

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Center for Advanced Rehab at Parkside, The		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Park City Road Rossville, GA 30741	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50940 Based on observations, staff interviews, record review, and review of the facilities policies titled, Medication Administration: General Guidelines and Insulin Pen, the facility failed to adhere to accepted standards of quality care for three Residents (R) (R93, R51, and R66) reviewed during medication administration. Specifically, the facility failed to give the correct dosage of medicated ointment, to prime an insulin pen, and have residents rinse their mouth after inhaler use. Findings include: Review of the undated facility's policy Medication Administration revealed under Policy section 11 a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects .14. Administer medication as ordered in accordance with manufacturer specifications 16. If using a corticosteroid, allow resident to rinse and gargle with water if desired, to remove medication from mouth and back of throat. 17. Sign MAR (medication administration record) after administered. Metered dose inhalers-follow manufacture's product information for administration instructions Review of the facility's undated policy titled Insulin Pen revealed under the Policy section 6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. 11.H. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not repeat until at least one drop appears. Review of the manufacturer's instructions for use of diclofenac sodium gel (medicated gel for pain and inflammation) revealed the Instructions section included Use enclosed dosing card to measure a dose For each lower body are (foot, ankle, or knee)-squeeze out 4.5 inches (4 grams).Store enclosed dosing card with your Diclofenac Sodium Topical Gel 1% product. The dosing card is re-usable. Review of the manufacture instructions for use of the manufacturer's name insulin pen revealed in the Instructions section included Priming your Pen. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each use, you may get too much or too little insulin. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 115040	Facility ID: 115040 If continuation sheet Page 1 of 15

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacturer's instructions Patient information Breztri aerosphere (brez-TREE), (an inhaled medication used to treat chronic obstructive pulmonary disease (COPD) that contains a corticosteroid.) revealed the Instructions section included How should I use BREZTRI AEROSPHERE? .Rinse your mouth with water and spit the water out after each dose (2 puffs) of BREZTRI AEROSPHERE. Do not swallow the water. This will help to reduce the chance of getting a fungus infection (thrush) in the mouth and throat. 1. On 3/12/2025 at 9:30 am, the surveyor observed Licensed Practical Nurse (LPN) BB administering diclofenac gel 1% (percent) to R93 on both knees. LPN BB squeezed an unmeasured amount of the gel into a small medicine cup and brought it to the resident's room. She applied the gel liberally to both knees. When the surveyor asked LPN BB how she ensured that she was administering the prescribed 4 grams (gr) of the gel, LPN BB admitted she did not know how to measure it correctly, stating that the pharmacy had not provided guidance on measurement. The surveyor then suggested that LPN BB retrieve the diclofenac gel from the medication cart and locate the measuring card in the packaging box. LPN BB retrieved the ruler from the box and admitted that she should have used it to measure the prescribed dosage before administering the medication. In an interview with the Director of Nursing (DON) on 3/12/2025 at 3:00 pm, she stated that the correct way to measure diclofenac gel is by squeezing the prescribed amount onto a measuring card to ensure accurate dosage administration. 2. On 3/12/2025 at 8:35 am, the surveyor observed LPN AA performing a medication pass for R51. During the observation, the nurse administered manufacturer's name insulin subcutaneously but did not prime the insulin pen before administration. Immediately after administering the insulin, the surveyor asked LPN AA whether she typically primed the insulin pen. LPN AA stated that she did, but since this was a newly opened pen, she did not think it was necessary, and she was also nervous. In an interview with the DON on 3/12/2025 at 3:00 pm, she stated that insulin pens must always be primed before use. 3. On 3/12/2025 at 9:05 am, LPN BB was observed performing a medication pass for R66. During the med pass, LPN BB administered Breztri Inhaler, However, the nurse did not offer the resident water to rinse their mouth and spit after use. In an interview with LPN BB following the medication administration, the surveyor asked what she should have done after administering the Breztri but failed to do. LPN BB admitted that she should have instructed the resident to rinse their mouth after use but forgot. In an interview with the DON on 3/12/2025 at 3:00 pm, she stated that rinsing the mouth after using an inhaler was important.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 51215 Based on observations, resident and staff interviews, record review, and review of the facility's policy titled, Activities of Daily Living (ADLs), the facility failed to provide two of five residents (R) (R77 and R97) who were dependent on staff for ADLs. Findings include: Review of the undated facility policy titled Activities of Daily Living (ADLs) documented under, Policy Explanation and Compliance Guidelines, . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the electronic medical records (EMR) for R77 revealed admission to the facility with diagnoses that include but not limited to weakness, retention of urine, unspecified, personal history of other (healed) physical injury and trauma, other chronic pain, low back pain, unspecified fall, repeated falls, body mass index [BMI] 19.9 or less, adult, hypo-osmolality and hyponatremia, pain, hypocalcemia, muscle wasting and atrophy, difficulty in walking, not elsewhere classified, muscle weakness (generalized), polyneuropathy, neuromuscular dysfunction of bladder, spinal stenosis. Review of admission Minimum Data Set (MDS) assessment for R77 dated 2/21/2025 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R77 had intact cognition. Section GG (Functional Abilities and Goals) documented R77 with an upper extremity of impairment on one side, lower extremity with impairment on one side, uses a walker, needs partial/ moderate assistance with shower/bathe, lower body dressing, toilet transfer, walking and putting on and taking off footwear. Section O (Special Treatments and Programs) documented R77 needing ongoing physical therapy (PT). Review of care plan for R77 revealed focus, goals and interventions documented, the resident has an ADL self-care performance deficit related to (r/t) impaired balance, weakness, deconditioning. The resident requires assistance of staff for bathing and showering, resident requires assistance with bed mobility, dressing, set up for meals, oral care, personal hygiene, bed mobility, repositioning, and toilet use. Further review of care plan documented, resident has urinary retention, bladder dysfunction, has one kidney, order to assist with self in and out catheter, risk for constipation, continent at all times, uses incontinence briefs, clean peri-area during rounds with incontinence episode, observe and document for UTI (urinary tract infection), pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and staff to provide in and out catheters as ordered. Review of physician's orders for R77 revealed, Straight cath (insert catheter to drain urine from bladder) resident while lying down r/t postural difficulty four times a day for neurogenic (lack of bladder control due to brain, spinal cord, or nerve problems) bladder, Diflucan oral tablet 100 milligrams (MG), give 1tablet by mouth in the afternoon for fungal infection for 2 days on 3/11/2025, and 3/13/2025. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 3/11/2025 at 11:19 am with R77 revealed her sitting on the side of her bed talking with her roommate. R77 stated she sometimes had accidents on her clothes due to straight catharizing herself at night and awakened in the morning with dried urine on her and her bed because no one came when she rang the bell for help. R77 stated, on the weekends and at night there is only one floor tech and one nurse, and they have a lot of other residents to care for. Sometimes I help my roommate because the staff takes so long to come. When I turn on my light and no one comes, then they tell me that they were busy with someone else. I believe that it is because of the urine staying on me for hours has caused me to have an itch in my private area. I saw the doctor today and informed him about the itch and he ordered something for it. Interview on 3/12/2025 at 11:00 am with R77 revealed her sitting on her bed talking to her roommate. R77 stated that nothing had changed and the staff still took a long time to come when she rang the call bell. She stated she fell asleep last night waiting on someone to come and assist and wasn't sure what time they came. She stated that she started the medication that the doctor ordered and hoped it would help her with the itch. She stated she can't wait to go home. Review of EMR for R97 revealed that she was admitted to the facility with diagnoses that include but not limited to unspecified fracture of lower end of right tibia, subsequent encounter for closed fracture with routine healing, unspecified fall, encounter for other orthopedic after care, generalized anxiety disorder, hypertensive heart disease with heart failure, chronic systolic (congestive) heart failure, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of the quarterly MDS for R97 dated 12/31/2024 documented in Section C (Cognitive Status) a BIMS score of 14, indicating little or no cognitive decline. Section F (Preferences for Customary Routine and Activities) documented very important for R97 to choose what clothes to wear, to choose between a tub bath, shower, bed bath, or sponge bath. Section GG Functional Abilities) documented R97 uses a walker and a wheelchair, needs partial/ moderate assistance with shower/bath, tub/shower transfer, needs substantial/ maximal assistance with lower body dressing, and toilet transfer. Section O (Special Treatments, Procedures, and Programs) documented R97 not currently receiving physical therapy. Review of care plan for R97 dated 4/26/2024 revealed focus, goals and interventions documented, The resident has an ADL self-care performance deficit r/t (related to) weakness, deconditioning, right tibia fracture, will improve current level of function in ADLs through the review date, resident would prefer female care only for all toileting hygiene and bathing. The resident requires assistance of staff for bathing and showering, resident requires assistance with bed mobility, dressing, set up for meals, oral care routine, personal hygiene, bed mobility, assist rails up to aid with bed mobility repositioning, toilet use, PT/ occupational therapy (OT) evaluation and treatment as per MD orders. Review of the physician's orders for R97 documented, Air mattress with alternating pressure for comfort related to cancer diagnosis and Sertraline HCl (hydrochloride) oral tablet 50 MG (milligrams), give 1.5 tablet by mouth at bedtime for depression. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 3/11/2025 at 11:51 am with R97 revealed her lying in bed with TV on and muted. R97 stated that she was a bit upset about her showers always being off, especially on the weekends. R97 stated, my Certified Nursing Assistant (CNA) was pulled from shower duty because she said they were short staffed, and now my showers have been put off three times and this upsets me. One time I went 9 days before I was given a shower. The last time they skipped my shower was this weekend. I told several people about it because I was upset, but then they gave it to me on Monday after I made them know I was upset. The CNA told me that the reason I got a shower on Monday instead of my regular scheduled shower day was because I told on them. Well, when you can't get out of bed, and you pee and poop on yourself, you need your shower. Interview on 3/12/2025 at 11:30 am with R97 revealed her lying in bed watching TV. She revealed she was waiting on her CNA to give her to assist her with care but would not be having a shower again till Thursday. R97 revealed that her CNA informed her that because she had gotten a shower on Monday, she would not be getting another one till her regular scheduled day which would be on Thursday. Interview on 3/13/2025 at 8:30 am with R97 revealed her lying in bed with the TV off. She stated she was waiting on her CNA as she should be getting a shower today, but no one had come in the room yet to inform her of a time for her shower. Review of the shower log and documentation in their electronic health record (EHR) revealed for 30 days, no documentation of showers given nor resident's refusal for dates 2/15/2025, 2/22/2025 and 3/8/2025. Review of two weeks staffing schedule grid indicated no staffing shortages for the last 30 days. Interview on 3/13/2025 at 8:43 am with CNA DD revealed she worked mostly on [NAME] Hall but works on other halls as well. She stated that most of the time she was R77 and R97's CNA and confirmed R97's shower schedule was on Tuesdays, Thursdays and Saturdays. CNA DD stated that she was not on [NAME] Hall this past Tuesday and was not sure if R97 got a shower, but admitted to giving R97 a shower the previous Thursday as scheduled. CNA DD stated, R97 usually receives her shower between 9:30 and 10:00 am and is scheduled to receive one today. She normally does not refuse her shower but if R97 try to refuse, then I give her some time to rest and reapproach her again later which she then takes it. CNA DD also stated that she assisted R77 with ADL care in the mornings but that most of the time R77 helps herself. Interview and record review on 3/13/2025 at 9:02 am with Registered Nurse (RN) EE mentioned she was the Unit Manager on [NAME] Hall and confirmed that R97 shower days were Tuesdays, Thursdays and Saturdays. RN EE stated that she knew that R97 received a shower on 3/7/2025 but admitted that there was no documentation confirming this activity. RN EE confirmed that in nursing when it's not documented, It's not done. Record review with RN EE confirmed that on 2/15/2025, 2/22/2025 and 3/8/2025 there were no signatures confirming R97 received showers on those days and that there was no documentation of refusal or other reason why the activity was not performed. RN EE admitted that the weekend CNA was responsible for giving R97 showers on the weekends. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/13/2025 at 9:41 am with the Director of Nursing (DON) and RN FF revealed that it was their expectation that all residents were receiving the care they deserve on all shifts each day. The DON stated that the facility had a shower team who provided showers during the week and sometimes on the weekends, but when they were not on staff, the CNAs were expected to give the shower. The DON admitted that all CNAs received indicators on the EHR in their task section when a resident was scheduled for a shower along with all other tasks. RN FF stated that all staff were expected to document on the EHR when a resident refused their shower and then notify the nurse. RN FF stated that it was then that the nurse on the floor would speak with the resident and try to either convince them to take their shower or offer them a bed bath.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50940 Based on observations, staff interviews, record review, and review of the facility policy titled, Medication Administration, the facility failed to maintain a medication error rate below five percent for two residents (R) (R93 and R51). Three medication errors of 42 opportunities were observed during medication administration resulting in a medication error rate of 7.14%. Findings include: Review of the undated facility's policy titled Medication Administration revealed under the Policy section: .11. a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects .14. Administer medication as ordered in accordance with manufacturer specifications 17. Sign MAR (medication administration record) after administered. Review of the facility's undated policy titled Insulin Pen, revealed the Policy section included 6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. 11 .H. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not repeat until at least one drop appears. Review of the manufacture instructions for use of manufacturer of insulin pen revealed the Instructions section included Priming your Pen. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Review of the manufacture instructions for use of diclofenac sodium gel revealed the Instructions section included Use enclosed dosing card to measure a dose For each lower body (foot, ankle, or knee)- squeeze out 4.5 inches (4 grams).Store enclosed dosing card with your Diclofenac Sodium Topical Gel 1% product. The dosing card is re-usable. On 3/12/2025 at 9:30 am, the surveyor observed Licensed Practical Nurse (LPN) BB administering diclofenac gel 1% to R93 on both knees. The surveyor noted that LPN BB squeezed an unmeasured amount of the gel into a small medicine cup and brought it to the resident's room. She applied the gel liberally to both knees. When interviewed immediately after administering the gel, the surveyor asked LPN BB how she ensured she was administering the prescribed 4 grams (gr) of the gel. LPN BB admitted that she did not know how to measure it correctly, stating that the pharmacy had not provided guidance on measurement. The surveyor then suggested that LPN BB retrieve the diclofenac gel from the medication cart and locate the measuring card in the packaging box. LPN BB retrieved the ruler from the box and admitted that she should have used it to measure the prescribed dosage before administering the medication. In an interview with the Director of Nursing (DON) on 3/12/2025 at 3:00 pm, she stated that the correct way to measure diclofenac gel was by squeezing the prescribed amount onto a measuring card to ensure accurate dosage administration. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/2025 at 8:35 am, the surveyor observed LPN AA performing a medication pass for R51. During the observation, the nurse administered manufacturer name of insulin pen insulin subcutaneously but did not prime the insulin pen before administration. Immediately after administering the insulin, the surveyor asked LPN AA whether she typically primed the insulin pen. LPN AA stated that she did, but since this was a newly opened pen, she did not think it was necessary, and she was also nervous. In an interview with the DON on 3/12/2025 at 3:00 pm, she stated that insulin pens must always be primed before use. On 3/12/2025 at 8:37 am, the surveyor observed a medication pass performed by LPN AA for R51. During the medication pass, ten medications were administered. Afterward, when the surveyor compared the administered medications against the MAR, it was noted that fluticasone nasal spray 50 mcg/act (micrograms per actuation)-one spray in each nostril for allergies-had been documented as given but was not actually administered to the resident. In an interview with LPN AA on 3/12/2025 at 2:10 pm, she admitted that she had marked the medication as given but forgot to administer it. She stated that she would administer it immediately.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51215 Based on observations, resident and staff interviews, record review, and review of the facility's policy titled, The name of corporation Nutritional Management, the facility failed to provide one of 42 sampled residents (R) (R77) with food and drink that was palatable, attractive, and at a safe and appetizing temperature. This failure had the potential to worsen the current condition of abnormal weight loss and low body mass index (BMI) of 19.9 or less. Findings include: Review of the facility's policy titled, The name of corporation Nutritional Management undated revealed under: Compliance Guidelines: 2. Identification/ assessment: .b. The dietary manager or designee shall obtain the resident's food and beverage preferences upon admission, significant change in condition, and periodically throughout his or her stay. c. A comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission, annually, and upon significant change in condition. Follow up assessment will be completed as needed. Review of electronic medical record (EMR) for R77 revealed admission to the facility with diagnoses that include but not limited to weakness, acquired absence of other specified parts of digestive tract, BMI (body mass index) 19.9 or less, adult, hypo-osmolality dilution of solutes in the blood) and hyponatremia (a condition where sodium levels in the blood are abnormally low), hypocalcemia (A condition where calcium levels in the blood are abnormally low), muscle wasting and atrophy, difficulty in walking, muscle weakness, abnormal weight loss. Review of admission Minimum Data Set (MDS) for R77 dated 2/21/2025 documented BIMS score of 15, indicating R77 had intact cognition. Section GG (Functional Abilities and Goals) documented R77 with an upper extremity of impairment on one side, lower extremity with impairment on one side, uses a walker, needs partial/ moderate assistance with shower/bathe, lower body dressing, toilet transfer, walking and putting on and taking off footwear. Section O (Special Treatments and Programs) documented R77 needing ongoing physical therapy (PT). Review of the care plan for R77 revealed focus, goals and interventions documented, the resident has potential nutritional problem related to (r/t) variation by mouth (po) intake, gastroesophageal reflux disease (GERD), will maintain adequate nutritional status, fluid restriction is free water only. Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors . Give appetite stimulant as ordered. Observe/document/report as needed basis (PRN) any signs and symptoms (s/sx) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Observe/record/report to physician (MD) PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% (percent) in 1 month, >7.5% in 3 months, >10% in 6 months. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Provide vitamins and serve supplements as ordered. Provide, serve diet as ordered. Monitor intake and record every (q) meal. Registered Dietician (RD) to evaluate and make diet change recommendations PRN. Weights as ordered. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders for R77 revealed, Thiamine 100 milligrams (mg) q day times 2 weeks. Begin ensure (nutritional supplement) vanilla or strawberry bid (twice daily). Begin promod (liquid protein) or similar daily. Ask patient if she will consider Marinol (synthetic form of THC-marijuana) 2.5 MG q day trial times 3 week for appetite stimulation. Weigh on admission then weekly x 4 weeks then monthly if stable. every day shift starting on the 1st and ending on the 2nd for 30 Days weigh monthly. Calcitriol Oral Capsule 0.25 microgram (mcg) (Calcitriol) Give 1 capsule by mouth one time a day every other day for Low Calcium level. Cyanocobalamin Oral Tablet 500 MCG (cyanocobalamin) Give 1 tablet by mouth one time a day for Supplements for 30 Days. Magnesium Oral Tablet (magnesium) Give 400 mg by mouth one time a day for Supplements. Nu-Iron Oral Capsule 150 MG (polysaccharide iron complex) Give 1 capsule by mouth one time a day every Mon, Wed, Fri (Monday, Wednesday, Friday) for Anemia for 30 Days. Potassium Chloride ER (extended release) Tablet Extended Release 10 MEQ Give 2 tablet by mouth two times a day for Supplements. Vitamin Deficiency System-B12 Injection Kit 1000 MCG/ milliliters (ML) (cyanocobalamin) Inject 1 ML intramuscularly one time a day every Fri for Supplement for 21 Days. Interview on 3/11/2025 at 11:19 am with R77 revealed R77 stated that the food was horrible at times, and she did not eat it. She stated that she ate mostly cheerios when the food was bad. She stated that she was never offered anything else to eat when she didn't eat the food but took what she liked off the tray. R77 stated that the tray was taken away after dinner, but no one ever asked why she hadn't eaten or offered her anything else to eat. R77 stated that she did not know what else they had available since they never got a menu, so she just asked for cheerios. Interview on 3/12/2025 at 12:30 pm with R77 revealed she did not eat dinner the night before. R77 stated she ate the chocolate pudding off the tray and ate cheerios from her drawer. She stated that again she was not offered anything different, nor did she ask. R77 stated that she did eat breakfast and lunch today but always kept a box of cheerios just in case. Interview on 3/12/2025 at 1:08 pm with the Registered Dietician (RD) revealed that the staff usually reported any food complaints to her or the dietary manager. The RD stated that she announced the alternates at morning meetings and the managers sometimes called or came by her office to inquire. The RD stated that on admission she met with the resident and went through the food preference sheet with them. She stated that there was a handwritten section for the residents to write if their choice was not preprinted on the sheet already. The RD stated that each resident's food likes and dislikes was then documented in the system. She further stated that if she visited a resident on admission and the resident wasn't available, she documented it and left herself a note to revisit another time. The RD also stated that she visited the resident daily until the interview was conducted. The RD denied ever being told R77 refused any meals but could not confirm the date she completed R77's admission interview. Interview on 3/13/2025 at 8:43 am with Certified Nursing Assistant (CNA) DD revealed that R77 sometimes did not eat meals, and she would ask if there was something else she could get the resident, and then got it. CNA DD stated that when a resident refused a meal, she often tried to offer something else and if they refused then it got reported to the nurse and she documented the refusal in the EMR. CNA DD stated, I can't remember a situation where the resident didn't eat; however, if she asked for a replacement, it would have been given to her. CNA DD admitted that she didn't always work on [NAME] Hall and was not sure if other CNAs were offering alternate meal choices to residents who refused their meal. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Center for Advanced Rehab at Parkside, The		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Park City Road Rossville, GA 30741	
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/13/2025 at 2:30 pm with License Practical Nurse (LPN) BB revealed that she was not aware of R77 refusing meals or not eating. LPN BB stated that the CNAs would usually offer a sandwich or something if a resident did not eat the meal provided.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50940 Based on observations, staff interviews, record review, and review of the facility's policies titled, Hand Hygiene, Medication Administration, and Cleaning and Disinfection of Resident-Care Equipment, the facility failed to consistently perform hand hygiene procedures while providing care to two of 42 sampled residents (R) (R57 and R32) and to sanitize shared medical equipment between residents' use for two of 42 sampled residents (R66 and R93) during medication pass observations. This failure had the potential to increase the risk of infection transmission among staff and residents. Findings include: Review of the undated facility policy titled Hand Hygiene revealed under Policy . section 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand Hygiene Table revealed the following conditions when hand hygiene is necessary to perform: .between resident contacts, before applying and after removing personal protective equipment (PPE), including gloves, before and after handling medications, .before performing resident care procedures, .when in doubt. Review of the undated Medication Administration policy revealed under Policy section 4. Wash hands prior to administering medications per facility protocol and product. Review of the undated facility policy titled Cleaning and Disinfection of Resident-Care Equipment revealed under Policy section 3. B. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident D. Multiple-resident use equipment shall be cleaned and disinfected after each use. 1. On 3/12/2025 at 8:25 am, the surveyor observed Licensed Practical Nurse (LPN) AA performing a medication pass for R57. LPN AA began preparing medications on the medication cart but did not sanitize her hands before starting the task. She then realized that the nasal spray she needed for the resident was missing from the cart, prompting her to stop and step out to the medication room to retrieve a new bottle. Upon returning to the cart, she did not sanitize her hands again and continued preparing the medications for the resident. When she entered the resident's room, she again failed to sanitize her hands before proceeding with medication administration. She only sanitized her hands upon leaving the room. Immediately after the medication pass, the surveyor asked LPN AA whether she should have performed hand hygiene before preparing the medications, upon returning to the medication cart with the nasal spray, and upon entering the resident's room. She admitted that she should have but stated that she was nervous and forgot to do so. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 3/12/2025 at 4:50 pm the surveyor observed LPN CC performing a blood glucose check on R32 followed by the administration of insulin, as per MD order. There were no concerns regarding the execution of these tasks, except for infection control practices related to hand hygiene. LPN CC was observed sanitizing her hands after leaving a previous resident's room but did not sanitize them before beginning care for a new resident (R32). She gathered all necessary supplies, entered the room, and donned (putting on) gloves without first sanitizing her hands before performing the blood glucose check. After removing her gloves, she again failed to sanitize her hands before stepping out of the room to prepare the insulin. Upon returning, she donned a new pair of gloves without sanitizing her hands and proceeded with insulin administration. LPN CC only washed her hands after completing the task and removing her gloves. Immediately after the observation, the surveyor asked LPN CC whether she should have sanitized her hands before and after donning gloves. LPN CC was unsure and stated that she had washed her hands after completing the previous resident's care. 3. On 3/12/2025 at 9:05 am, LPN BB was observed during a medication pass for R66. The nurse entered the resident's room for medication administration. She checked the resident's blood pressure (BP) before administering the medications and placed the BP monitor on the bedside table without using a barrier. She proceeded with medication administration. Upon completing the medication administration, she put the BP monitor in her pocket and then returned it to the medication cart without cleaning it. She then proceeded with the medication pass for another resident, R93. She prepared medications for the resident at the medication cart and placed the uncleaned BP monitor in her pocket again. She entered the resident's room without sanitizing the BP monitor and her hands. After checking the resident's BP, she returned the monitor to her pocket and administered the medications. Although she sanitized her hands before leaving the room, she did not sanitize the BP monitor upon returning to the medication cart. When interviewed immediately after the medication pass about whether she was supposed to sanitize her hands upon entering the room and clean shared equipment before and after each resident's use, LPN BB acknowledged that she should have done so but stated that she was nervous and failed to do that. In an interview with the Director of Nursing (DON) on 3/12/2025 at 3:00 pm, she stated that staff were expected to practice frequent hand hygiene, especially when providing resident care, and that the use of gloves does not replace handwashing. She emphasized that staff were required to follow facility policies. Regarding shared equipment, the DON repeated that staff were expected to adhere to facility policies and ensure proper cleaning of shared equipment between residents' use.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51215 Based on observations, staff interviews, record review, and review of the facility's policies titled, [name of facility owner] Antibiotic Stewardship Program and Infection Prevention and Control Program, the facility failed to properly establish/implement a surveillance plan for identifying, tracking, monitoring and/or reporting of infections and antibiotic (ABT) use among residents and staff. This failure had the potential to delay detection of infection and care for all residents and increase the risk of infection transmission among staff and residents. The deficient practice had the potential to affect all residents residing in the facility. The facility census was 120 residents. Findings include: Review of the undated facility's policy titled [name of facility owner] Antibiotic Stewardship Program, revealed under Policy Explanation and Guidelines: . 4. a. i. Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR form prior to notifying the physician. ii. Laboratory testing shall be in accordance with current standards of practice. b. i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made. ii. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness, iii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. On page 2, under 5. Nursing will monitor the initiation of antibiotics based on the residents and conduct an antibiotic timeout within 48- 72 of antibiotic therapy to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be based on the findings. Review of the facility's policy titled Infection Prevention and Control Program revealed under Policy Explanation and Guidelines: . 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual agreement based upon a facility assessment and accepted national standards. b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee. c. The RNs and LPNs participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections. (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 3/12/2025 at 1:44 pm with the Infection Preventionist (IP) revealed that the Infection Prevention and Control Program (IPCP) was initiated due to Quality Assurance and Performance Index (QAPI). The IP stated that he looked daily for new antibiotic orders in the electronic medical record (EMR) and added the resident to his running list. The IP stated that antibiotic orders were not reconciled with the pharmacist or the doctor (MD) and admitted that labs or other cultures were not closely monitored nor reviewed to avoid unnecessary antibiotic use or discontinuation if required. The IP stated that residents generally continue the ABT ordered until the medication was completed or discontinued by the doctor. The IP further stated that they do not have an active monitoring of the ABT stewardship program, and that the documentation wasn't accurate so it's not currently being used. He admitted to not having a system set up to monitor and follow lab/culture results, or ABT use and monitoring for effective intervention. He admitted to keeping a list for [NAME] ordered and adding new residents when they were admitted with ABT orders along with any labs and removed them when it was completed. He stated, I monthly review the EMR to monitor for ABT and sensitivity to inform the MD. The IP revealed he was unable to complete the ABT surveillance process due to the nurses not doing their part. He stated, I spoke to our Director of Nursing (DON) to complete in-services and educate the nurses about making a case in the EMR when ABT was ordered for it to notify me. Interview on 3/12/2025 at 2:45 pm with the DON, they stated, I have only been here for six weeks and was only told by the IP about educating the nurses on creating a case for ABT use in the EMR on 3/11/2025. It was explained to me that when the resident was placed on an ABT, the nurse should be triggering a case in order for the IP to pick up the resident for monitoring. I am not familiar with the system as I came from another state that did not have this and therefore, I have to research and educate myself before educating the nurses about it. It is my understanding that the nurses inform the MD of the resident's symptoms and then the MD decides if he wants to put the resident on ABT as well as order labs and then the IP tracks it. My expectation is that IP is pulling records on a daily basis to get the ABT info but I'm not sure how it's being done.		