside milk cooler. Observation of first cooler located in the back of the kitchen revealed a quart sized covered container labeled green lima beans was dated [DATE] Interview with DM revealed that container should have been discarded on [DATE] per facility policy that states leftover foods are be discarded after 72 hours if not used. Observation on [DATE] at 10:30 a.m. of the dried food storage revealed three four-pound bags of new potatoes that were spoiled and had brown liquid puddled under each bag and small flies flying around the box they were stored in with a foul smell noted. DM confirmed that potatoes were rotten and removed them from the pantry area. Further observation on [DATE] at 10:35 a.m. revealed that the freezer door was frozen shut and DM was unable to open the door. DM revealed that the door often freezes shut and maintenance is notified, and they come and fix the issue. Interview on [DATE] at 10:40 a.m. with DM revealed that the head cook is responsible for making sure that all expired foods are discarded and properly rotated out daily as needed. Further interview also revealed that a daily cleaning schedule is posted for the staff to follow and that the expectation is that the schedule is completed and followed daily. Review of facility kitchen Daily cleaning schedule dated Aug. ,[DATE], 2020 revealed the tray line cleaning had been completed four of seven days, blender/food processor two of seven days, knife rack two of seven days, can opener two of seven days, refrigerator three of seven days, grill zero of seven days, steam table three of seven days, garbage cans and lids three of seven days, Ice machine - scoop three of seven days, tray carts- wiped and sanitized two of seven days, floors zero of seven days, steamer was to be cleaned weekly there was no documentation of cleaning for the week, the last noted date for cleaning and organizing refrigerator was documented on [DATE]. Interview on [DATE] at 4:20 p.m. with Administrator revealed that she is aware of the freezer door malfunction, and further states that the door had been freezing since a sprinkler head was added inside of the freezer. Continued interview also revealed that the time when the door is freezing shut is when it is held open for a period for staff to unload food when supplies are delivered. Administrator also acknowledge that there was also an issue with the food steamer located in the kitchen and revealed that the door has an issue with staying closed and sealed.