| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115025 | A. Building<br>B. Wing | 10/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Glenwood Health Center by Harborview | 4115 Glenwood Rd<br>Decatur, GA 30032 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579<br><br>Based on observations, record review, interviews, and review of the facility's policy titled Promoting/Maintaining Resident Dignity, the facility failed to ensure resident's dignity was maintained by not displaying clinical information related to swallowing, openly posted in the resident's room for visitors to see when visiting resident or her roommate for one of one resident (R) R94 of 102 sampled residents.<br><br>Findings:<br><br>Review of the facility policy titled Promoting/Maintaining Resident Dignity revised 4/1/2024, revealed that it is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: Number 11: Staff are to maintain resident privacy.<br><br>Review of the electronic medical record (EMR) revealed R94 was admitted to the facility on [DATE] with diagnoses including cirrhosis of the liver, acute pancreatitis, and oropharyngeal dysphagia.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Brief Interview for Mental Status score of 13, which means that the resident was cognitively intact. Section E revealed that the resident hallucinates, and Section GG revealed that the resident needed set up help for eating.<br><br>Review of the care plan revised on 10/4/2024 indicated that risk is at nutritional risk related to alcoholic cirrhosis of liver, dysphagia, and her need for a therapeutic and mechanically altered diet, which she is frequently noncompliant. Interventions to care include observe/document/report any signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, and refusing to eat, provide diet as ordered, registered dietician to evaluate and make recommendations as needed. Further review documented that R94 needs a mechanical soft diet texture and liquid consistency is recommended, her son brings regular textured food during visits.<br><br>Observation on 9/24/2024 at 11:28 am revealed in room [ROOM NUMBER] revealed a sign taped above the head of bed A, providing clinical information that resident was to have thickened liquids. The sign stated the residents name and was signed 'S therapy'. During further interview about the placement of the sign, the resident stated, I don't know who put that there?,<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115025 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/11/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Glenwood Health Center by Harborview | | STREET ADDRESS, CITY, STATE, ZIP CODE: 4115 Glenwood Rd Decatur, GA 30032 | |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 9/25/2024 at 1:35 pm, Licensed Practical Nurse (LPN) 00 stated the only reason she could think of for the sign to be posted with the residents name revealing that she requires thickened liquids, is that the family wants it to be there. She stated that all staff knows that she has thickened liquids.<br><br>Interview on 9/25/2024 2:15pm, speech therapist (SLP) was interviewed He stated that the resident is non complainant with diet and is constantly asking staff to give her regular thin liquids. He then stated that son has been educated when she is on case load and then stated that he will document, the education, and it occurred sometime during the summer. He then stated that it had probably not cared planned and that he did not ask the family if it was okay to hand the sign above the bed.<br><br>10/7/2024 at 2:45pm, the Director of Nurses was interviewed. If a resident had a note with their name and diet over their bed, it was likely because a family member requested it. She would have to look at the policy, but every time she recalls this happening was a result of a family request. |

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F 0554

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Allow residents to self-administer drugs if determined clinically appropriate.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138

Based on observations, record review, interviews, and review of the facility policy titled Resident Self-Administration of Medication the facility failed to assess and determine if one of one resident (R) (R83) from a sample of 102, for the ability to safely self-administer medications, prior to the resident exercising that right.

Findings include:

1. Review of the policy titled Resident Self-Administration of Medication reviewed 3/1/2024 documented the policy of the facility is to support each residents right to self-administer medications. A resident may only self-administer medication after the facility interdisciplinary team has determined which medication may be administered. Policy Explanation and Compliance Guidelines: Number 1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team. Number 3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following:

a. The medications appropriate and safe for self-administration;

b. The resident's physical capacity to swallow without difficulty, open medication bottles, administer injections;

c. The resident's cognitive status, including their ability to correctly name their medications and know what

conditions they are taken for;

d. The resident's capability to follow directions and tell time to know when medications need to be taken;

e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing,

and signs of side effects, and when to report to facility staff.

f. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate

when this occurs.

g. The resident's ability to ensure that medication is stored safely and securely.

Number 13. The care plan must reflect resident self-administration and storage arrangements for medications.

(continued on next page)

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 10/2/2024 at 10:43 am, in R83's room revealed at bedside the following items: Latanoprost Opthalmic Solution, two vapor inhaler, one container VapoRub, one bottle of calcium magnesium & zinc plus vitamin D vitamins, one bottle of vitamin C 500 milligrams (mg), one open tube of Tylenol Precise Pain-Relieving Lidocaine four percent (%) Cream, and Biofreeze on the night stand next to the bed.<br><br>Review of the clinical record revealed R83 was admitted to the facility on [DATE] with diagnoses including ventricular tachycardia, glaucoma, bilateral cataract, subacute hepatic failure, thrombophilia, and hypertension.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. No moods or behaviors exhibited. Resident needs assistance with activities of daily living (ADL) care.<br><br>Review of R83's care plan initiated 3/31/2024 revealed no evidence that resident was assessed to self-administer medications, or to keep rubbing alcohol at bedside.<br><br>Review of the R83's current Physician Orders revealed there was no order for the following meds that were identified at residents bedside: vapor inhaler, vapor rub, calcium magnesium & Zinc plus vitamin D, Tylenol Precise Pain-Relieving Cream Lidocaine 4 percent (%), or Bio freeze. Further review revealed an order for Latanoprost 0.005% eye solution, order date 4/2/2024 and Vitamin C 500 milligrams (mg), order date 4/10/2024. There was no evidence that resident had a Physician Order to have medications at bedside for self-administration.<br><br>Interview on 10/3/2024 at 2:23 pm, the Director of Operations (DO) confirmed that the over the counter medications found in R83's room should not be there.<br><br>Interview on 10/8/2024 at 10:00 am, Registered Nurse (RN) CCC revealed no over the counter medications should be in the residents possession because they can cause an adverse reactions with other medications the residents are prescribed. During further interview, she stated that if medications are found at resident bedside, she would ask the resident where the medication came from, explain why he/she should not have the medication and ask permission to remove the medication.<br><br>Interview on 10/8/2024 at 10:05 am, Director of Nursing (DON) revealed residents are not to have any type of medications at the bedside, for self-administration, if they do not have a physicians order to keep at bedside. During continued interview, she stated that over the counter medications can cause adverse reactions with other medications the resident is prescribed. The DON stated the Certified Nursing Assistants (CNAs) are the eyes and ears and once the problem is identified she would complete an investigation as well as reeducate the staff, residents and family members. |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50526<br><br>Based on observation, resident and staff interviews, record review, and review of the facility's policy titled Resident Rights, the facility failed to offer one of 13 sampled residents (R) (R266) baths as scheduled. This failure had the potential to affect the resident's comfort, body image and increase the risk for infections.<br><br>Findings include:<br><br>Review of the facility's policy titled Resident Rights dated February 2021, under the Policy Statement revealed, Employees shall treat all residents will be treated with kindness, respect and dignity. Under Policy Interpretation and Implementation revealed, 1. Federal and state laws guarantee certain basic rights to all resident of this facility. These rights include the resident's right to: (e.) self-determination.<br><br>Review of R266's face sheet revealed the resident admitted with the following diagnoses that included but are not limited to wasting disease, human immunodeficiency virus, protein calorie malnutrition, and sepsis due to escherichia coli.<br><br>Review of R266's Admission Minimum Data Set (MDS) dated [DATE] revealed Section C-Cognitive Pattern, a Brief Interview of Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact; Section F-Preferences for Customary Routine and Activities indicated it was very important to choose clothing, between a tub bath, shower, bed bath or sponge bath and privacy; Section GG-Functional Abilities and Goals revealed the resident required partial/moderate assist for showering and a substantial maximum assistance with toileting hygiene and dependent with lower body dressing; Section H-Bladder and Bowel indicated no toileting program, always incontinent of urine and bowels.<br><br>Review of R266's care plan dated 9/22/2024 revealed problem of activities of daily living (ADL) care deficit with goal of maintaining abilities with interventions that included but not limited to: ensure effective pain management prior to ADL activities, provide cuing with tasks as needed, and encourage the resident to participate to the fullest extent possible with each interaction.<br><br>Review of the facility's shower sheets for R266 revealed shower days were scheduled for three nights per week. Further review of the one shower sheet provided by the facility since admitted d 9/18/2024 marked bed baths with no documentation of refusals noted.<br><br>Interview on 9/23/2204 at 3:15 pm with R266 revealed he was not sure how long he had been at the facility (admit 9/6/2024) but stated they do not take care of me. R266 further stated he had only had two baths since admission. He stated, they had him on night shift and he did not like it. He further stated that he told staff he did not want a bath in the middle of the night.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 9/25/2024 at 1:47 pm with Certified Nursing Assistant (CNA) HH revealed R266 was easily agitated. She further revealed all showers/baths are documented on a bath sheet and in the Electronic Medical Record (EMR) that included refusals. She stated, if the resident refuses, they would offer again and if they still refused the nurse would talk with the resident and all refusals should be marked on bath sheet and in the EMR.<br><br>Interview on 9/25/2024 at 1:54 pm with Unit Manager CC revealed, she was also unable to locate any further documentation of baths for R266. She revealed that the bath schedule was based on room number but if they request a different time, she will adjust and accommodate the request. She further revealed she was not aware of any residents at this time who had requested a different schedule.<br><br>Interview on 10/2/2024 at 10:53 am revealed with Director of Nursing revealed residents should be accommodated if their bath schedule were not acceptable, and that she would look into the night baths being completed within certain hours and only for total care residents. |

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| F 0574<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The resident has the right to receive notices in a format and a language he or she understands.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50374<br><br>Based on observations, record review, resident and staff interviews, and review of the facility's policy titled, Language Assistance Service, the facility failed to ensure one of two sampled residents (R) (R182) with Limited English skills, was provided with resources to access and understand communications regarding his healthcare regimen.<br><br>Findings include:<br><br>Review of the facility's policy titled, Language Assistance Service revised 6/1/2024 indicated it is the policy of the facility to take responsible steps to ensure that individuals with Limited English Proficiency (LEP) are not discriminated against and have access to language assistance services and meaningful communication involving their medical conditions, treatment, and other vital documents. Compliance Guidance: Number 1. The facility will identify the language and communication needs of the individual with LEP during the prescreening and admission process. Number 3. Language assistance will be provided in-person or remotely by a qualified interpreter and/or the use of qualified bilingual or multilingual staff; through written translation performed by a qualified translator, of written content in paper or electronic form into or from languages other than English; and written notice of availability of language assistance service. Number 8. All staff will be provided notice of this policy, and staff that may have direct contact with individuals with LEP will be trained n effective communication techniques, including the effective use of an interpreter. Number 9. The facility will conduct a regular review of the language access needs of the resident population, as well as update and monitor the implementation of the policy. Language Assistance Services my include but not limited to: (1) Oral language assistance, including interpretation in non-English languages provided in-person or remotely by a qualified interpreter for an individual with limited English proficiency; (2) written translation, performed by a qualified translator, of written content in paper or electronic form into or from languages other languages; and (3) Written notice of availability of languages assistance services.<br><br>Review of the clinical record revealed R182 was admitted to the facility on [DATE] with diagnoses including encephalopathy, dementia, benign prostate hypertrophy (BPH), depression, and hypertension (HTN).<br><br>Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not scored, unable to determine cognitive level, due to resident rarely/never understood, with ability to understand others sometimes. Further review revealed R182 requires moderate assistance and supervision with activities of daily living (ADLs). Care Area Assessment Summary (CAAS) triggered Communication for care planning.<br><br>Review of the care plan dated 2/20/2024 documented R182 is at risk for impaired communication due to not always being understood and he speaks Spanish, little to no English. Resident may require non-verbal cueing/gestures, communication devices, and/or communication services for optimal care/services. Interventions to care include use non-verbal cueing and gestures to help convey ideas and plan of care, utilize communication services, communication devices, and/or Spanish speaking staff as needed, answer questions and repeat as needed and listen carefully, validate verbal and non-verbal expressions.<br><br>(continued on next page) |

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| F 0574<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 9/22/2024 at 1:15 pm, R182 spoke little to no English as he was seen attempting to communicate with his roommate. R182 was observed pointing to different items in his room while speaking Spanish. Surveyor asked R182 questions but unable to communicate due to the communication barrier.<br><br>Observation on 9/22/2024 at 2:00 pm, R182 was at the nurses station speaking in Spanish and using pointing gestures to communicate. It was observed staff attempting to communicate with R182 without using any type of communication device/translation service.<br><br>Interview on 9/25/2024 at 9:18 am, with R182 and a Spanish speaking surveyor interpreting for him, revealed R182 expressed his concerns with his communication. R182 stated he knows a few words in English and the staff attempt to communicate with him using the words that he knows. He stated his roommate speaks a limited amount of Spanish and helps him with communicating with the staff his needs or concerns. During continued interview, he expressed that he usually points to items as a means to communicate his needs. R182 continued to state it is frustrating at times due to the communication barrier. When asked about his knowledge regarding his care plan and treatment, R182 stated he is not clear about the care he is receiving or the medications he is taking. He stated the admission paperwork was presented in the English language and he did not understand what it was about, but stated he trusts the facility to do right by him because they are the experts.<br><br>Interview and observation on 9/25/2024 at 11:48 am, Unit Manager (UM) NN revealed the dementia care unit did not have a posted language line at the nurse station, for staff to use with R182 communication needs. During further interview, UM NN stated they have a communication binder for a language line but the page was missing. UM NN stated she would have to try to find the information.<br><br>Observation on 9/25/2024 at 12:00 pm, R182 was standing at the nurses' station communicating in Spanish. He appeared to be frustrated when communicating with staff members. R182 approached surveyor and began to express his concerns in Spanish and started pointing at his room. It did not appear that staff understood what he was trying to communicate with them.<br><br>Interview and observation on 9/25/2024 at 12:30 pm, License Practical Nurse (LPN) ZZ stated Dogwood Hall and Georgia Hall do not have access to a language line. LPN ZZ stated she was not aware of a language line nor information on how to obtain language information.<br><br>Observation on 9/25/2024 at 12:33 pm, both East and [NAME] Unit nurses station do not have information on the unit pertaining to accessing a language line or information on how to obtain it.<br><br>Interview on 9/25/2024 at 1:36 pm, Certified Nursing Assistant (CNA) UUU stated she is aware that R182 has limited communication with English. She stated he will point at things, or use gestures in attempts to make his needs known. CNA UUU continued to state she does not use an app translator for everyday communication but will use it if there is an emergency or communication becomes complex.<br><br>Interview on 9/25/2024 at 1:49 pm, UM NN stated R182 understands a little English and knows a fair number of words, but will reply in Spanish. She stated she uses her phone and resident will read what is being translated.<br><br>(continued on next page) |

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| F 0574<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 9/25/2024 at 2:00 pm, with Social Worker (SW) UU revealed she is not familiar with R182 communication barriers. She stated she is new to the position and would have to ask the Administrator about resources for communication for residents who have limited English.<br><br>Interview with Admission Director (AD) at 2:14 pm revealed she is familiar with R182 because she did the admission packet. She stated she was not informed that he had difficulty communicating in English. When asked about what form of communication was used for R182's admission, she confirmed it was conducted in English writing and an app was used to aid in communication the admission process. During further interview, she stated she could not determine if R182 understood what was being presented to him. The AD stated R182 should have been care plan for interventions for staff to utilize a language line to assist as a communication device. She further stated anyone can update a resident's care plan, when needed.<br><br>Interview on 9/25/2024 at 2:20 pm, the Director of Nursing (DON) and the Regional Nursing Consultant revealed that the staff should be using some form of communication assistance, if residents don't seem to understand what is being explained to them. She stated the staff are trained to do so and confirmed staff can use any application, if necessary, as a form of communication. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579<br><br>Based on observations, record review, and resident and staff interviews, the facility failed to ensure that it was maintained in a safe, clean, and comfortable home-like environment for 12 rooms (G224, G226, G227, G228, G229, G230, D201, W143, M101, M106, M107, M108) on four of five wings (Georgia Wing, [NAME] Wing, Dogwood Wing, and Magnolia Wing) including dirty bathrooms with noisy and dusty exhaust vents, broken light switches, dirty packaged terminal air conditioner (PTAC) units, a broken window, and dead insects in resident rooms. In addition, the laundry room had rancid odor, leaking pipes, dirty laundry overflowing from laundry chute onto floor, trash and lint atop the dryers, and a dusty fan in the clean laundry room. The census was 210.<br><br>Findings:<br><br>1. Observation on 9/22/2024 at 2:21pm, Georgia Wing shared bathroom in room [ROOM NUMBER]/226, revealed the base/support for the toilet was noted to be covered in rust colored substance; the door frame had the same rust colored substance; the light switch was pushed up in the on position, but the light did not come on for resident use when using the bathroom.<br><br>Observation on 9/22/2024 at 2:50 pm, Georgia Wing shared bathroom in room [ROOM NUMBER]/229, revealed the out take vent was covered with a fuzzy grey substance and was making a churning sound when in the on position; there were dead bugs in the bathroom light globe; and the hand sanitizer pump in room [ROOM NUMBER] was empty.<br><br>Observation on 9/22/2024 at 3:32 pm, Georgia Wing, in room [ROOM NUMBER], the base board behind the door is missing.<br><br>Observation on 9/22/2024 at 4:05 pm, Georgia Wing room [ROOM NUMBER], the filter on the packaged terminal air conditioner (PTAC) unit, both PTAC filters were covered with fuzzy grey colored substance, and there was black colored particles on the left side filter.<br><br>Observation on 9/23/2024 at 2:37 pm, Georgia Wing in room [ROOM NUMBER], revealed the window has a crack in the glass, and a dead bug on the window sill.<br><br>Observation on 9/23/2024 at 2:47 pm, Georgia Wing shared bathroom in room [ROOM NUMBER]/226 revealed a strong urine smell in the bathroom, bathroom light still does not work, the base boards were covered with rust colored substance; and the base of the toilet continued to be covered with a rust-colored substance.<br><br>Observation on 9/23/2024 at 3:01 pm, Georgia Wing room [ROOM NUMBER], PTAC filter remains covered with fuzzy grey substance.<br><br>Observation on 9/23/2024 at 3:15 pm, Georgia Wing in room [ROOM NUMBER], revealed the bathroom exhaust fan had grey dust build-up, and the fan squeals loudly. The bathroom light flickers in the on position.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 50526<br><br>2. Observation and interview on 9/22/2204 at 1:30 pm, Dogwood Wing in room [ROOM NUMBER], revealed a large amount of trash on the floor around the bed and the trash can was out of reach of the resident. There was a strong odor noted in the room. The toilet bowl had brown fluid around back part of commode. R48 has a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitvely intact. He stated the housekeepers rarely come in to clean his room, maybe every three days. R48 also stated the water in the bathroom often runs a rusty in color. Water turned on and was not rusty color at this time.<br><br>50374<br><br>3. Observations on the Magnolia Wing revealed:<br><br>*9/22/2024 room [ROOM NUMBER] revealed PTAC air filter were filled with debris.<br><br>*9/22/2024 room [ROOM NUMBER] revealed PTAC air filter were filled with debris.<br><br>*9/22/2024 room [ROOM NUMBER] revealed PTAC air filter were filled with debris.<br><br>*9/22/2024 room [ROOM NUMBER] revealed PTAC air filter were filled with debris.<br><br>Interview on 10/5/2024 at 10:34 am, with Regional Maintenance Director revealed the facility is currently cleaning air filters every three months. Upon verifying the manufacturers recommendations, he stated the air filters are supposed to be cleaned every month. Regional Maintenance Director provided an email indicating the change to be made for cleaning the PTAC air filters from every three months to once per month.<br><br>Interview on 10/7/2024 at 12:18 pm, with Corporate Maintenance Director revealed the PTAC air filters need to be cleaned every three-months based on Tels (web-based ticketing system to track day-to-day building operations) they use for all of their facilities. The Maintenance Director was present and corrected him that based on manufacturers recommendations PTAC air filters are supposed to be cleaned every month.<br><br>49138<br><br>4. Observation on 9/23/2024 at 3:47 pm, 10/4/2024 at 2:32 pm, and 10/7/2024 at 9:10 am, [NAME] Wing room [ROOM NUMBER], revealed the PTAC unit to have debris on the inside of the unit throughout the length of the survey.<br><br>Tour of laundry room on 10/9/2024 on 2:11 pm, with Laundry/Housekeeping Manager NNN revealed a rancid smell. A leaking pipe in the laundry room was observed attached to the wall above an active surge protector. This leaking pipe was slowly dripping a wet liquid substance on a wire connected to the surge protector. The laundry Chute had an overflow of dirty linens spilling on to the floor, most of which were not in bags. Observation of the dryer room revealed two broken dryer machines and two dryer machines that were not reaching the proper temperatures. One of the drying machines was observed missing a door.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 10/9/2024 at 2:40 pm, revealed a total of four dryers, but only two are operational. There are exposed pipes at the top of the dryers with lint and debris substance on top. In the washing area there was a pipe coming down the wall that was leaking water. At the top of that same wall there was a big fan full of fuzzy dark gray and black like substance.<br><br>Observation on 10/10/2024 at 11:08 am revealed the fan had been cleaned. The laundry Chute door is now being closed so that clothes are not falling onto the floor or overflowing into the bin. There was a team of individuals working on the leaking pipe in the laundry room. Observed on top one of the washing machines was a white and brownish grimy substance.<br><br>Interview/Walk Around on 10/9/2024 at 11:30 am, the Administrator Assistant (AA), Maintenance Director (MD), and Housekeeping/Laundry tech PPPP revealed that all washers are in working order. The AA stated that if the washers are going in and out, that is a power issue and not an issue with the washers and dryers, themselves. During continued interview, the AA revealed dirty clothes are supposed to be dropped down the Chute and there is a staff member waiting at the bottom of the Chute to get the clothes as they come through. He reiterated that the clean clothes are taken out of the laundry room before they start working on the dirty clothes/linens.<br><br>Interview on 10/10/2024 at 11:08 am, the MD stated they tried to swap out parts from one of the other dryers to see if that would fix the broken dryer. However, that didn't work, so the MD stated they were going to call out a service team. The MD confirmed that this is an issue that needs to be addressed. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47947<br><br>Based on interviews, record review, and review of the facility policy titled Abuse, Neglect and Exploitation, the facility failed to report injuries of unknown origin to the State Survey Agency (SSA) within the required timeframe for one of four sampled residents (R) (R154) reviewed for abuse and neglect. The failure of the facility to report this incident has the likelihood of leading to future unreported injuries of unknown origin, with the potential to affect resident's quality of life.<br><br>Findings include:<br><br>Review of the policy titled Abuse, Neglect and Exploitation revised 3/1/2024, revealed the policy of the 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. Components of the facility abuse prohibition plan: IV. Identification of Abuse, Neglect, and Exploitation Letter B. Possible indicators of abuse include: 3. Physical injury of a resident of unknown source. V. Investigation of Alleged Abuse, Neglect, and Exploitation Letter A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. VII. Reporting/Response Letter A. The facility will develop and implement written policies and procedures that: Number 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement, when applicable) within specified timeframes:<br><br>a. Immediately, but not later than two hours after the allegations is made, if the events that<br><br>cause the allegation involve abuse or result in serious bodily injury.<br><br>b. No later than 24 hours if the events that cause the allegation do not involve abuse and do not<br><br>result in serious bodily injury.<br><br>Review of the electronic medical record (EMR) for R154 revealed he was admitted to the facility on [DATE] with diagnoses including lobular pneumonia, pressure ulcer to sacral region, hypertension (HTN), chronic respiratory failure, and traumatic brain dysfunction.<br><br>The resident's most recent annual Minimum Data Set (MDS) assessment dated [DATE], revealed his Brief Interview for Mental Status (BIMS) was not coded, indicating cognition could not be determined, due to resident is rarely/never understood. Resident is totally dependent on staff for all care.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Facility Incident Report Form (FRI) dated 12/29/2023 documented the type of injury as injury of unknown source. The details of the incident revealed family member called to state resident (R154) has a hip fracture. Resident is not in facility, transferred to hospital on 12/27/2023 due to (SOB) shortness of breath. Investigation started. The date and time of the incident was incomplete - documented as TBD (to be determined). Injury is identified as hip fracture with no details yet. The steps taken by the facility to prevent further incidents was documented as family member called to state resident (R154) has a hip fracture. Resident is not in facility, transferred to hospital on 12/27/2023 due to (SOB) shortness of breath.<br><br>Review of the Five-Day follow-up dated 1/8/2024 summarized the details of the incident: on December 27, 2023, R154 was sent to hospital via emergency medical services (EMS) due to respiratory failure. He had two transfers that same day, 12/27/2023: from the facility to the local hospital; then from the local hospital to a higher-level care facility. After admission to a higher-level care facility, R154's spouse contacted the facility and reported to the Director of Nursing (DON) that the resident had a femur fracture that was diagnosed in the hospital, with no additional details. An investigation was started. Documentation was requested and reviewed by the DON, and concluded that the incident was unsubstantiated.<br><br>Interview on 10/9/2024 at 11:45 am, Regional Nurse Consultant (RNC) and Regional Director of Operations (RDO) confirmed that R154's wife called the facility on 12/27/2023 and reported that her husband had a hip fracture, diagnosed during the hospital admission, and confirmed the incident was reported to the state on 12/29/2023. During further interview, the RDO stated that she is not sure why the incident was not reported until 12/29/2023, but she would contact the previous Administrator FFFF to obtain more information about the reporting dates.<br><br>Interview on 10/9/2024 at 12:30 pm, the RNC and RDO revealed the facility had requested hospital records for R154 on 12/27/2023 to confirm the femur fracture, but the records were not received until 12/29/2023, and that is why the incident was reported to the SSA on 12/29/2023. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138<br><br>Based on observations, record review and interviews, the facility failed to ensure that Minimum Data Set (MDS) assessments were accurate for one of one residents (R) (118) from a sample of 102, related to smoking.<br><br>Finding included:<br><br>Review of the clinical record revealed R118 was admitted to the facility on [DATE] with diagnoses including paraplegia, metabolic encephalopathy, right/left hand contractures, hypertension and lack of coordination.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was coded as 14, which indicated no cognitive impairment. Section J revealed the section for Current Tobacco Use was unmarked.<br><br>Review of the facility-provided document titled Smoking List 9/23 revealed R118's name was not on the list.<br><br>Review of the smoking assessments dated 3/25/2024 and 7/15/2024 revealed R118 did not use smoking/tobacco/nicotine products.<br><br>Review of R118's care plan revised 2/14/2023 revealed there was no evidence of a care plan addressing resident being a smoker.<br><br>In an interview on 10/7/2024 at 9:10 am, R118 stated he occasionally smoked, and further stated he smoked once or twice every two to three months.<br><br>In an interview on 10/7/2024 at 2:20 pm, the MDS Regional Coordinator (MDSRC) stated residents who occasionally smoke need to be care planned and an assessment should be done as well. The MDSRC confirmed R118's smoking assessment documented he did not smoke.<br><br>In an interview on 10/7/2024 at 2:28 pm, R118 revealed that he last smoked outside in the front smoking area of facility.<br><br>During an observation on 10/7/2024 at 2:49 pm, with the MDSRC, revealed R118 was outside in the front smoking area of the facility smoking a cigarette with staff present. The MDSRC confirmed R118 was outside smoking.<br><br>In an interview on 10/6/2024 at 5:33 pm, the Director of Nursing (DON) and Regional Nurse Consultant revealed the nursing staff was responsible for completing the smoking assessments.<br><br>A policy on resident assessment was requested but not received.<br><br>Cross Refer F689 |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44757<br><br>Based on observations, record review, resident and staff interviews, and review of the policy titled Comprehensive Care Plans, the facility failed to develop and/or implement the person-centered care plan for six residents (R) (R71, R266, R19, R25, R111, R118) reviewed for smoking. In addition, the facility failed to develop a care plan for one resident (R172) related to Post Traumatic Stress Disorder (PTSD). The facility's failures created potential risks for the safety and well-being of the residents. The sample size was 102 residents.<br><br>On 10/9/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents.<br><br>The facility's Corporate Regional Director of Operations, Corporate Regional Nurse Consultant (RNC), and Director of Nursing (DON) was informed of an Immediate Jeopardy (IJ) on 10/9/2024 at 3:11 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on 9/22/2024. Upon survey entrance to the facility, residents were observed sitting out front of the facility, smoking unsupervised. Throughout the duration of the survey, the facility failed to monitor the smoking practices by not maintaining accurate smoking assessments, allowing residents to keep smoking materials in their possession, not supervising residents while smoking, and allowing a resident in the dementia care unit to smoke inside the facility.<br><br>A Credible Allegation of Compliance was received on 10/11/2024. Based on observations, record review, resident and staff interviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed as of 10/11/2024. The facility remains out of compliance while the facility continues management level oversight as well as continues to develop and implement a Plan of Correction. (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures regarding facility smoking practices, to include smoking assessments, and following care plans related to smoking. Resident records were reviewed to ensure that resident care and treatment was current and accurate.<br><br>Findings include:<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 1. A review of the facility policy titled Comprehensive Care Plans reviewed 10/1/2024 indicated the Policy Statement: Facility will develop and implement a comprehensive-person centered care plan for each resident. Consistent with resident rights, that includes measurable objectives and timeframes to meet a residents medical, nursing, mental and psychosocial needs. Person-centered care means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. Policy Explanation and Compliance Guidelines: Number 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. Number 3. The comprehensive care plan will describe, at a minimum, the following:<br><br>a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and<br><br>psychosocial well-being.<br><br>b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her<br><br>right to refuse treatment.<br><br>d. The resident's goals for admission, desired outcomes, and preferences for future discharge.<br><br>e. Discharge plans, as appropriate.<br><br>f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural<br><br>identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur<br><br>with the resident. The care plan will identify the language spoken and tools used to communicate.<br><br>g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of<br><br>trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's<br><br>exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of<br><br>the trigger on the resident.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Number 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.<br><br>A. Review of the electronic medical record (EMR) for R71 revealed an admitted [DATE] with diagnosis that include conversion disorder with seizures or convulsions, traumatic brain injury (TBI), muscle weakness, unspecified intellectual disabilities, dysphagia, lack of coordination, other specified forms of tremor, and lattice degeneration of retina.<br><br>A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was coded as 12, which indicated moderate cognitive impairment. Section J on the 3/26/2024 annual MDS revealed resident was coded as a current tobacco user.<br><br>A review of the smoking assessments dated 3/22/2024, 3/28/2024, 7/4/2024, and 10/5/2024 for R71 documented that resident should only smoke during morning, afternoon, and evening smoke breaks, should wear an apron, requires supervision- including retrieval of supplies, and needs someone to light/extinguish cigarette. Review of R71's smoking assessments revealed yes to the question, does resident smoke?<br><br>A review of R71's care plan initiated 6/11/2021 and revised 10/5/2024 revealed that resident was an unsafe smoker, she is non-compliant with smoking policy - resident was observed smoking in her bathroom (10/10/2017), she solicits smoking materials from other residents, staff, and visitors (2/17/2016), she refused to wear smoking apron (3/7/2024). Interventions to care include educate and provide safety awareness for smoking, instruct resident about the facility policy on smoking: locations, times, safety concerns, resident requires a smoking apron, and notify charge nurse immediately if it is suspected resident has violated facility smoking policy.<br><br>Observation on 10/4/2024 at 12:09 pm, R71 was outside smoking and not wearing a smoking apron. She is observed to have burn holes in her shirt as she is seen wiping the ashes off of her clothes.<br><br>B. Review of the EMR for R266 revealed he was admitted to the facility on [DATE] with diagnoses including pneumonia, protein calorie malnutrition, sacral pressure ulcer, deep vein thrombosis, and sepsis due to escherichia coli (e-coli).<br><br>A review of the admission MDS dated [DATE] revealed a BIMS was coded as 14, which indicated no cognitive impairment. Section J revealed resident was not coded as a current tobacco user.<br><br>A review of the smoking assessments dated 10/6/2024 revealed the question does resident use smoking/tobacco/nicotine products? Response was documented no-stop here.<br><br>A review of R266's care plan revised on 9/20/2024 revealed resident did not have a care plan for smoking. He has a behavior care plan which documented R266 was observed smoking in his room on 9/19/2024, without an intervention to address his smoking.<br><br>Observation on 10/10/2024 at 2:18 pm, R266 was outside smoking in his wheelchair. There were no staff members supervising the resident during the smoke break.<br><br>49673<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | C. Review of the EMR for R19 revealed he was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, malignant neoplasm of lower gastrointestinal tract, diabetes, end stage renal disease (ESRD), hypertension, and depression.<br><br>A review of the quarterly MDS dated [DATE] revealed a BIMS score of six which indicated that the resident had severe cognitive impairment. Section J on the 12/23/2023 annual MDS revealed resident was not coded as a current tobacco user.<br><br>A review of the smoking assessment dated [DATE] revealed R19 requires supervision with retrieval of smoking supplies.<br><br>A review of R19's care plan revised 10/6/2024 revealed resident is a smoker and requires supervision and will not have injury related to smoking. Interventions to care include smoking assessment per facility protocol, staff supervision during smoking, and staff to maintain/store all smoking materials.<br><br>Observation and Interview on 10/7/2024 at 12:03 pm, R19 observed smoking outside in the front smoking area unsupervised. Resident was noted to be wearing a pair of pants with one visible burn hole on them. Interview with resident at this time confirmed that he had a burn hole in his pants. He stated that he keeps his cigarettes and lighter with him.<br><br>50374<br><br>D. Review of the EMR for R25 revealed he was admitted to the facility on [DATE] with diagnoses including dementia, cognitive communication deficit, lack of coordination, mood and psychotic disorders, hypertension (HTN), and anxiety.<br><br>Review of the quarterly MDS dated [DATE] documented a BIMS score of five, indicating severe cognitive impairments. Section J revealed resident was not coded as a current tobacco user; however, the 3/24/2024 annual MDS revealed resident was coded as a current tobacco user.<br><br>A review of the smoking assessment dated [DATE] revealed due to R25's behavior and score with smoking assessment, resident will need supervision with smoking and he requires someone to light/extinguish the cigarette.<br><br>A review of R25's care plan initiated on 11/5/2021 revealed R25 is an unsafe smoker and will not smoke without supervision. Resident was found smoking in his room and was documented that he will only smoke in appropriate area under direct supervision. Further review documented removal of all smoking devices from resident room and store in locked container.<br><br>Observation on 9/24/2024 at 10:06 am, R25 was outside in the dementia care smoking area smoking unsupervised. There were no staff members outside at this time.<br><br>Interview on 10/7/2024 at 10:08 am, R25 stated he smokes two to three times a day and revealed that he keeps his own cigarettes and lighter in his room. During further interview, he stated nobody helps him with his cigarettes and lighter, and states that he can do it on his own.<br><br>49140<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | E. Review of the EMR for R111 revealed he was admitted to the facility on [DATE] with diagnoses including dementia, cognitive communication deficit, major depressive disorder, and anxiety disorder.<br><br>A review of the annual MDS dated [DATE] revealed a BIMS score of two, indicating the resident is severely cognitively impaired. Section J revealed resident was not coded as a current tobacco user.<br><br>A review of the smoking assessment dated [DATE] revealed that residents safety awareness was good and no supervision required, which is conflicting with his current plan of care.<br><br>A review of R111's care plan revised 7/9/2025 revealed resident is a smoker and he will not suffer injury from unsafe smoking practices and will not smoke without supervision. Interventions to care include resident requires supervision while smoking.<br><br>Observation on 10/6/2024 at 3:58 pm, R111 on the memory care unit, pulled a cigarette out of his right pocket and a lighter out of his left pocket. He lit the cigarette and began smoking, inside the building. Surveyor informed Medical Records Clerk (MRC) MM that R111 had lit a cigarette and began to smoke it while inside the building, and she went down the hall and took the cigarette and lighter from him.<br><br>49138<br><br>F. Review of the EMR for R118 revealed he was admitted to the facility on [DATE] with diagnoses including acute kidney failure, metabolic encephalopathy, paraplegia, right/left hand contractures, hypertension and major depressive disorder.<br><br>A review of the quarterly MDS assessment dated [DATE] revealed a BIMS was coded as 15, which indicated no cognitive impairment. Section J revealed resident was not coded as a current tobacco user.<br><br>A review of the smoking assessment dated [DATE] revealed the question does resident use smoking/tobacco/nicotine products? Response was documented no-stop here.<br><br>A review of R118's care plan revised on 3/29/2022 revealed he did not have a care plan to address resident's smoking preference. He did have a care plan addressing a focus that R118 chooses to leave the facility for social interactions with friends, including alcohol consumption and drugs.<br><br>Interview on 10/7/2024 at 9:10 am, R118 stated he was an occasional smoker and he smokes once or twice every two to three months.<br><br>Interview on 10/7/2024 at 2:20 pm, with MDS Regional Coordinator indicated that residents that use any type of tobacco/nicotine products are required to have a smoking assessment and a care plan addressing their smoking status. She confirmed R118's smoking assessment documented that he was not a smoker.<br><br>Observation on 10/7/2024 at 2:49 pm, R118 was observed outside front of the facility smoking, without wearing a smoking apron.<br><br>46579<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Glenwood Health Center by Harborview | | STREET ADDRESS, CITY, STATE, ZIP CODE 4115 Glenwood Rd Decatur, GA 30032 | |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 2. Review of the EMR for R172 revealed he was admitted to the facility on [DATE] with diagnoses that included seizures, encephalopathy, post-traumatic stress disorder (PTSD), and major depressive disorder.<br><br>Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 00, which indicates the residents cognitive status cannot be determined. No moods or behaviors exhibited. Resident has medically complex conditions, including PTSD.<br><br>A review of R172's care plan initiated on 10/2/2024 revealed focus areas documenting resident receives antidepressant medication and has impaired cognitive function/dementia or impaired thought processes related to impaired decision making and long and short-term memory loss. Further review of the care plan did not address a focus area or interventions addressing residents diagnosis of PTSD.<br><br>Interview on 10/5/2024 at 4:10 pm, the Regional Director of Clinical Reimbursement (RDCR) revealed that information for the completion of the MDS is gathered from resident hospital records, EMR, staff, resident, and family interviews. The RDCR stated that the interdisciplinary team (IDT) team is responsible for the developing resident comprehensive person-centered care plans. During further interview, she stated the MDS is updated quarterly, annually, or for a significant change in condition. The RDCR confirmed that R172 did not have a care plan addressing how to care for a resident with PTSD.<br><br>Review of the psychotherapist notes for resident R172 revealed that resident had periods of agitation during visits and experienced episodes of depression and being withdrawn.<br><br>The facility implemented the following actions to remove the Immediate Jeopardy:<br><br>1. The facility failed to develop a comprehensive person-centered care plan for residents R25, R145, R111, R19, R71, R118, R266 and R365. On 10/9/2024 the Regional Nurse Consultant and Director of Nursing reviewed and revised each of their smoking care plans to ensure that they are person centered and comprehensive.<br><br>2. The Regional Director of Operations on 10/9/2024 in-serviced the Director of Nursing, Assistant Director of Nursing, Minimum Data Set nurses and Regional Nurse Consultant on the smoking policy, ensuring that smoking care plans are followed and completed timely, and importance of accurate smoking assessments. The Administrator will be in-serviced prior to returning to work by the Regional Director of Operations.<br><br>3. Regional Director of Operations on 10/9/2024 in-serviced the MDS nurses on reviewing for complete and accurate comprehensive person-centered smoking care plans for all residents who smoke.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 4. On 10/9/2024 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Regional operations, and/or Regional Nurse began in-servicing all staff on the smoking policy, all residents on Dementia Unit will be required to wear smoking aprons, smoking times, and on the smoking monitors will be present at all smoke breaks (Registered Nurse 10 of 10, Licensed Practical Nurse 33 of 34, Certified Nurse assistant 62 of 67, Certified Medication Aides 7 of 8, Respiratory Therapist 1 of 2, Dietary 14 of 25, Therapy 8 of 13, Administrative 18 of 1 8, Maintenance 4 of 4, Housekeeping 30 of 37, Activities 3 of 4 staff). The current percentage of staff educated is 86% at this time. In addition, clinical staff are being in serviced on importance of following smoking care plans and completing timely and accurate smoking assessments.<br><br>5. Currently 10 of 10 Registered Nurses, 33 of 34 Licensed Practical Nurses, 62 of 67 Certified Nurse assistants, and 7 of 8 Certified Medication Aides have been in serviced on importance of following care plans. There is currently 94% in serviced completion.<br><br>6. On 10/9/2024 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Regional operations, and/or Regional Nurse began in-servicing all staff on the smoking monitors will be present at all smoke breaks.<br><br>7. All new licensed staff will be in-serviced on these items above during the orientation process by the Assistant Director of Nursing and/or Director of Clinical Education.<br><br>8. We have no agency staff currently.<br><br>9. AD Hoc Quality Assurance Performance Improvement (QAPI) meeting was completed on 10/10/2024 for policy review and root cause analysis was determined staffing education was needed. Attendance to the meeting was Regional Director of Operations, Director of Nursing, Regional Nurse, [NAME] President of Quality, business office manager, dietary manager, dietary assistant manager, medical supply clerk, transportation coordinator, Director of Rehab, Social Worker, and Unit Managers. The Medical Director was notified by phone.<br><br>10. Corrective actions will be completed by 10/10/2024.<br><br>Alleged date of IJ removal: l0/11/2024<br><br>The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows:<br><br>1. Care Plan and Smoking Assessment Review : R25 - Unsafe smoker, Care plan revised on 10/9/2024, Smoking assessment was completed on 10/9/2024- requires supervision. R145 - is a safe smoker however was observed lighting cigarettes for other residents. R145 is a safe smoker 10/9/2024- R111- is an unsafe smoker. 10/9/2024-requires supervision and an apron. R19 - is an unsafe smoker 10/11/2024- needs supervision and an apron. R71- is an unsafe smoker. Resident solicits to residents, staff, and/or visitors when cigarettes are not available. Resident has a history of being non-compliant with smoking policy - 10/9/2024-requires supervision and an apron. R118 - is unsafe smoker, 10/9/2024 - requires apron, cigarette holder, someone to light and extinguish and supervision. R266- Resident is a safe smoker. 10/9/2024- no supervision, R365- is a safe smoker; however, sometimes non-compliant with the smoking policy. History of lighting other resident's cigarettes 10/9/2024-independent smoker.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 2. In an interview on 10/11/2024 at 4:09 pm, with Regional Director of Operations (RDO) revealed in-service education was conducted by her and Training and Development Coordinator, Licensed Practical Nurse (LPN) Unit Manager (UM) GGGG. She stated her in-service included ensuring the residents have their smoking aprons, smoking times, and direct supervision over all smokers safe and unsafe.<br><br>In an interview on 10/11/2024 at 4:29 pm, with Regional Nurse Consultant (RNC) revealed her most recent in-service education was on 10/9/2024 by the RDO and LPN UM GGGG. She stated the in-service education she received was relating to the smoking policy, abiding by smoking times and ensuring all smokers are care planned. She stated she learned once a person who wants to smoke is identified a smoking assessment is completed.<br><br>In an interview on 10/11/2024 at 4:49 pm, the Director of Nursing (DON) revealed she received in-service from her Regional Director of Operations on 10/9/2024. She stated she was educated on the new smoking times, smoking policy and creating safe smoking habits for residents. She stated she was taught smoking assessments must be done quarterly and as needed (PRN) and all care plans must be updated to ensure they are in alignment with the assessment. She revealed she was taught to ensure unsafe smokers will not have their equipment on them, instead they will be locked in a lock box.<br><br>In an interview on 10/11/2024 at 5:14 pm, the Assistant Director of Nursing (DON) revealed she received in-service education on 10/9/2024 and 10/11/2024 relating to all the smokers in the building. She stated she learned the smokers cannot smoke anytime they like and that they are not allowed to hold their own smoking material. She stated her in-service education consisted of smoker's policy, timely assessments and care plans. She stated each resident must be supervised every 2 hours, and a smoking list kept at each nursing section.<br><br>3. Interview on 10/11/2024 at 4:49 pm, the Minimum Data Set nurse JJJJJ revealed she received in-service education on 10/9/2024 and 10/11/2024 from the Regional Director of Operations. She stated the RDO covered topics such as updating care plans, the smoking policy and smoking assessments for all residents that smoke.<br><br>4. Interview on 10/11/2024 with LPN KKKK at 4:20 pm, stated she received in-service on smoking last week and this week. She signed the in-service sign in sheet. The training pertained to the residents, fire extinguisher, aprons, and smoking hours. In addition to care plan for safe smokers and unsafe smokers. She continued to state the Unit Manager KKKK gave the staff the updated list of smokers with safe and unsafe identified residents. The smoker list is posted in the CNA book and the Nurse book behind the nurse's station.<br><br>Interview on 10/11/2024 at 4:37 pm, the Scheduling Manager revealed she received smoking in-service training. She stated everyone on Magnolia Hall is consider unsafe. She continued to state apron should be on, they are not to have cigarettes or lighters on person. Smoking box is kept at the nursing station. Further, the nursing keeps the list of the smokers, also list in the smoke box upstairs. The fire blankets are kept in the boxes in both locations up and down stairs. Additionally, the smoking assessment must be done by the nurses, clinical manager or MDS personnel. Once the assessment is completed it is put in the care plan.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 10/11/2024 at 4:29 pm, with Certified Nursing Assistant (CNA) MMMM, stated she received smoking in-service recently. The in-service training pertained to the safety of the residents, the nurses conducting the smoking assessments. She continued to state the nurses are the monitors and the CNA are making sure they keep their smoking aprons on and providing supervision.<br><br>5. Review of the in-service training for the removal plan determined all numbers are accurate.<br><br>6. Interview on 10/11/2024 at 4:20 pm, with LPN KKKK stated she received in-service on smoking last week and this week. She signed the in-service sign in sheet. The training pertained to the residents, fire extinguisher, aprons, and smoking hours. In addition to care plan for safe smokers and unsafe smokers. She continued to state the Unit Manager gave the staff the updated list of smokers with safe and unsafe identified residents. The smoker list is posted in the CNA book and the Nurse book behind the nurse's station.<br><br>Interview on 10/11/2024 at 4:25 pm, with CNA NNNN stated she did receive in-service pertaining to smoking. In-service referred to the up-to-date policy, safe smokers, and unsafe smokers. She stated the safe smoker do not have to have an apron on versus the unsafe smokers don't have to have an apron. Nurses are the ones who do the smoking assessment. The updated list is found at the nurse station. Unit upstairs smokes every two hours and downstairs on Magnolia start at 10:00 am - 6:00 pm.<br><br>Interview on 10/11/2024 at 4:29 pm, with CNA MMMM stated she received smoking in-service recently. The in-service training pertained to the safety of the residents, the nurses conducting the smoking assessments. She continued to stated nurses are the monitors and the CNA are making sure they keep their smoking aprons on and providing supervision.<br><br>Interview on 10/11/2024 at 4:32 pm, with LPN OOOO revealed she has received the in-service training for smoking. She stated the training pertained to safe and unsafe smoker, the smoking aprons, light the cigarettes and monito them. If the resident is deemed safe still monitor. She continued to state nurses can do the assessment for smoking. All Magnolia residents are monitored at all times during smoking times. In addition, to keep the cigarettes locked in the smoke box which is located in the Activities office. If any new staff, the staff can show them the list that is posted at the nurse's station.<br><br>7. Interview with Regional Director of Operations and Regional Nurse Consultant on 10/11/2024 at 3:35 pm, both stated new onboarding employees will review the smoking policy as part of their orientation process. During this onboarding process the smoking components are:<br><br>There is a new Smoking Schedule, and all staff should direct residents to the times.<br><br>Smoking Assessment will be conducted as soon as the resident is identified as a smoker with care plan.<br><br>All unsafe smokers should have a care plan, assessment, supervised residents will have on a smoking apron<br><br>at all times.<br><br>All residents on Magnolia are required to wear a smoking apron.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Smoking Monitors should be present at all schedule smoking break times.<br><br>Importance of following smoking care plans and accurately completing smoking assessment in a timely<br><br>manner.<br><br>Ensure smoking aprons are on correctly, residents are not allowed to light other resident cigarettes.<br><br>Residents not on the smoking list are not allowed to smoke until the Charge Nurse, Administrator, or<br><br>Director of Nursing have been notified and Smoking Assessment is completed.<br><br>8. We have no agency staff currently.<br><br>9. Record Review of the AD HOC QAPI Meeting confirmed the root cause was determined and that education to staff and residents on the smoking policy and expectations was needed, and a set smoking schedule established.<br><br>Record Review revealed the removal plan binder with printed sheets in large bold print of the smoking schedule for the designated smoking area in courtyard and downstairs courtyard outside of Magnolia. Smoking schedule starts at 6:00 am - 6:30 am and repeating availability every 2 hours for 24 hours a day for a total of twelve (12) smoke breaks. The Downstairs Courtyard outside of Dementia Unit smoking schedule is 10:00 am - 10:30 am, 12:00 pm - 12:30 pm, 2:00 pm - 2:30 pm, 4:00 pm - 4:30 pm, and final break for the night at 6:00 pm - 6:30 pm for a total of five (5) smoking breaks.<br><br>Interview on 10/11/2024 at 3:58 pm, with Regional Director of Operations assisted in verifying and identifying the staff that was present at the AD HOC QAPI Meeting:<br><br>- Regional Nurse Consultant was present<br><br>- [NAME] President of Quality was present<br><br>- Business Office Manager was present<br><br>- Dietary Manager was present<br><br>- Dietary Assistant Manager was present<br><br>- Medical Supply Clerk was present<br><br>- Transportation Coordinator was present<br><br>- Director of Rehabilitation was present<br><br>- Social Worker was present<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - Unit Managers IIII, GGGG, CC, ZZ were present<br><br>- Medical Director was present<br><br>Record review of the AD HOC QAPI Meeting Log revealed Medical Director was notified over the phone.<br><br>Phone Interview on 10/11/2024 at 4:11 pm, with Medical Director confirmed he attended the AD HOC QAPI meeting over the phone.<br><br>Record review of the AD HOC QAPI Meeting Log for F835 confirmed all stated staff was present at the AD HOC QAPI Meeting.<br><br>No other concerns identified. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44757<br><br>Based on observations, record review, resident and staff interviews, and review of the facility's policy titled Smoking Policy - Residents, and Resident Smoking and Banned Item List and Safe Water Temperatures and Oxygen Storage, the facility failed to ensure that the environment and facility were free from potential accident hazards for residents and staff. Specifically: 1. Immediate Jeopardy was identified for facility's failure to enforce the smoking policy and Banned Item List for eight of 44 sampled residents reviewed for smoking (R) (R71, R266, R145, R365, R25, R111, R118, R19); 2. Failed to ensure three residents (R83, R60, and R91) were not allowed to keep hazardous materials in their rooms; 3. Failed to maintain safe and comfortable water temperatures below 120 degrees Fahrenheit in 18 rooms on five of five units (E111, E112, E108, E107, E102, E101, W134, W129, W124, G217, G224, G229, D215, D206, D203, M109, M101, M118); and 4. Failed to properly secure a portable oxygen cylinder in one resident room (W132). The facility's failures created potential risks for the safety and well-being of the residents, staff, and any visitors in the building.<br><br>On 10/9/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents.<br><br>The facility's Corporate Regional Director of Operations, Corporate Regional Nurse Consultant (RNC), and Director of Nursing (DON) was informed of an Immediate Jeopardy (IJ) on 10/9/2024 at 3:11 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on 9/22/2024. Upon survey entrance to the facility, residents were observed sitting out front of the facility, smoking unsupervised. Throughout the duration of the survey, the facility failed to monitor the smoking practices by not maintaining accurate smoking assessments, allowing residents to keep smoking materials in their possession, not supervising residents while smoking, and allowing a resident in the dementia care unit to smoke inside the facility.<br><br>A Credible Allegation of Compliance was received on 10/11/2024. Based on observations, record review, resident and staff interviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed as of 10/11/2024. The facility remains out of compliance while the facility continues management level oversight as well as continues to develop and implement a Plan of Correction. (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures regarding facility smoking practices, to include smoking assessments, and following care plans related to smoking. Resident records were reviewed to ensure that resident care and treatment was current and accurate.<br><br>Findings include:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 1. A review of the facility policy titled Smoking Policy - Residents revised August 2022 revealed Policy Statement: This facility has established and maintains safe resident smoking practices. Policy Interpretation and Implementation: Number 1. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Number 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances. Number 6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes a. current level of tobacco consumption; b. method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); c. desire to quit smoking; d. ability to smoke safely with or without supervision (per completed Safe Smoking Evaluation). Number 8. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff. Number 9. Any smoking-related privileges, restrictions, and concerns (need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Number 11. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. Number 12. Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable safety lighters are permitted. Number 13. Residents are not permitted to give smoking items to other residents. Number 14. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision.<br><br>A review of the facility policy titled Resident Smoking Policy revised 3/21/2024 revealed Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, as related to smoking. Policy Explanation and Compliance Guidelines: Number 5. Residents who smoke will be assessed using the Resident Safe Smoking Assessment to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. Number 7. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas, at designated times, and in accordance with his/her care plan. Number 9. All safe smoking measures will be documented on each residents care plan Supervision will be provided as indicated on each residents care plan. Number 11. If a resident or family does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures. Number 12. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.<br><br>A review of the undated facility document titled Banned Item List revealed the following items: Cigarettes and cigarette lighters, smokeless tobacco, and vapes.<br><br>Observation on 9/22/2204 at 1:15 pm, upon survey entrance revealed approximately 12 residents crowded in the front of the building smoking. No staff members were present in the area and no residents had on aprons.<br><br>Observation on 9/24/2024 at 10:06 am to 10:17 am, revealed there were five residents smoking unsupervised outside the dementia care/behavior unit smoking area. There was no evidence of facility staff members outside monitoring the residents smoking during this time frame.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A. Review of the clinical record revealed R71 was admitted to the facility on [DATE] with diagnoses including seizure disorder, traumatic brain injury (TBI), schizoaffective disorder, depression and age-related bilateral cataracts.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was coded as 12, which indicated moderate cognitive impairment. Section J on the 3/26/2024 annual MDS revealed resident was coded as a current tobacco user.<br><br>Review of facilities Smoking List dated 9/23-with no year indicated, revealed R71's name was on the list of residents identified as a tobacco user.<br><br>Review of the facilities Smoking List dated 9/23-with no year indicated, revealed R71's name was on the list of residents identified as a tobacco user.<br><br>Review of R71's documentation related to the smoking assessments revealed that the most recent assessment was completed on 10/5/2024. The smoking assessment revealed she prefers to smoke morning, afternoon, and evening. Further review revealed she requires an apron, someone to light/extinguish the cigarette, and supervision.<br><br>Review of R71's care plan initiated 6/11/2021 and revised 10/5/2024 revealed that she was an unsafe smoker, she is non-compliant with smoking policy - resident was observed smoking in her bathroom, she solicits smoking materials from other residents, staff, and visitors. Interventions to care include educate and provide safety awareness for smoking, instruct resident about the facility policy on smoking: locations, times, safety concerns, resident requires a smoking apron.<br><br>Observation on 10/4/2024 at 11:09 am, R71 was observed during smoke break to be wearing a smoke apron, but she does not have the apron on correctly. The apron is hanging around her neck off the shoulders and between her legs. She smokes with the assistance of both hands using one hand to hold the cigarette and the other hand to move her hand up and down from her mouth. Further observation revealed there are visible burn holes (approximately two centimeters) in her green shirt from the cigarettes.<br><br>Observation on 10/4/2024 at 12:09 pm, R71 is back outside smoking and does not have on a smoking apron on this time. She is observed to have burn holes in her shirt as she is seen wiping the ashes off of her clothes.<br><br>B. Review of the clinical record revealed R266 was admitted to the facility on [DATE] with diagnoses including pneumonia, protein calorie malnutrition, sacral pressure ulcer, deep vein thrombosis, and sepsis due to escherichia coli.<br><br>Review of the admission MDS dated [DATE] revealed a BIMS was coded as 14, which indicated no cognitive impairment. Section J revealed resident was not coded as a current tobacco user.<br><br>Review of facilities Smoking List dated 9/23-with no year indicated, revealed R266's name was not on the list of residents identified as a tobacco user.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115025 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/11/2024 |
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| NAME OF PROVIDER OR SUPPLIER Glenwood Health Center by Harborview | | STREET ADDRESS, CITY, STATE, ZIP CODE 4115 Glenwood Rd Decatur, GA 30032 | |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of R266's documentation related to the smoking assessments revealed that the most recent assessment was completed on 10/6/2024. The smoking assessment revealed the resident does not use smoking/tobacco/nicotine products.<br><br>Review of R266's care plan revised 9/21/2024 revealed no evidence addressing residents desire to keep a cigar in his possession to dry puff (a puff taken before lighting a cigar to taste the cigar's flavors).<br><br>Observation on 10/7/2024 at 11:00 am, revealed resident with an un-lit cigar in his mouth. Interview with resident at this time stated he does not smoke it; he just dryly puffs on it because he is trying to quit smoking.<br><br>C. Review of the clinical record revealed R145 was admitted to the facility on [DATE] with diagnoses including depression.<br><br>Review of the annual MDS assessment dated [DATE] revealed a BIMS was coded as 13, which indicated no cognitive impairment. Section J revealed resident was coded as a current tobacco user.<br><br>Review of facilities Smoking List dated 9/23-with no year indicated, revealed R145's name was on the list of residents identified as a tobacco user.<br><br>Review of R145's documentation related to the smoking assessments revealed that the most recent assessment was completed on 7/12/2024. The smoking assessment revealed the resident was assessed as an independent smoker at any time morning, afternoon and evening.<br><br>Review of R145's care plan revised 7/21/2024 documented that resident was a safe smoker and will not have any injury related to smoking. Interventions to care include smoking assessment per facility protocol. Further review revealed resident would adhere to all smoking policies.<br><br>Observation on 10/4/2024 at 11:09 am, revealed R145 outside in smoking area, retrieved a lighter from his pants pocket and lit the cigarette for another resident. He then walked towards a bush, took a pack of cigarettes out of his pants pocket, removed a cigarette from the pack, lit it, and walked to his rollator sat down and began smoking. R145 has another new pack of cigarettes in his shirt pocket and gives one cigarette from the pack to another resident.<br><br>D. Review of the clinical record revealed R365 was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis with joint contractures, depression, and gastroesophageal reflux disease (GERD).<br><br>There is no MDS data available for this resident.<br><br>Review of facilities Smoking List dated 9/23-with no year indicated, revealed R365's name was on the list of residents identified as a tobacco user.<br><br>Review of R365's documentation related to the smoking assessments revealed that the most recent assessment was completed on 9/18/2024. The smoking assessment revealed she prefers to smoke morning, afternoon, and evening. Further review documented her ability to hold and handle smoking/tobacco/nicotine products was poor with weakness and contractures.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of R365's care plan initiated 6/20/2024 revealed that she was a smoker and that she will not suffer injury from unsafe smoking practices. Interventions to care include instruct resident about smoking risks and hazards and facility policy, including locations, times, and safety concerns.<br><br>Observation on 9/25/2024 at 11:09 am, revealed R365 goes out to the smoking area to smoke. She has her cigarette in her hand and pulls her lighter from the seat of her rollator.<br><br>Observation on 9/25/2024 at 3:30 pm, revealed R365 smoking outside under the small, covered portion in front of the building with no staff in sight. The resident had her cigarettes and a lighter in her possession. She was observed to be lighting other residents cigarettes.<br><br>Interview on 10/5/2024 at 11:33 am, Activity Assistant (AA) LL, revealed that each smoking area has a smoke box that has the residents' smoking materials. Activity Assistant LL stated some residents are allowed to keep their own cigarettes with them, but they are not allowed to keep any lighters. When asked how she identifies which residents are allowed to keep their cigarettes, she revealed the Director of Nursing (DON) does an assessment to determine if they are safe or not safe. She stated if they are assessed to be safe smokers, then they can keep their own cigarettes. During further interview, she stated if there was an issue with the residents during smoking breaks, she would report the concern to the DON or the Social Services Director. She stated if the staff see the residents with lighters, they will ask the resident for the lighters.<br><br>50374<br><br>E. Review of the clinical record revealed R25 was admitted to the facility on [DATE]with diagnoses including dementia, cognitive communication deficit, lack of coordination, atherosclerotic heart disease, mood and psychotic disorders, and generalized muscle weakness.<br><br>Review of the quarterly MDS dated [DATE] documented a BIMS score of five, indicating severe cognitive impairments. Section J on the 3/24/2024 annual MDS revealed resident was coded as a current tobacco user.<br><br>Review of facilities Smoking List dated 9/23-with no year indicated, revealed R25's name was on the list of residents identified as a tobacco user.<br><br>Review of R25's documentation related to the smoking assessments revealed that the most recent assessment was completed on 9/12/2024. The smoking assessment revealed he prefers to smoke morning, afternoon, and evening. Further review revealed due to resident's behavior and score with smoking assessment, resident will need supervision with smoking and he requires someone to light/extinguish the cigarette.<br><br>Record review of R25's care plan initiated on 11/5/2021 revealed R25 is an unsafe smoker and will not suffer injury from unsafe smoking practices and will not smoke without supervision. Resident was found smoking in his room and was documented that he will only smoke in appropriate area under direct supervision. Interventions to care include provide direct supervision while smoking, staff to light/extinguish cigarette and supervision including retrieval of cigarettes and lighter, educate resident about smoking risks and hazards, instruct on facility policy on smoking including locations, times, and safety concerns, remove all smoking devices from resident room and store in locked container, and notify Charge Nurse if it is suspected resident has violated facility smoking policy.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation on 9/24/2024 at 10:06 am, R25 was outside in the dementia care smoking area smoking unsupervised. There were no staff members outside at this time.<br><br>Observation on 10/7/2024 at 10:04 am, Activity Assistant (AA) WWW was supervising the smoke break with no safety smoking tools outside with the residents.<br><br>Interview on 10/7/2024 at 10:08 am, R25 stated he typically smokes two to three times a day and revealed that he keeps his own cigarettes and lighter in his room. During further interview, he stated nobody helps him with his cigarettes and lighter, and states that he can do it on his own.<br><br>the facility failed to ensure that the environment and facility were free from potential accident hazards for residents and staff. Specifically: 1. Immediate Jeopardy was identified for facility's failure to enforce the smoking policy and Banned Item List for eight of 44 sampled residents reviewed for smoking (R) (R71, R266, R145, R365, R25, R111, R118, R19); 2. Failed to ensure three residents (R83, R60, and R91) were not allowed to keep hazardous materials in their rooms; 3. Failed to maintain safe and comfortable water temperatures below 120 degrees Fahrenheit in 18 rooms on five of five units (E111, E112, E108, E107, E102, E101, W134, W129, W124, G217, G224, G229, D215, D206, D203, M109, M101, M118); and 4. Failed to properly secure a portable oxygen cylinder in one resident room (W132). The facility's failures created potential risks for the safety and well-being of the residents, staff, and any visitors in the building.<br><br>On 10/9/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents.<br><br>The facility's Corporate Regional Director of Operations, Corporate Regional Nurse Consultant (RNC), and Director of Nursing (DON) was informed of an Immediate Jeopardy (IJ) on 10/9/2024 at 3:11 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on 9/22/2024. Upon survey entrance to the facility, residents were observed sitting out front of the facility, smoking unsupervised. Throughout the duration of the survey, the facility failed to monitor the smoking practices by not maintaining accurate smoking assessments, allowing residents to keep smoking materials in their possession, not supervising residents while smoking, and allowing a resident in the dementia care unit to smoke inside the facility.<br><br>A Credible Allegation of Compliance was received on 10/11/2024. Based on observations, record review, resident and staff interviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed as of 10/11/2024. The facility remains out of compliance while the facility continues management level oversight as well as continues to develop and implement a Plan of Correction. (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures regarding facility smoking practices, to include smoking assessments, and following care plans related to smoking. Resident records were reviewed to ensure that resident care and treatment was current and accurate.<br><br>Findings include:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 1. A review of the facility policy titled Smoking Policy - Residents revised August 2022 revealed Policy Statement: This facility has established and maintains safe resident smoking practices. Policy Interpretation and Implementation: Number 1. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Number 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances. Number 6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes a. current level of tobacco consumption; b. method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); c. desire to quit smoking; d. ability to smoke safely with or without supervision (per completed Safe Smoking Evaluation). Number 8. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff. Number 9. Any smoking-related privileges, restrictions, and concerns (need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Number 11. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. Number 12. Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable safety lighters are permitted. Number 13. Residents are not permitted to give smoking items to other residents. Number 14. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision.<br><br>A review of the facility policy titled Resident Smoking Policy revised 3/21/2024 revealed Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, as related to smoking. Policy Explanation and Compliance Guidelines: Number 5. Residents who smoke will be assessed using the Resident Safe Smoking Assessment to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. Number 7. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas, at designated times, and in accordance with his/her care plan. Number 9. All safe smoking measures will be documented on each residents care plan Supervision will be provided as indicated on each residents care plan. Number 11. If a resident or family does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures. Number 12. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.<br><br>A review of the undated facility document titled Banned Item List revealed the following items: Cigarettes and cigarette lighters, smokeless tobacco, and vapes.<br><br>Observation on 9/22/2204 at 1:15 pm, upon survey entrance revealed approximately 12 residents crowded in the front of the building smoking. No staff members were present in the area and no residents had on aprons.<br><br>Observation on 9/24/2024 at 10:06 am to 10:17 am, revealed there were five residents smoking unsupervised outside the dementia care/behavior unit smoking area. There was no evidence of facility staff members outside monitoring the residents smoking during this time frame.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A. Review of the clinical record revealed R71 was admitted to the facility on [DATE] with diagnoses including seizure disorder, traumatic brain injury (TBI), schizoaffective disorder, depression and age-related bilateral cataracts.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was coded as 12, which indicated moderate cognitive impairment. Section J on the 3/26/2024 annual MDS revealed resident was coded as a current tobacco user.<br><br>Review of facilities Smoking List dated 9/23-with no year indicated, revealed R71's name was on the list of residents identified as a tobacco user.<br><br>Review of the facilities Smoking List dated 9/23-with no year indicated, revealed R71's name was on the list of residents identified as a tobacco user.<br><br>Review of R71's documentation related to the smoking assessments revealed that the most recent assessment was completed on 10/5/2024. The smoking assessment revealed she prefers to smoke morning, afternoon, and evening. Further review revealed she requires an apron, someone to light/extinguish the cigarette, and supervision.<br><br>Review of R71's care plan initiated 6/11/2021 and revised 10/5/2024 revealed that she was an unsafe smoker, she is non-compliant with smoking policy - resident was observed smoking in her bathroom, she solicits smoking materials from other residents, staff, and visitors. Interventions to care include educate and provide safety awareness for smoking, instruct resident about the facility policy on smoking: locations, times, safety concerns, resident requires a smoking apron.<br><br>Observation on 10/4/2024 at 11:09 am, R71 was observed during smoke break to be wearing a smoke apron, but she does not have the apron on correctly. The apron is hanging around her neck off the shoulders and between her legs. She smokes with the assistance of both hands using one hand to hold the cigarette and the other hand to move her hand up and down from her mouth. Further observation revealed there are visible burn holes (approximately two centimeters) in her green shirt from the cigarettes.<br><br>Observation on 10/4/2024 at 12:09 pm, R71 is back outside smoking and does not have on a smoking apron on this time. She is observed to have burn holes in her shirt as she is seen wiping the ashes off of her clothes.<br><br>B. Review of the clinical record revealed R266 was admitted to the facility on [DATE] with diagnoses including pneumonia, protein calorie malnutrition, sacral pressure ulcer, deep vein thrombosis, and sepsis due to escherichia coli.<br><br>Review of the admission MDS dated [DATE] revealed a BIMS was coded as 14, which indicated no cognitive impairment. Section J revealed resident was not coded as a current tobacco user.<br><br>Review of facilities Smoking List dated 9/23-with no year indicated, revealed R266's name was not on the list of residents identified as a tobacco user.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of R266's documentation related to the smoking assessments revealed that the most recent assessment was completed on 10/6/2024. The smoking assessment revealed the resident does not use smoking/tobacco/nicotine products.<br><br>Review of R266's care plan revised 9/21/2024 revealed no evidence addressing residents desire to keep a cigar in his possession to dry puff (a puff taken before lighting a cigar to taste the cigar's flavors).<br><br>Observation on 10/7/2024 at 11:00 am, revealed resident with an un-lit cigar in his mouth. Interview with resident at this time stated he does not smoke it; he just dryly puffs on it because he is trying to quit smoking.<br><br>C. Review of the clinical record revealed R145 was admitted to the facility on [DATE] with diagnoses including depression.<br><br>Review of the annual MDS assessment dated [DATE] revealed a BIMS was coded as 13, which indicated no cognitive impairment. Section J revealed resident was coded as a current tobacco user.<br><br>Review of facilities Smoking List dated 9/23-with no year indicated, revealed R145's name was on the list of residents identified as a tobacco user.<br><br>Review of R145's documentation related to the smoking assessments revealed that the most recent assessment was completed on 7/12/2024. The smoking assessment revealed the resident was assessed as an independent smoker at any time morning, afternoon and evening.<br><br>Review of R145's care plan revised 7/21/2024 documented that resident was a safe smoker and will not have any injury related to smoking. Interventions to care include smoking assessment per facility protocol. Further review revealed resident would adhere to all smoking policies.<br><br>Observation on 10/4/2024 at 11:09 am, revealed R145 outside in smoking area, retrieved a lighter from his pants pocket and lit the cigarette for another resident. He then walked towards a bush, took a pack of cigarettes out of his pants pocket, removed a cigarette from the pack, lit it, and walked to his rollator sat down and began smoking. R145 has another new pack of cigarettes in his shirt pocket and gives one cigarette from the pack to another resident.<br><br>D. Review of the clinical record revealed R365 was admitted to the facility on [DATE] with diagnoses including rheumatoid arthritis with joint contractures, depression, and gastroesophageal reflux disease (GERD).<br><br>There is no MDS data available for this resident.<br><br>Review of facilities Smoking List dated 9/23-with no year indicated, revealed R365's name was on the list of residents identified as a tobacco user.<br><br>Review of R365's documentation related to the smoking assessments revealed that the most recent assessment was completed on 9/18/2024. The smoking assessment revealed she prefers to smoke morning, afternoon, and evening. Further review documented her ability to hold and handle smoking/tobacco/nicotine products was poor with weakness and contractures.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>50374<br><br>Based on observations, staff interviews, and review of the facility's policy titled Sufficient and Competent Nursing, the facility failed to ensure nursing staff provided supervision and oversight for residents, as evidenced by nursing staff sleeping and watching videos during a third shift observation. The census was 210.<br><br>Findings include:<br><br>Review of the facility's undated policy titled Sufficient and Competent Nursing under the Policy Statement revealed, Our facility provides enough nursing staff with the appropriate skills and competency to provide nursing and related care and services for all residents in accordance with resident care plans and assessment. Under the Policy Interpretation and Implementation section revealed, 1. Licensed nurses and certified nursing assistants are available 24 hours a day, seven 7 days a week to provide competent resident care services including: (a) assuring resident safety, (b) attaining or maintaining the highest practical physical, mental, and psychosocial well-being of each resident and (d) responding to resident needs .2.(b) A charge nurse is a licensed nurse with designated responsibilities that may include staff supervision.<br><br>Observation on 10/3/2024 at 3:50 am, revealed on the Magnolia Hall (dementia care unit) staff members were behind the nurse's station on their personal phone, sleeping, and watching movies on a laptop. Specifically, Certified Nurse Assistant (CNA) GGGG was sleeping at the nurse station with her head down; CNA HHH and CNA HHHH were both in the resident dining room with their back turned away from the resident's rooms watching a movie on a laptop computer; Licensed Practical Nurse (LPN) IIII was nodding at the nurse station and Infection Preventionist (IP) was scrolling on her phone at the nurse's station.<br><br>Interview on 10/3/2024 at 10:21 am, with the Director of Nursing (DON) revealed they do not currently have a night supervisor. The DON revealed, the LPN's on each hall are the Charge Nurses for the overnight shifts. She continued to state the Magnolia Hall has four to five staff members for the overnight shift with an additional staff member as a sitter. The DON stated the observation related to the overnight staff who were observed sleeping was not brought to her attention. She further stated she expects the staff to be held accountable for their actions and to perform their professional duties and responsibilities. She revealed, the 11:00 pm - 7:00 am shift supervisor was to make sure things on their floor were going well.<br><br>Interview on 10/3/2024 at 11:30 am, the DON, Regional Nurse Consultant (RNC), and Regional Director of Operations (RDO) confirmed staff should not be sleeping, should not be on their phones, and should not be watching movies on the unit and those actions were not acceptable. They stated that CNA GGGG was on her 30-minute break when the surveyor observed her sleep behind the nurse's station. During further interview, the Regional Director of Operations stated there were no residents harmed during that duration of time, and believes there should not be a federal regulation violation. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115025 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/11/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Glenwood Health Center by Harborview | 4115 Glenwood Rd<br>Decatur, GA 30032 |

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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.

50526

Based on observations, staff interviews, and review of the facility policies titled Medication Administration, and Medication Storage, the facility failed to maintain the correct narcotic count in one of five medication carts (West Wing); failed to ensure one of five medication carts (Dogwood Hall) was locked when not in use, and that medications were not left on top of cart, accessible to residents and non-licensed staff; and failed to ensure expired medications were removed from one of five med carts (Dogwood Hall). The facility census was 210.

Findings include:

Review of the policy titled Medication Administration, revised 6/1/2024, revealed Policy Explanation and Compliance Guidelines: Number 4. Wash hands prior to administering medication per facility protocol. Number 13. Identify expiration date. If expired, notify nurse manager. Number 14. Remove medication from source taking care not to touch medication with bare hand. Number 21. If medications is a controlled substance, sign narcotic book. Number 23. Correct any discrepancies and report to nurse manager.

Review of the policy titled Medication Storage revised 3/1/2023, indicated it is the policy of the 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, and security. Policy Explanation and Compliance Guidelines: General Guidelines: Number 1c. during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Number 2d. Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies.

Observation on 10/2/2024 at 9:23 am during morning medication (med) pass on the [NAME] Wing, Licensed Practical Nurse (LPN) AA was preparing to administer Lyrica (a medication to treat nerve and muscle pain, including fibromyalgia; it can also treat seizures) 200 milligrams (mg). Lyrica is a schedule V controlled substance. She was not observed to have washed her hands or to use hand sanitizer prior to beginning the med pass. LPN AA unlocked the narcotic box and retrieved one Lyrica capsule from the medication punch card, leaving six capsules in the Kardex. She opened the narcotic book to sign out the Lyrica capsule, and the narcotic sign out sheet indicated seven capsules left, however there were only six left in the Kardex. LPN AA then opened the top drawer of the medication cart, and took out pill cup, and indicated this is the extra one that should have been wasted with the night shift nurse before leaving. LPN AA then called another LPN to waste the drug. Both nurses signed waste and LPN AA placed the capsule in the sharp's container on the medication cart.

Observation made on 10/2/2024 at 10:15 am, during medication administration on Dogwood Hall with Registered Nurse (RN) BB, revealed RN BB left a medication punch card with gabapentin capsules unattended on top of medication cart while he went to administer medication to a resident.

(continued on next page)

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation made on 10/2/2024 at 10:35 am, of Dogwood Hall medication cart, revealed one Humulin (short acting insulin) Kwik Pen 70/30 - 100 units per milliliter (ml) with open date 9/1/2024 and expiration date of 10/1/2024 stored with insulin pens for current use.The pen had a sticker with open date noted as 9/1/2024 and the discard date of 10/1/2024.<br><br>Interview on 10/2/2024 at 9:50 am, LPN AA confirmed the Lyrica medication should have been wasted with the night shift nurse, but she left prior to wasting medication.<br><br>Interview on 10/2/2024 at 10:32 am, with RN BB, revealed he leaves medication cards on top of cart so he will remember to reorder them for the residents. He offered no comment regarding the possibility of someone picking the card up, when questioned. During further interview, he confirmed that the insulin medication was expired according to the open date, and it should have been discarded.<br><br>Interview on 10/2/2024 at 10:41 am, the Director of Nursing (DON) confirmed all medications for waste must be destroyed and witnessed by two licensed nurses using the drug buster. She stated her expectations are for this to be done immediately, and no drugs should be left out.<br><br>46579<br><br>Observation on 10/3/2024 at 3:30 am, during a night shift observation, revealed on the Dogwood Hall, one nursing staff member sitting at the nurses station. The medication cart was noted to be unlocked, with syringes and bags of tube feeding formula sitting on top.<br><br>Observation and interview on 10/3/2024 at 3:53 am, LPN returned to the unlocked medication cart on Dogwood Hall, and quickly locked it. She was asked if that cart was supposed to be unlocked, and she stated that it was not to be left unlocked.<br><br>Interview on 10/9/2024 at 2:05 pm, the DON stated that it is unacceptable for the medication carts to be unlocked and unattended. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138<br><br>Based on observations, record review, resident and staff interviews, and review of the facility policy titled, Food Preparation Guideline, the facility failed to prepare food by methods that conserve nutritive value, flavor, and appearance for one of one residents (R) (R91) of 102 sampled residents .<br><br>Findings include:<br><br>Review of the facility policy titled Food Preparation Guideline revised on 6/1/2024 revealed it is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status. Definitions: Food attractiveness refers to the appearance of the food when served to residents. Food palatability refers to the taste and/or flavor of the food. Policy Explanation and Compliance Guidelines: 2. Food shall be prepared by methods that conserve nutritive value, flavor and appearance.<br><br>Review of the electronic medical records (EMR) revealed R91 was admitted to the facility on [DATE] with diagnoses that include, but not limited to acute kidney failure, chronic obstructive pulmonary disease (COPD), and bipolar disorder.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed in a brief interview for mental status (BIMS) score of 14, indicating intact cognition. No moods or behaviors exhibited. She had no documented functional impairments.<br><br>Interview on 9/23/2024 at 3:32 pm with R91 revealed she had been at the facility for five years. She was observed to be alert and oriented. She revealed that she was served a burnt grilled cheese sandwich, and the kitchen staff refused to replace it. A picture was provided by R91 dated 7/21/2024 of a burnt grilled cheese sandwich and hard pizza with burnt crust dated 8/2/2024.<br><br>Interview on 10/4/2024 at 9:36 am with the Lead Dietary Aide (LDA) revealed he worked at the prep stations when he entered work at 5:30 am, assisted on the tray line, and prepped cooking items. The LDA stated he checked tray cards because we have a lot of new staff, so I'm down there watching. After reviewing the photo of R91's burnt grilled cheese sandwich, the LDA confirmed that food should never have been sent out like that.<br><br>Interview on 10/4/2024 at 10:00 am with the [NAME] EEE revealed she had been employed at the facility for [AGE] years. After reviewing the photo of R91's burnt grilled cheese sandwich, [NAME] EEE confirmed that it did not happen on the morning shift. During further interview, she stated if the food doesn't look right, it should not be served. It should be remade.<br><br>Interview on 10/7/2024 at 12:18 pm with the Assistant Dietary Manager (ADM) was shown a photo of R91's food, and the ADM confirmed the meal displayed in R91's meal photo was prepared by evening shift and was unacceptable. He stated that he would not eat it, so why expect someone else to eat it?<br><br>Interview on 10/9/2024 at 10:32 am with Regional Director of Operations (RDO) revealed that she liked burnt food, but if a resident does not like burnt food, the food item should be replaced. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49673<br><br>Based on observations, interviews, and review of facility's policies titled Date Marking for Food Safety and Record of Food Temperatures, the facility failed to ensure proper food labeling and storage, failed to discard food items by the expiration dates, failed to ensure foods were maintained at proper temperatures, and failed to maintain sanitary conditions of the ice machine. The census was 210.<br><br>Findings Include:<br><br>Review of the undated policy titled Food Receiving and Storage, revealed Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Compliance: Number 6. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in - first out system. Number 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).<br><br>Review of the policy titled Date Marking for Food Safety, dated [DATE] revealed Policy Statement: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. Policy Explanation and Compliance Guidelines for Staffing: Number 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. Number 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. Number 5. The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. (For example, food prepared on Tuesday shall be discarded on or by Friday.) Number 6. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. Number 7. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed.<br><br>Review of policy titled Record of Food Temperatures, reviewed [DATE] revealed it is the policy of the facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled. Policy Explanation and Compliance Guidelines: Number 10. Ready-to-eat foods that require heating before consumption should be taken directly from a sealed container or an intact package from an approved food processing source and heated to at least 135 degrees F for holding for hot service. Number 11. No food will be served that does not meet the food code standard temperatures. Number 12. Food will not be cooked or reheated using the steam table because it does not bring food to the proper temperature within acceptable timeframes.<br><br>Observation on [DATE] at 12:23 pm during initial kitchen tour with cook EEE, revealed the following:<br><br>*uncovered ice scoop laying on top of the ice machine<br><br>*unwrapped yellow slices of block cheese in cooler<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | *one gallon pitcher of brown liquid not labeled nor dated in cooler<br><br>*31 individual single serve foam cups of liquids without a label or date in cooler<br><br>*one 1.8 pound (lb) expired box of biscuit mix in dry storage<br><br>*one 11.3 ounce (oz) expired package of gravy mix in dry storage<br><br>*one 1.8 lb package of opened mashed potatoes without open date or use by date in dry storage<br><br>*one opened box of scallop potatoes without open date or use by date in dry storage<br><br>*two eight-quart containers of red food substance resembling Jello, unlabeled and no use by date in refrigerator<br><br>*one eight-quart container of yellow food substance resembling pudding, unlabeled and no use by date in refrigerator<br><br>*large pan of cut apples, unlabeled and no use by date, in milk refrigerator<br><br>*Two 100 count box expired single serve sour cream cups on top of milk storage refrigerator<br><br>*four one-gallon bags of food items (two with a white unidentified food substances, one with cut cucumbers, and one with block cheese) unlabeled and no use by date in walk in cooler<br><br>During continued tour, observation of a double sink used for washing and prepping vegetables/produce and thawing meat was observed with dirty dish container inside the sink; under [NAME] the three-compartment sink was rust, dirt, and debris; can opener revealed red/brown build up substance, sugar container observed with scoop inserted inside the sugar bin.<br><br>Observation on [DATE] at 1:06 pm, [NAME] XXX opened a stock can of chicken noodle soup, poured it into a Stainless Steele pan on the steam table line, and prepared to serve residents during the lunch tray serving.<br><br>Interview on [DATE] at 1:08 pm, [NAME] EEE revealed the proper serving procedure for hot foods was to bring goods to 135 degrees before placing on serving line. [NAME] EEE removed soup from steam table and instructed cook XXX to bring soup to temperature by placing in oven.<br><br>Observation on [DATE] at 10:14 am, revealed 41 individual one lb seasoning containers without an open or discard date, 25 of the 1 lb containers were left open and unattended; lighter fluid was found near plastic and paper; 61 four fluid oz containers of prune juice with expiration date ,d+[DATE]; ice machine ventilation openings were covered in layers of dust like particles. Inside ice machine revealed a black flake material inside the machine on the ice.<br><br>Observation on [DATE] at 9:57 am, revealed the hood vent was not cleaned by 'next service date' of , d+[DATE].<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on [DATE] at 9:36 am, with Lead Dietary Aide (LDA) DDD stated dietary department is short staffed, and wrong items are placed on trays because they are still learning. The LDA DDD stated they are trying to ensure all dietary staff know how to perform each duty in the kitchen, but some staff that are nonchalant about it. During further interview, LDA DDD stated the cooks and supervisors are responsible for labeling food.<br><br>Interview on [DATE] at 10:00 am, with [NAME] EEE revealed everyone is responsible for labeling and dating foods items, but whatever they use they are supposed to put open date and used by date. [NAME] EEE revealed the facility is in the middle of hiring new staff and getting new management, and states that is why people are not doing their jobs and being nonchalant. [NAME] EEE confirmed if management is not here, cooks are in charge. [NAME] EEE shared the items found outdated or no label is from people not doing their jobs and being nonchalant.<br><br>Interview on [DATE] at 12:18 pm, with Assistant Dietary Manager (ADM) revealed he makes sure the kitchen runs properly, residents get what they need, food ordering, performs preference likes and dislikes, and attends resident council meetings. ADM shared labeling/dating is everyone responsibility and he check in the morning with assistance sometimes from prep dietary staff. ADM confirmed the expired, unlabeled and undated items were overlooked. ADM mentioned the last in-service was on [DATE] on food storage, labeling, and dating, but stated obviously still has work to be done. |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>44757<br><br>Based on observations, record review, interviews, review of the Administrator Job Description and Director of Nursing Job Description, and review of the policy titled Smoking Policy - Residents, the facility administration failed to provide oversight and monitoring of the facility operations related to enforcement of its smoking policy and failed to ensure that licensed nursing staff were knowledgeable and competent to assess residents and implement care plans for smoking. The facility's failures created potential risks for the safety and well-being of the residents. The census was 210 residents.<br><br>Specifically<br><br>1. Facility Administrator and Director of Nursing (DON) failed to perform duties of their job descriptions that facilitated providing a safe environment to the residents of the facility.<br><br>2. Administration failed to enforce the facility smoking policy by allowing residents to keep smoking materials on their person, allowed residents to smoke unsupervised, and failed to maintain accurate smoking assessments that correlated to person-centered care plans.<br><br>Cross Refer F689<br><br>3. Facility Administration failed to develop and/or implement the smoking care plans for six identified residents (R) R71, R266, R19, R25, R111, R118.<br><br>Cross Refer F656<br><br>On 10/9/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents.<br><br>The facility's Corporate Regional Director of Operations, Corporate Regional Nurse Consultant (RNC), and Director of Nursing (DON) was informed of an Immediate Jeopardy (IJ) on 10/9/2024 at 3:11 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on 9/22/2024. Upon survey entrance to the facility, residents were observed sitting out front of the facility, smoking unsupervised. Throughout the duration of the survey, the facility failed to monitor the smoking practices by not maintaining accurate smoking assessments, allowing residents to keep smoking materials in their possession, not supervising residents while smoking, and allowing a resident in the dementia care unit to smoke inside the facility.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A Credible Allegation of Compliance was received on 10/11/2024. Based on observations, record review, resident and staff interviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed as of 10/11/2024. The facility remains out of compliance while the facility continues management level oversight as well as continues to develop and implement a Plan of Correction. (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures regarding facility smoking practices, to include smoking assessments, and following care plans related to smoking. Resident records were reviewed to ensure that resident care and treatment was current and accurate.<br><br>Findings include:<br><br>Review of the undated and un-signed document titled Administrator Job Description, indicated the position purpose is to lead, guide, and direct the operations of the healthcare facility in accordance with local, state, and federal regulations, standards, and established facility policies and procedures to provide appropriate care and services to residents. Major duties and Major Duties and Responsibilities:<br><br>*Plans, develops, organizes, implements, evaluates, and directs the overall operations of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations.<br><br>*Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance<br><br>indicators.<br><br>*Evaluates key performance indicators with department heads to determine the need for action from leadership<br><br>and/or management such as re-education or revisions relayed to the facility's outcomes, regulatory compliance<br><br>and/or customer satisfaction.<br><br>*Leads and coordinates daily, weekly, monthly management team meetings to discuss priorities and develop<br><br>solutions with facility leaders.<br><br>*Evaluates work performance of department heads and maintains accountability across all departments.<br><br>*Knows and understands general nursing practices and procedures, ONRA regulations, Code of Federal<br><br>Regulations, Appendix PP State Operations Manual, reimbursement processes, Life Safety Code regulations,<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | applicable labor relations law, and all other regulatory entities.<br><br>*Communicates directly with residents, medical and nursing staff, family members, department heads and members<br><br>of the interdisciplinary team to coordinate care and services. Responds and resolves complaints and concerns when<br><br>necessary.<br><br>*Reads and stays informed regarding regulatory, business practices and other changes influencing facility outcomes;<br><br>thereby, facilitating continued success for all.<br><br>*Reports any allegations of abuse, neglect, misappropriation of property, exploitation, or mistreatment of residents<br><br>to appropriate regulatory entities. Protects resident from abuse and cooperates with all investigations.<br><br>Review of the undated and un-signed document titled Director of Nursing Job Description, indicated the position purpose is to plan, organize, develop, and direct the overall operations of the Nursing Services Department in accordance with local, state, and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical director, to provide appropriate care and services to the residents. Major duties and Major Duties and Responsibilities:<br><br>*Plans, develops, organizes, implements, evaluates and directs the overall operations of the Nursing Services<br><br>department, as well as its programs and activities, in accordance with current state and federal laws and regulations.<br><br>*Interprets and communicates policies and procedures to nursing staff, and maintains staff practices and<br><br>implementations.<br><br>*Participates in daily or weekly management team meeting to discuss census changes, resident changes in status,<br><br>complaints ot concerns.<br><br>*Participate in Quality Assurance Performance Improvement (QAPI) or facility assessment activities as needed, such<br><br>as carrying out duties assigned as part of a performance improvement committee.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | *Ensures delivery of compassionate quality care and nursing supervision as evidenced by adequate staff coverage on<br><br>the units, general cleanliness, and maintaining optimal resident functions.<br><br>*Collaborates with members of the interdisciplinary team, physicians, consultants, and community agencies to identify<br><br>and resolve issues and improve the quality of services.<br><br>*Performs rounds to observe resident and ensure nursing needs are being met.<br><br>*Monitors, assists and implements the infection control program in accordance with current infection control<br><br>guidelines to prevent the development and transmission of disease and infection.<br><br>*Communicates directly with residents, medical and nursing staff, family members, department heads and members<br><br>of the interdisciplinary team to coordinate care and services and respond to and resolve complaints and concerns.<br><br>*Oversees resident incidents and concerns daily to identify and unusual occurrences and reports them promptly to<br><br>the Administrator and/or state agency for appropriate ations.<br><br>*Monitors for allegations of potential abuse or neglect, misappropriations of resident property and participates in the<br><br>investigative process.<br><br>A review of the facility policy titled Smoking Policy - Residents revised August 2022 revealed Policy Statement: This facility has established and maintains safe resident smoking practices. Policy Interpretation and Implementation: Number 2. Smoking is permitted in designated resident smoking areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances. Number 9. Any smoking-related privileges, restrictions, and concerns (need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Number 11. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. Number 13. Residents are not permitted to give smoking items to other residents. Number 14. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision.<br><br>Observation on 9/22/2024 at 1:15 pm, upon survey entrance revealed approximately 12 residents crowded in the front of the building smoking. No staff members were present in the area and no residents were wearing smoking aprons.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115025 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/11/2024 |
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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation on 9/24/2024 at 10:06 am to 10:17 am, revealed there were five residents smoking unsupervised outside the dementia care/behavior unit smoking area. There was no evidence of facility staff members outside monitoring the residents smoking during this time frame.<br><br>Observation on 10/4/2024 at 11:09 am, resident outside in smoking area, observed to have possession of lighter and cigarettes. Resident gave another resident a cigarette and lit it for him.<br><br>Observation on 10/5/2024 at 3:58 pm, resident on the memory care unit, lit a cigarette and began smoking, inside the building.<br><br>Observation on 10/7/2024 at 10:04 am, the Activity Assistant (AA) WWW was supervising the smoke break with no safety smoking aprons outside with the residents.<br><br>Interview on 10/6/2024 at 5:53 pm, with the Corporate Representative stated everyone will be re-assessed in the building, its according to the assessment and the policy whether or not they can be automatically deemed as a responsible smoker. It largely depends on where they are.<br><br>Interview on 10/6/2024 at 5:53 pm with the Corporate Representative stated everyone will be re-assessed in the building, its according to the assessment and the policy whether or not they can be automatically deemed as a responsible smoker. It largely depends on where they are.<br><br>Interview on 10/7/2024 at 10:08 am, the Activities Director (AD) LLL revealed there are three Activity Assistants who rotate monitoring during the smoke breaks. She described the training as a walk through in order to train the Activity Assistants, then she will observe them do what she has shown them. During further interview, she revealed staff would know which residents smoke and whether they need any special supervision, the more they work with the residents. She stated rhe nursing department gives the activity department the smoking list and then she will give it to her assistants.<br><br>Interview on 10/7/2024 at 5:33 pm, the DON and Regional Nurse Consultant (RNC) indicated residents who are unsafe smokers must abide by the scheduled smoking times. They revealed that it is the responsibility of the nursing staff to complete resident smoking assessments, on admission and quarterly thereafter. During further interview, both the DON and the RNC stated residents are not allowed to smoke inside the building, and that will automatically make a resident be put on the unsafe smoking list.<br><br>The facility implemented the following actions to remove the Immediate Jeopardy:<br><br>1. The facility failed to address:<br><br>A. Resident #25 and #365 smoking unsupervised. On 10/9/2024 the Regional Operations and Director of Nursing instituted smoking times for all residents who smoke. The smoke breaks will be supervised by smoking monitors who will be staff assigned daily. The smoke breaks times are as follows: Courtyard smoking schedule starts at 6:00 am - 6:30 am and repeating availability every 2 hours for 24 hours a day for a total of twelve (12) smoke breaks. The Downstairs Courtyard outside of Dementia Unit smoking schedule is 10:00 am - 10:30 am, 12:00 pm - 12:30 pm, 2:00 pm - 2:30 pm, 4:00 pm - 4:30 pm, and final break for the night at 6:00 pm - 6:30 pm for a total. of five (5) smoking breaks.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | B. Resident #145 and #365 observed lighting other residents' cigarettes. A smoking assessment was completed on two hundred and twelve (212) residents and identified sixty-one (61) residents that chose to smoke. Residents #145 and #365 outcome was a safe smoker. Education on only lighting their own cigarettes was provided to both residents. List of residents who choose to smoke was compiled by the Director of Nursing and Regional Nurse on 10/9/2024. The list contains sixty-one (61) residents with twenty-seven (27) residents who are identified on the list as needing smoking aprons.<br><br>C. Resident #111 observed lighting a cigarette in the building. The Director of Nursing completed a new smoking assessment on 10/9/2024 and confiscated the residents lighter and cigarettes making him an unsafe smoker.<br><br>D. Resident #19 observed what appeared to be cigarette burns on clothes. List of residents who need smoking aprons was compiled by Director of Nursing and Regional Nurse on 10/9/2024. Residents that require a smoking apron are identified by the resident's name on the list available at each nursing station and updated accordingly by the Director of Nursing.<br><br>E. Resident #71 observed with smoking apron on incorrectly on one instance and one time without a smoking apron on: Smoking monitoring assigned will be responsible for ensuring smoking aprons are used correctly.<br><br>F. Resident #118 observed with no smoking apron, no smoking assessment, and no smoking care plan. The residents' smoking assessment was completed by the Director of Nursing and the smoking care plan was completed by Minimal Data Specialist on 10/9/24.<br><br>G. Resident #266 observed with no smoking apron and staff were unaware he is a smoker. Director of Nursing completed a smoking assessment for the resident on 10/9/2024. List of residents that are identified beside their name as unsafe require smoking aprons.<br><br>H. The facility failed to develop a comprehensive person-centered care plan for residents #25, #145, #111, #19, #71, #118, #266 and #365. On 10/9/2024 the Regional Nurse and Director of Nursing reviewed and revised eight (8) of eight (8) residents smoking care plans to ensure that they are person centered and comprehensive.<br><br>2. On 10/9/2024 the Director of Nursing, Minimal Data Specialist, and/or Regional Nurse began reviewing and revising all sixty-one (61) smoking care plans to ensure that they are person centered and comprehensive.<br><br>3. On 10/9/24 the Director of Nursing, Assistant Director of Nursing, Unit Manager, Minimal Data Specialist, and/or Regional Nurse completed a smoking assessment on two hundred and twelve (212) residents and identified sixty-one (61) residents that choose to smoke. Smoking assessments were conducted to identify residents who choose to smoke, reassess for unsafe smoking residents, identify residents who need smoking aprons and any other safety measures.<br><br>4. On 10/9/24 the Director of Nursing and Regional Nurse compiled a list of unsafe smokers, safe smokers and those residents who require a smoking apron. The list of sixty-one (61) residents will be available at each nursing station for the smoking monitors to reference. The list will be updated accordingly by the Director of Nursing.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 5. The Regional Operations on 10/9/2024 in-serviced the Director of Nursing, Assistant Director of Nursing, Minimal Data Specialist and Regional Nurse on the smoking policy, ensuring that smoking care plans are followed and completing timely and accurate smoking assessments. The Administrator will be in service prior to returning to work by the Regional Operations.<br><br>6. Regional Operations on 10/9/2024 in-serviced the Minimal Data Specialists on reviewing and completing accurate comprehensive person-centered smoking care plans for all residents who smoke.<br><br>7. On 10/9/2024 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Regional Operations, and/or Regional Nurse began in-servicing all staff (Registered Nurse 10 of 10, Licensed Practical Nurse 33 of 34, Certified Nurse assistant 62 of 67, Certified Medication Aides 7 of 8, Respiratory Therapist 1 of 2, Dietary 14 of 25, Therapy 8 of 13, Administrative 18 of 18, Maintenance 4 of 4, Housekeeping 30 of 37, Activities 3 of 4 staff) on the smoking policy. The current percentage of staff educated is 86% at this time.<br><br>8. All residents on the Dementia Unit will be required to wear a smoking apron, all residents will adhere to the set smoking times for designated areas, designated staff will be assigned daily as smoking monitors and will be present at all smoke breaks, ensuring that smoking care plans are followed and completing timely and accurate smoking assessments.<br><br>9. The Director of Nursing, Assistant Director of Nursing and/or Regional Nurse began in person educating on 10/9/2024 with all staff on education for daily assigning of smoking monitors, and expectations on ensuring that smoking aprons are donned correctly, residents are not allowed to help other residents light their cigarettes and to ensure that all residents who require smoking aprons have one on. They also instructed the smoking monitors that any residents that are not listed on the smokers list should not be allowed to smoke. If any residents not on the list are attempting to smoke, they must notify the Charge Nurse, Director of Nursing, Administrator or Assistant Director of Nursing so that they can complete a smoking assessment. They were also in-serviced that all residents downstairs on the Downstairs Dementia unit will be required to wear a smoking apron during their monitored smoke breaks. The Downstairs Courtyard outside of Dementia Unit smoking schedule is 10:00 am - 10:30 am, 12:00 pm - 12:30 pm, 2:00 pm - 2:30 pm, 4:00 pm - 4:30 pm, and final break for the night at 6:00 pm - 6:30 pm for a total of five (5) smoking breaks.<br><br>10. The Regional Operations on 10/9/2024 decided that all resident's downstairs on the Downstairs Dementia Unit will be required to wear a smoking apron during their monitored smoke breaks. She instructed the Director of Nursing and Regional Nurse on this directive.<br><br>11. On 10/9/2024 the Regional Operations and Director of Nursing instituted smoking times for all residents who smoke. The smoke breaks will be supervised, and times as follows: Courtyard smoking schedule starts at 6:00 am - 6:30 am and repeating availability every 2 hours for 24 hours a day for a total of twelve (12) smoke breaks. The Downstairs Courtyard outside of Dementia Unit smoking schedule is 10:00 am - 10:30 am, 12:00 pm - 12:30 pm, 2:00 pm - 2:30 pm, 4:00 pm - 4:30 pm, and final break for the night at 6:00 pm - 6:30 pm for a total of five (5) smoking breaks.<br><br>12. All new Staff will be in serviced on these items during the orientation process by the Assistant Director of Nursing and/or Director of Clinical Education.<br><br>13. We have no agency staff currently.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 14. Job descriptions of Director of Nursing and Administrator were reviewed by the Regional Operations, Regional Nurse, [NAME] President of Quality. Director of Nursing and Administrator (contacted via phone) were educated and voiced understanding of responsibilities and job duties.<br><br>15. AD Hoc QAPI meeting was completed on 10/10/2024 for policy review and root cause analysis. The root cause was determined that education to staff and residents on the smoking policy and expectations was needed, and a set smoking schedule established. Attendance to the meeting was Regional Director of Operations, Director of Nursing, Regional Nurse, [NAME] President of Quality, business office manager, dietary manager, dietary assistant manager, medical supply clerk, transportation coordinator, Director of Rehab, Social Worker, and Unit Managers. The Medical Director was notified by phone.<br><br>16. Corrective actions will be completed by 10/10/2024.<br><br>Alleged date of IJ removal: 10/11/2024<br><br>The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows:<br><br>A. Record Review on 10/11/2024 at 3:50 pm revealed the removal plan binder with printed sheets in large bold print of the smoking schedule for the designated smoking area in courtyard and downstairs courtyard outside of Magnolia. Smoking schedule starts at 6:00 am - 6:30 am and repeating availability every 2 hours for 24 hours a day for a total of twelve (12) smoke breaks. The Downstairs Courtyard outside of Dementia Unit smoking schedule is 10:00 am - 10:30 am, 12:00 pm - 12:30 pm, 2:00 pm - 2:30 pm, 4:00 pm - 4:30 pm, and final break for the night at 6:00 pm -6:30 pm for a total. of five (5) smoking breaks.<br><br>Observation on 10/11/2024 at 4:45 pm revealed smoking schedules posted with large bold letters of the smoking schedule for the designated smoking areas and hanging on a wall board outside of elevator and near front entrance receptionist desk.<br><br>B. Interview on 10/11/2024 at 6:07 pm with R365 confirmed she received education to only light her own cigarette by Social Worker RRR. Furthermore, R365 revealed she feels like she is a safe smoker.<br><br>Interview on 10/11/2024 at 6:10 pm with R145 confirmed he received education to only light his own cigarette but does not remember who provided the education. Furthermore, R145 revealed he feels like he is a safe smoker.<br><br>C. Interview on 10/11/2024 at 6:00 pm with R111 revealed he never had any cigarettes on him. He stated he does not have any cigarettes or cigars currently on him. He stated the Unit Manager educated him on the safety of smoking and especially not smoking inside of the building. He stated that he wears an apron when he is on his smoking break.<br><br>D. Record Review on 10/11/2024 at 5:30 pm revealed the residents that are required to have a smoking apron and are identified by the resident's name on the list available at each nursing station and updated by the Director of Nursing.<br><br>E. Interview on 10/11/2024 at 6:05 pm with R71 confirmed she wears an apron when she goes on her smoking break, and she further confirmed a smoking apron is provided.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | F. Record Review on 10/11/2024 at 5:30 pm revealed the residents' smoking assessment was completed by the Director of Nursing and the smoking care plan was completed by Minimal Data Specialist on 10/9/2024.<br><br>G. Interview on 10/11/2024 at 6:10 pm with R266 revealed he is a smoker but just started smoking not too long ago. He stated he is offered an apron; however, he is considered a safe smoker. He stated he smokes during the designated smoking break.<br><br>Interview on 10/11/2024 at 6:20 pm with Licensed Practical Nurse (LPN) Unit Manager (UM) CC revealed R266 was assessed as a safe smoker because he can light his own cigarette, hold it steady and dispose of his ashes.<br><br>H. Record Review on 10/11/2024 at 5:30 pm revealed the following:<br><br>Care Plan and Smoking Assessment Review: R25- Unsafe smoker, Care plan revised on 10/9/2024. Smoking assessment was completed on 10/9/2024- requires supervision. R145- is a safe smoker; however, was observed lighting cigarettes for other residents. R145 is a safe smoker 10/9/2024- R111- is an unsafe smoker. 10/9/2024-requires supervision and an apron. R19- is an unsafe smoker 10/11/2024- needs supervision and an apron. R71- an unsafe smoker. Resident solicits to residents, staff, and/or visitors when cigarettes are not available. Resident has a history of being non-compliant with smoking policy-10/9/2024-requires supervision and an apron. R118- is unsafe smoker, 10/9/2024-requires apron, cigarette holder, someone to light and extinguish and supervision. R266- Resident is a safe smoker. 10/9/2024- no supervision, R365 - is a safe smoker; however, sometimes non-compliant with the smoking policy. History of lighting other resident's cigarettes 10/9/2024-independent smoker.<br><br>2. Interview on 10/11/2024 at 6:55 pm with, the Director of Nursing confirmed she reviewed and revised all sixty-one (61) smoking care plans to ensure that they are person centered and comprehensive<br><br>Interview on 10/11/2024 at 6:58 pm with, Minimum Data Specialist (MDS) BBB confirmed she reviewed and revised all sixty-one (61) smoking care plans to ensure that they are person centered and comprehensive.<br><br>Record review on 10/11/2024 of all sixty-one (61) smoking residents confirmed smoking<br><br>care plans to ensure that they are person centered and comprehensive.<br><br>3. Interview on 10/11/2024 at 6:55 pm, with DON, confirmed she completed a smoking assessment on two hundred and twelve (212) residents and identified sixty-one (61) residents that choose to smoke. Furthermore, DON confirmed a smoking assessment was conducted to identify residents who choose to smoke, reassess for unsafe smoking residents, identify residents who need smoking aprons and any other safety measures.<br><br>Interview on 10/11/2024 at 7:02 pm, with Assistant Director of Nursing (ADON), confirmed she completed a smoking assessment on two hundred and twelve (212) residents and identified sixty-one (61) residents that choose to smoke. Furthermore, ADON confirmed a smoking assessment was conducted to identify residents who choose to smoke, reassess for unsafe smoking residents, identify residents who need smoking aprons and any other safety measures<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 10/11/2024 at 7:00 pm with. LPN UM IIII confirmed he completed a smoking assessment on two hundred and twelve (212) residents and identified sixty-one (61) residents that choose to smoke. Furthermore, UM confirmed a smoking assessment were conducted to identify residents who choose to smoke, reassess for unsafe smoking residents, identify residents who need smoking aprons and any other safety measures<br><br>Interview on 10/11/2024 at 6:55 pm, with Regional Nurse Consultant (RNC), confirmed she completed a smoking assessment on two hundred and twelve (212) residents and identified sixty-one (61) residents that choose to smoke. Furthermore, RNC confirmed a smoking assessment was conducted to identify residents who choose to smoke, reassess for unsafe smoking residents, identify residents who need smoking aprons and any other safety measures<br><br>Interview on 10/11/2024 at 6:58 pm with MDS Data Specialist BBB confirmed she completed a smoking assessment on two hundred and twelve (212) residents and identified sixty-one (61) residents that choose to smoke. Furthermore, MDS confirmed a smoking assessment was conducted to identify residents who choose to smoke, reassess for unsafe smoking residents, identify residents who need smoking aprons and any other safety measures<br><br>Record review on 10/11/2024 confirmed smoking assessments on two hundred and twelve (212) residents and identified sixty-one (61) residents that choose to smoke. Furthermore, record review confirmed smoking assessment were conducted to identify residents who choose to smoke, reassess for unsafe smoking residents, identify residents who need smoking aprons and any other safety measures.<br><br>4. Record Review on 10/11/2024 of Plan of Correction Binder confirmed a master list of unsafe smokers, safe smokers and those residents who require a smoking apron.<br><br>Confirmation on 10/11/2024 at 4:39 pm confirmed a list of sixty-one (61) residents who smoke on [NAME] Wing nurses' station.<br><br>Confirmation on 10/11/2024 at 4:45 pm confirmed a list of sixty-one (61) residents who smoke on East Wing nurses' station.<br><br>Confirmation on 10/11/2024 at 4:51 pm confirmed a list of sixty-one (61) residents who smoke on Dogwood and Georgia Hall's nurse's station.<br><br>Confirmation on 10/11/2024 at 4:55 pm confirmed a list of sixty-one (61) residents who smoke on Magnolia Hall's nurses' station.<br><br>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 5. Interview on 10/11/2024 at 7:00 pm with VP of Quality has in-serviced all staff making sure the staff are all aware of the smoking list and aware of the smoking carts. All staff have been randomly quizzed on the in-service. They are by hall and unit it is in the care plan since all staff have access to it. Have made staff aware of who is an unsafe smoker vs who is. Educated staff on assisting the residents on wearing the aprons appropriately and that they should be over the resident clothes. There is a designated area of smoking area for staff. Staff had a quiz they took about the smoking times and areas. Made sure all the administrative positions who are not currently in the building will be educated before they come back on shift. Lighters and cigarettes are secured, and residents know they cannot be in their rooms. If there is a resident who wants to smoke after hours, then that would be a 1:1 for the residents. Is unaware of a disposable safety lighter but will find out to see if it is beneficial for them.<br><br>6. Regional Operations on 10/9/2024 in-serviced the Minimal Data Specialists on reviewing and completing accurate comprehensive person-centered smoking care plans for all residents who smoke.<br><br>7. A review of the Ad Hoc Quality Assurance Performance Improvement (QAPI) Smoking Policy dated 10/9/2024 detailed four areas that were reviewed. Area one identified issues or concerns. Area two identified steps to immediate correct issue. Area three how are you going to prevent it from happening in future. Area four how will facility monitor compliance with smoking policy. There is an attached sign in form where names are printed, signature, date attended, department, and shift. There are a total of 26 names on the list including those from Administration, Nursing department, Dietary, Social Work, Medical Records, and housekeeping.<br><br>8. Observation on 10/11/2024 from 4:00 pm to 4:25 pm at designated smoking area for Dementia Unit. eight residents went outside, they were assisted by three staff members (2 nurses and 1 Activities assistant). At 4:10 pm all residents received smoking aprons and staff members helped each to put apron on to ensure that residents' clothing is protected. Cigarettes were distributed from plastic container labeled cigarettes for each resident. Staff lighted cigarettes for each resident. At the end of smoking break all cigarettes buds were collected by the staff and disposed.<br><br>Observed blue binder at nursing station on the Dementia Unit and verified that binder has a list of all smoking residents from that unit. All smoking resident from Dementia Unit were marked unsafe smokers, requiring supervision and smoking aprons.<br><br>Interview on 10/11/2024 at 4:40 pm with Regional Director of Operations for Georgia revealed that staff received education on how to supervise residents during smoking times. Facility created a Quiz about safety during smoking times and keep quizzing all staff.<br><br>Observation on 10/11/2024 at 4:00 pm revealed five staff member assisting residents with putting on a smoke apron and lighting resident's cigarettes. There are six residents with aprons. The aprons were on the residents fully covering their clothes while they smoked. There were three smokers with no aprons. Residents with aprons are being assisted by staff with lighting their cigarettes. When the residents were finished smoking, the aprons were observed being disinfected, aired out, folded, then put in a bag.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation on 10/11/2024 at 4:34 pm revealed staff collecting lighters from the residents without aprons who were given lighters to light their cigarettes. The remaining residents were unsafe smokers and did not have lighters in their possession and went back into the building after the smoke break was complete.<br><br>9. Interview on 10/11/2024 at 7:00 pm, with VP of Quality has in serviced all staff making sure the staff are all aware of the smoking list and aware of the smoking carts. All staff have been randomly quizzed on the in-service. They are by hall and unit it is in the care plan since all staff have access it. Have made staff aware of who is an unsafe smoker vs who is. Educated staff on assisting |

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| Glenwood Health Center by Harborview | 4115 Glenwood Rd Decatur, GA 30032 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579<br><br>Based on observations, record review, staff interviews, and review of the facility policies titled Infection Surveillance, Infection Prevention and Control Program, Tracheostomy Care, Hand Hygiene, and Routine Cleaning and Disinfection, the facility failed to maintain an effective infection prevention and control program that demonstrated ongoing surveillance, recognition, investigation and control of infections to prevent possible cross contamination. Specifically, facility staff failed to wash and/or sanitize hands during the provision of tracheostomy care, during medication administration, during the handling of clean linens, passing ice to residents; failed to maintain hand sanitizer dispensers; failed to store residents personal care items appropriately; failed to clean and disinfect reusable equipment (blood pressure machine); and failed to clean resident bathrooms appropriately. The census was 210.<br><br>Findings:<br><br>1. Review of the facility policy titled Infection Surveillance reviewed 6/1/2024 revealed Policy: A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order is to reduce infections and prevent the spread of infections. Policy Explanation and Compliance Guidelines: Number 7. Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends. Number 12. revealed that Data to be used in the surveillance activities may include, but are not limited to: a. 24-hour shift reports<br><br>b. Lab reports<br><br>c. Antibiograms<br><br>d. Antibiotic use reports from pharmacy<br><br>e. Medication regimen review reports<br><br>f. Skills validations for hand hygiene, PPE, and/or high-risk procedures<br><br>g. Rounding observation data<br><br>h. Documentation of signs and symptoms in clinical record<br><br>Interview on 10/5/2024 at 9:46 am, the Director of Nursing (DON) was asked for the facility's infection control line listings for the past year, the infection control education, hand hygiene observations, vaccine records for five selected residents, and antibiotic stewardship. Review of the provided documents occurred.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115025 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/11/2024 |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facilities surveillance data for October 2023 through September 2024 revealed the infection control line listings did not have documentation reflecting facility's tracking and trending of infections. The infections listed on the line listing did not have symptoms, any testing and results listed, or antibiotic start and stop dates. There were also no infection rates included for the months. The only months with facility maps associated with the infections were August and September.<br><br>Interview on 10/7/2024 at 1:20 pm, the DON revealed she had been doing the Infection Preventionist work until the Infection Preventionist returned full time.<br><br>2. Review of the facility policy titled Hand Hygiene revised 5/30/2024, revealed the Policy: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.<br><br>Observation on 9/22/2024 at 9:46 am, during the initial screening of the residents on the Georgia Wing revealed there were only two hand sanitizer dispensers on the hall for rooms 217 through 230.<br><br>Observation on 9/22/2024 at 2:50 pm, Georgia Wing in room [ROOM NUMBER] revealed the hand sanitizer dispenser in room was not functioning.<br><br>Observation on 9/22/2024 at 3:51 pm, Georgia Wing in room [ROOM NUMBER] revealed the hand sanitizer dispenser was not functioning.<br><br>Observation on 9/22/2024 at 3:54 pm, Georgia Wing in room [ROOM NUMBER] revealed that the hand sanitizer dispenser was not functioning.<br><br>Observation on 9/22/2024 at 3:54 pm, Georgia Wing in room [ROOM NUMBER] revealed that the hand sanitizer dispenser was not functioning.<br><br>3. Observation on 9/22/2024 at 2:50 pm, Georgia Wing shared bathroom in room [ROOM NUMBER]/229 revealed one unlabeled bath basin and one unlabeled bed pan on the bathroom floor. They did not have a room number or a resident name on them, nor were they in a bag.<br><br>Observation on 9/22/2024 at 3:15 pm, Georgia Wing shared bathroom in room [ROOM NUMBER]/226 revealed one bath basin and one urinal in the bathroom, unbagged and unlabeled.<br><br>Observation on 9/22/2024 at 3:51 pm, Georgia Wing shared bathroom of 228/230 revealed one urinal, and one bed pan in the bathroom and was not labeled and was not in a bag.<br><br>Observation on 9/23/2024 at 2:37 pm, Georgia Wing shared bathroom in room [ROOM NUMBER]/226 revealed the bath basin and urinal were still present, unlabeled, and un-bagged.<br><br>Observation on 9/23/2024 at 3:02 pm, Georgia Wing shared bathroom in room [ROOM NUMBER]/230 revealed that the urinal in the bathroom was not labeled and not in a bag.<br><br>Interview on 9/24/2024 at 12:35 pm, CNA GGGG verified the personal care items (bath basin/bedpan/urinal) in the shared bathrooms on the Georgia Wing were not labeled with room number or resident name, and none of them were in a bag.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 10/7/2024 at 1:20 pm, the DON stated that it is her expectation that all bath basins, bed pans, and urinals be labeled and bagged. She stated that it is not as important as the date but at least the name and that it is bagged.<br><br>4. Review of the facility policy titled Routine Cleaning and Disinfection revised on 4/20/2024 indicated Policy Statement: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Definitions: Cleaning refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products. Disinfection refers to thermal or chemical destruction of pathogenic and other types of microorganisms. Standard Precautions refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Policy Explanation and Compliance Guidelines: Number 1. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at the time of discharge. Number 5. Standard precautions will be adhered to when cleaning any blood or body fluid spills, or soiled material that have the potential to contain these or other potentially contaminated substances. Number 11. Staff will ensure cleaning carts are checked and stocked with necessary supplies at the beginning of each shift.<br><br>Observation on 10/3/2024, at 4:02 am, during an 11:00 pm - 7:00 am shift observation, Licensed Practical Nurse (LPN) TTT was observed entering a room on the Dogwood Wing with the rolling electronic blood pressure machine. After a few minutes in the room, she was observed leaving the room with the blood pressure machine, and without cleaning/disinfecting the machine, she entered another room across the hall. After a few minutes, she left that room without cleaning the machine. She left the machine in the hallway and returned to the medication cart.<br><br>Observation on 10/3/2024 at 4:08 am, during an 11:00 pm - 7:00 am shift observation, CNA SSS was observed leaving a room and going to a computer in the hallway, presumably to be charting for resident care. A resident came out of his room and asked CNA SSS for a cup of ice. She walked away from the computer and walked down to the ice cooler, picked up the ice scoop, and filled a cup of ice for the resident. She walked back to the residents room and gave him the cup of ice and left the room. She went to a linen cart on the hallway and grabbed some clean linen from the cart, and then entered the room again with the linen. After she left the room, she returned to the computer. She never stopped to wash her hands or apply hand sanitizer before, during, or after the series of tasks.<br><br>Interview on 10/3/2024 at 4:12 am, LPN TTT was questioned about the process for cleaning equipment that is shared between residents. She stated that it is to be cleaned after every three residents. She then stated that it is to be cleaned with a bleach wipe that has a 3-minute kill time.<br><br>Interview on 10/3/2024 at 4:20 am, CNA SSS was interviewed about getting ice and clean linen without cleaning her hands, after exiting residents rooms, and after working on the computer. She revealed that she should have cleaned her hands before obtaining ice for the resident. She also stated that she should have cleaned her hands before obtaining clean linen because she is not supposed to be wearing gloves in the hallway.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 10/7/2024 at 1:20 pm, the DON stated that hand hygiene should be completed before and after care and between residents. During further interview, she stated that if staff are charting the computer, and went to get ice, they should perform hand hygiene before getting the ice. She stated that hand hygiene education is something that occurs continuously.<br><br>50526<br><br>Review of the facility policy titled Hand Hygiene revised 5/30/2024, revealed the Policy: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.<br><br>Observation on 10/2/2024 at 9:23 am, during morning medication administration with LPN AA began to prepare resident medications and failed to perform hand hygiene prior to, or following medication administration for each resident. During the preparation, she placed a medication in a medicine cup, and two pills fell into the cup. Using her bare hands, LPN AA took the extra tablet out of the medicine cup and discarded it into the sharps container. In addition, she failed to clean and disinfect shared equipment (blood pressure cuff) between uses for other residents.<br><br>Interview on 10/2/2024 at 9:50 am, with LPN AA confirmed that all shared equipment should be cleaned between resident use, and that she did not wash her hands or use hand sanitizer after every resident. Also states she cannot touch any of the medicine.<br><br>Interview on 10/2/2024 at 10:41 am, the DON stated that all staff should be washing their hands between each resident they care for, and the medication nurses should definitely at least be using hand sanitizer during medication administration. During further interview, she stated that staff should be taking precautions with infection control and cleaned shared equipment with an appropriate disinfectant for the appropriate dwell time.<br><br>5. Review of the policy titled Tracheostomy Care dated 1/1/2023, section; Number 6. procedure with use of reusable cannula: items a through o revealed policy statement for staff to perform hand hygiene, put on exam gloves, mask and eye protection to perform tracheostomy care. Further states remove exam gloves are used to remove old dressing and discard of exam glove with dressing. Staff member will then prepare the equipment needed at bedside table, open the sterile tracheostomy care kit, and apply sterile gloves. Pour saline water into basin of kit with non-dominant gloved hand. Remove and clean inner cannula using sterile technique. Clean stoma with normal saline or sterile water, moistened gauze, and dry the area. Change tracheostomy ties, dispose of equipment and perform hand hygiene. Document procedure and report signs or symptoms of infections to the physician.<br><br>Observation on 9/22/2024 at 2:15 pm revealed R154 with tracheostomy tube in place, noted with a copious amount of yellow thick secretions noted coming out around tubing and drainage on gauze. Oxygen at 2.5 liters per minute via tracheostomy collar.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 9/22/2024 at 2:20 pm, Respiratory Therapist (RT) KK performed tracheostomy care/suctioning. RT KK brought the supply cart into residents room on side of bed near the door, donned non-sterile gloves, removed the gauze around trach, wiped with 4x4 gauze, reached into pack of non-sterile gauze with contaminated gloves for more gauze, continuing to wipe away secretions. He reached into gauze pack again with contaminated gloves, a total of four times. RT KK then opened suctioning cath kit, placed sterile gloves to side and picked up suction catheter with contaminated gloves, catheter brushed against bed curtain as he reached for suction cannister tubing out of the drawer. RT KK then suctioned trach three times holding finger over opening for continuous suction during insertion and removal of suction catheter. R154 coughed continually. Return of thick white secretions noted. RT KK removed suction catheter placed in trash and laid suction tubing over the suction machine uncovered. RT KK did not wash his hands or use hand sanitizer prior to or after the provision of tracheostomy care.<br><br>Interview on 9/22/2024 at 2:26 pm, with RT KK stated suctioning tracheostomy is not a sterile procedure for R154, referring to resident as he gets suctioned so frequently. During further interview, RT KK stated he gets gauze out of the bag as needed throughout the procedure and uses package until it is gone for any resident needing respiratory care. He stated he always brings the supply cart into resident room for care.<br><br>Interview on 9/25/2024 at 9:51 am, RT JJ revealed tracheostomy suctioning is always a sterile procedure, if new non-sterile gauze is needed during procedure. RT JJ revealed she will change gloves as that would ensure remaining gauze in bag would remain clean.<br><br>Interview on 10/2/2024 at 10:45 am, the DON revealed the Respiratory Therapists report to her, and she stated they have completed the competency check off for tracheostomy care. She stated her expectation is for tracheostomy care to be done following policy and best practices to ensure sterile technique is maintained.<br><br>Interview on 10/3/2024 at 1:27 pm, the Infection Preventionist confirmed that tracheostomy care and suctioning begins with removing current dressing with exam gloves, but then moves to a sterile procedure per policy. During further interview, she revealed at no point should staff go back into a package of clean gauze with contaminated gloves. She stated her expectations are to follow policies.<br><br>Review of the Competency Assessment for Tracheostomy Care for Respiratory Therapists KK and JJ, with all areas marked as yes indicating demonstrated competency. The competency checkoff's are dated 3/24/2024 (RT JJ) and 5/29/2024 (RT KK).<br><br>50170<br><br>6. Review of the facility policy titled Infection Prevention and Control Program reviewed 3/12/2024 documented the Policy: The 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 per national standards and guidelines. Policy Explanation and Compliance Guidelines: Number 12. Linens:<br><br>a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection.<br><br>(continued on next page) |

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| | 115025 | A. Building<br>B. Wing | 10/11/2024 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b. Clean linen shall be separated from soiled linen at all times.<br><br>c. Clean linen shall be delivered to resident care units on covered linen carts with covers down.<br><br>d. Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets.<br><br>e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom.<br><br>f. Environmental services staff shall not handle soiled linen unless it is properly bagged.<br><br>Observation on 10/9/2024 at 2:11 pm, upon entry to the laundry room noted a rancid smell. The laundry chute had an overflow of dirty linens spilling on to the floor, most were not in bags.<br><br>Interview on 10/9/2024 at 2:50 pm, with Assistant Administrator stated that dirty clothes are supposed to be dropped down the laundry chute, there is a staff member waiting at the bottom of the chute to get the clothes as they come down. He did not provide an explanation as to why the laundry chute was full and spilling onto the floor.<br><br>Observation on 10/10/2024 at 11:08 am, the laundry chute is now being closed so that clothes aren't falling onto the floor or overflowing into the bin.<br><br>50272<br><br>7. Review of the facility policy titled Routine Cleaning and Disinfection revised on 4/20/2024 indicated Policy Statement: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Definitions: Cleaning refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products. Disinfection refers to thermal or chemical destruction of pathogenic and other types of microorganisms. Standard Precautions refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Policy Explanation and Compliance Guidelines: Number 1. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at the time of discharge. Number 5. Standard precautions will be adhered to when cleaning any blood or body fluid spills, or soiled material that have the potential to contain these or other potentially contaminated substances. Number 11. Staff will ensure cleaning carts are checked and stocked with necessary supplies at the beginning of each shift.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview on 10/2/2024 at 10:39 am, with Housekeeping Aide AAA exited from room G229's bathroom carrying an exposed toilet brush, dripping with water, as she walked through the room out to the hallway. She then proceeded to go the room across from G229. Housekeeping Aide AAA was asked about the protocol regarding the handling of dirty cleaning items, such as the toilet brush after use, and she stated they're supposed to have a bucket to carry the toilet brush back to the cart. She stated she doesn't have a bucket at the moment, since there is only one bucket for the entire building. During continued interview, Housekeeping Aide AAA stated she normally mops the floors afterward and was waiting for the surveyors to leave the room before she could mop.<br><br>Interview on 10/7/2024 at 12:47 pm, with the Housekeeping Director (HD) revealed once the housekeeping aides clean the toilet bowl, they have a bowl with the toilet brush that is connected together, and they have to put brush in the bowl and transport the brush back to the cart once they are done cleaning the bathroom. The HD stated his expectations are that once housekeeping aides are done cleaning the toilet, they transport the toilet brush in the brush bowl back in to the cart. He stated they don't use buckets. During further interview, he stated he has provided housekeeping aides with in-service training on infection control practices regarding housekeeping. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50374<br><br>Based on observations, staff interviews, and review of the facility's policy titled, Answering the Call Light the facility failed to ensure resident call lights were within reach to allow the residents to call for staff assistance in seven of 22 rooms (101, 106, 105, 103, 104, 111, 107) on the memory care unit (Magnolia). This failure placed the residents at risk of accidents, injuries, and/or unmet needs.<br><br>Findings include:<br><br>Review of the facility's policy titled Answering the Call Light revised September 2022 documented the purpose of this procedures is to ensure timely responses to the resident's request and needs. General Guidelines: Number 4. Be sure that the call light is plugged in and functioning at all times. Number 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.<br><br>Observations on 9/22/2024 at 1:23 pm, 9/23/2024 at 9:38 am, 9/24/2024 at 10:03 am, and 9/25/2024 at 9:45 am in room [ROOM NUMBER], revealed the call light was lying on the floor, and not in the reach of the resident (R130).<br><br>Observation on 9/25/2024 at 9:38 am in room [ROOM NUMBER], revealed both the call lights were behind the bed and not reachable to the resident (R182).<br><br>Observation on 9/25/2024 at 9:39 am in room [ROOM NUMBER], revealed the call light was lying on the floor, and not reachable to the resident (R189).<br><br>Observation on 9/25/2024 at 9:44 am in room [ROOM NUMBER], revealed one of the call lights under the bed and not within reach of the resident (R126).<br><br>Observation on 9/25/2024 at 9:44 am in room [ROOM NUMBER], revealed the call light was positioned on the vacant side of the room inaccessible to the resident (R21).<br><br>Observation on 9/25/2024 at 9:56 am in room [ROOM NUMBER], a three-bed suite, revealed one of three call lights was on the floor and not reachable to the resident (R49).<br><br>Observation on 9/25/2024 at 9:56 am in room [ROOM NUMBER], revealed the call light was lying on the floor, not within reach to the resident (R10).<br><br>Observation and interview on 10/3/2024 at 11:11 am, the Assistant Administrator, Maintenance Director, and the Regional Maintenance Director confirmed the call light in room [ROOM NUMBER] (R130) was on the floor and out of reach from the resident.<br><br>Interview on 10/8/2024 at 10:16 am, Certified Nursing Assistant (CNA) II confirmed that the residents' call device was supposed to be beside the residents or on the bed at all times.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 10/8/2024 at 10:22 am, Unit Manager (UM) NN revealed call devices should be placed on the bed, beside the resident on the bed, or where they could access them.<br><br>Interview on 10/8/2024 at 10:26 am, the Regional Nurse Consultant (RNC) revealed there may be situations where the residents could knock the call device on the floor, but the staff should pick it up and position it to the bed. She stated all staff receive education training on call devices along with the residents. |