STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115044	A. Building B. Wing	03/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azalea Health Center by Harborview	1600 Anthony Road Augusta, GA 30904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914 Based on observations, staff interviews, and review of the facility's policy titled, Safe and Homelike Environment, the facility failed to ensure a clean, homelike, and safe environment for one of three units (Unit 2). Specifically, the facility failed to ensure that the resident's living areas were free of clutter, that privacy curtains were clean and free of debris, and that the resident's rooms were provided with necessary repairs. These deficient practices had the potential to place residents at risk of living in an unsanitary and unsafe living environment and a potential for diminished quality of life. Findings include: Review of the facility Policy titled, Safe and Homelike Environment, dated 3/1/2024, revealed the Policy Explanation and Compliance Guidelines section included . 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. Observations on 3/14/2025 at 8:52 am and 3/15/2025 at 9:52 am in room [ROOM NUMBER] revealed Bed C had personal items stored on the floor and stacked in the corner of the room. Bed D had multiple items stored on the overbed table area, cluttered with various items and clothing noted in bags. Observations on 3/14/2025 at 9:15 am and 3/15/2025 at 9:12 am in room [ROOM NUMBER] revealed sheet rock exposed by the door entering the room, Bed A side of the room was cluttered with adult briefs, Bed B side of the room was cluttered with personal items from the floor to midway the window with personal items, the sheet rock behind Bed B was exposed, and the sink ledge was chipped with jagged edges exposed. Observations on 3/14/2025 at 9:45 am and 3/15/2025 at 9:20 am revealed the bathroom door in room [ROOM NUMBER] was hard to open, making it hard for residents to access the bathroom. The room was cluttered with personal items on the Bed A side of the room, black marks were noted on the wall at the entrance to the room on the left side, and the wallpaper was peeling from the wall by the sink. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 3/14/2025 at 9:50 am and 3/15/2025 at 9:37 am in room [ROOM NUMBER] revealed the privacy curtain had brown spots noted throughout the curtain, starting from the middle of the curtain to the hem. Further observation revealed that the Bed A side of the room was cluttered with personal items, including clothes and boxed food items, a pile of adult briefs, a tote bag, and personal care items on top of the dresser drawers behind the door, and the sink in room [ROOM NUMBER] was cluttered with various items. Observations on 3/14/2025 at 10:10 am and 3/15/2025 at 9:40 am in room [ROOM NUMBER] revealed the wall under the window had scattered patches of a brown substance. The tile in the ceiling to the right of the room had a large brown stain noted on two tiles in the upper corner. The space between Bed B and the window was cluttered with a clear tote noted on the floor and a laundry basket full of clothes on top of it. Observations on 3/14/2025 at 10:15 am and 3/15/2025 at 9:15 am in room [ROOM NUMBER] revealed two wheelchairs and a rollator stored in the area between Beds C and D with clothing items resting on them. During observation, it was noted there was only room for the residents in Bed C and D to transfer from one side of the bed with limited space. Confirmation walking rounds on 3/16/2025 at 2:42 pm with the Administrator and the Environmental Services Manager confirmed all observations that were noted during the survey process. An interview with the Administrator revealed letters would be going out to the residents and residents' families for the removal of the overflow of belongings from the rooms to reduce the clutter. 49675 Observations on 3/15/2025 at 8:25 am and 3/16/2025 at 2:30 pm of the laundry room revealed missing ceiling tiles, water-stained ceiling tiles, ceiling tiles that were falling apart, and a ventilation unit wrapped in an aluminum foil-like material secured with duct tape with insulation spilling out of one end and in the middle. During concurrent interviews and observations on 3/16/2025 at 2:30 pm, the Administrator and Director of Housekeeping confirmed the findings in the laundry room. The Administrator stated his intention was to have the ceiling replaced in the next two months and was ordering new lighting and ceiling tiles.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 41165 Based on observations, staff interviews, and review of the facility policy titled, Medication Administration, the facility failed to ensure that residents' medications were free from misappropriation by licensed nursing staff during medication administration observations. Findings include: A review of the facility policy titled, Medication Administration, revised 6/1/2024, revealed the Policy Explanation and Compliance Guidelines section included .10. Ensure that the six rights of medication administration are followed: a. Right Resident, b. Right Drug, c. Right Dosage, d. Right Route, e. Right Time, f. Right Documentation. During medication administration observation on 3/15/2025 at 9:18 am, Registered Nurse (RN) EE stated that R17's metoprolol extended-release (ER) 50 milligram (mg) (a medication used to lower blood pressure and heart rate) was not available on the medication cart. Continued observation and interview at 10:15 am revealed RN EE stated she would obtain the medication from the facility's backup dispensing system and walked away. At 10:25 am, RN EE returned to the medication cart with a medication cup containing two tablets. She stated that she went to the nurse at Station 2 and asked her to give her two metoprolol ER 25 mg tablets. In an interview on 3/15/2025 at 10:29 am, at the Nurses' Station 2, Licensed Practical Nurse (LPN) CC stated that she pulled two metoprolol 12.5 mg tablets from another resident's medication pack and provided them to RN EE. LPN CC further stated that she knew that she should not have pulled the medication from another resident's medication supply, but she wasn't thinking. In an interview on 3/16/2025 at 3:20 pm, the Director of Nursing (DON) stated that if a resident's medication was not available, the nurse should obtain the medication from the facility's backup medication-dispensing system, and if it was not available in the backup system, the nurse should call the pharmacy.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42463 Based on observations, staff interviews, record review, and review of the facility's policy titled, Resident Assessment-Coordination with PASARR Program, the facility failed to submit for a Preadmission Screening and Resident Review (PASRR) Level II after a new mental illness diagnosis was added for four of 35 sampled residents (R) (R5, R2, R14, and R294) reviewed for PASRR. This deficient practice had the potential to place R5, R2, R14, and R294 at risk of not receiving services and/or care according to their needs. Findings include: Review of the facility's policy titled, Resident Assessment-Coordination with PASARR Program, dated 3/1/2022, revealed the section titled Policy Explanation and Compliance Guidelines included . 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority .9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: (b) A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. 1. Review of the Admission Record revealed R5 was admitted to the facility on [DATE] with diagnoses that included, but not limited to, unspecified dementia of unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and Post-Traumatic Stress Disorder (PTSD). Depression was added as a diagnosis on 11/6/2023. Review of R5's Annual Minimum Data Set (MDS) dated [DATE] Section A (Identification Information) documented the resident had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of eight (indicating moderate cognitive impairment). Section I (Active Diagnosis) revealed non-Alzheimer's dementia, depression (other than bipolar), and PTSD. Section N (Medications) revealed the resident received antidepressant medications during the look-back period of the assessment. Section O (Special Treatments, Procedures, and Programs) revealed no psychological therapy during the look-back period of the assessment. Review of R5's Physician Orders, dated 10/4/2023, revealed the resident was currently receiving sertraline hydrochloride (HCL) tablet 75 milligrams (mg) by mouth one time a day for depression. Review of R5's PASRR Level I assessment dated [DATE] revealed R5 did not have a primary diagnosis of dementia, did not have a terminal illness, and did not have a diagnosis of a serious mental illness or mental disorder. Further review of R5's electronic health records (EHR) revealed no submissions for a PASRR Level II after the new mental illness diagnoses were added. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility-provided list of residents with Level II PASRR within the facility revealed that R5's name was not listed. In an interview on 3/15/2025 at 5:00 pm, the Regional Nurse Consultant confirmed R5 did not have a PASRR Level II. She stated that R5 qualified as a PASRR Level I and provided the PASRR Level I screen. 2. Review of the Admission Record revealed that R2 was admitted to the facility on [DATE] with diagnoses that included, but not limited to, depression, PTSD, anxiety disorder and unspecified dementia, unspecified severity (all added on 4/26/2024), adjustment disorder with mixed anxiety and depressed mood added on 8/27/2024, and delusional disorder added on 5/14/2024. Review of R2's Annual MDS dated [DATE] Section A (Identification Information) documented the resident had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Section C (Cognitive Patterns) revealed a BIMS score of 13 (indicating little to no cognitive impairment). Section I (Active Diagnosis) revealed anxiety disorder, depression (other than bipolar), and PTSD. Section N (Medications) revealed the resident received antipsychotics, antidepressants, and opioid medications during the look-back period of the assessment. Section O (Special Treatments, Procedures, and Programs) revealed no psychological therapy during the look-back period of the assessment. Review of R2's Physician Orders, dated 2/7/2025, revealed the resident was currently receiving fluoxetine HCL oral capsule 20 mg, two capsules by mouth one time a day for depression, and quetiapine fumarate oral tablet 100 mg, one tablet by mouth at bedtime for delusional disorder. Review of R2's PASRR Level I assessment dated [DATE] revealed R2 did not have a primary diagnosis of dementia and had a serious mental illness or mental disorder of depression. Further review of R2's EHR revealed no submissions for a PASRR Level II after the new mental illness diagnoses were added. Review of the facility-provided list of residents with Level II PASRR within the facility revealed that R2's name was not listed. In an interview on 3/16/2025 at 11:32 am, the Director of Operations (DOO) and MDS Director HH reviewed R5 and R2's EHRs. MDS Director HH confirmed R5 and R2 had documented qualifying diagnosis for a PASRR Level II, and a PASRR Level I screen had not been resubmitted after R5 and R2 received the new diagnoses. The DOO revealed that they had a new Social Services Director (SSD) at the facility who was being trained. She stated she expected staff to resubmit the PASRR Level I screenings if qualifying diagnoses were added. In a telephone interview on 3/16/2025 at 11:43 am, the SSD revealed she was new in her role but was responsible for submitting PASRRs. She revealed that she had only worked in the facility for one week and was currently training with MDS Director HH. She stated that she had no knowledge of R2 or R5's diagnoses or PASRR status and was still learning the process. 41914 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review for R14 revealed the resident was admitted to the facility on [DATE] with a diagnosis of, but not limited to, bipolar disorder. Review of the Admission MDS dated [DATE] revealed Section A (Identification Information) documented the resident had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Section I (Active Diagnoses) documented manic depression (bipolar disease) as a diagnosis. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Pattern) documented a BIMS of 12 (indicating moderate cognitive impairment). Section I (Active Diagnoses) documented manic depression (bipolar disease) as a diagnosis. Review of R14's medications revealed the resident was currently prescribed clonazepam 1 mg by mouth two times daily for anxiety, quetiapine fumarate 100 mg one tablet by mouth every morning and at bedtime for bipolar, and sertraline HCL 75 mg one tablet by mouth one time a day for depression. Review of R14's PASRR Level I assessment dated [DATE] revealed R14 did not have a primary diagnosis of dementia, did not have a terminal illness, and did not have a diagnosis of a serious mental illness or mental disorder. Further review of R14's EMR revealed a diagnosis of bipolar disorder that was initiated on 4/2/2024 with no indication of a PASRR Level II submission on behalf of R14. Review of the Progress Notes located in the EHR revealed an entry dated 3/30/3034 at 9:24 pm that R14 exhibited screaming constantly, crying, and hallucinations. Review of the Behavioral Monitoring document for R14 indicated that resident exhibited behavioral symptoms six of 31 days in January 2025 (1/13/2025, 1/15/2025,1/20/2025, 1/21/2025 1/29/2025 and 1/31/2025) and 12 of 28 days in February 2025 (2/1/2025, 2/3/2025, 2/6/2025, 2/7/2025, 2/11/2025, 2/13/2025, 2/13/2025, 2/17/2025,2/18/2025, 2/20/2025, 2/21/2025, 2/27/2025, and 2/28/2025). Review of the facility-provided list of residents with Level II PASRR within the facility revealed that R14's name was not listed. Observation on 3/14/2025 at 2:35 pm revealed R14 was yelling out help, help. There was staff in the resident's room providing care to other residents. Observation on 3/15/2025 at 8:31 am and 10:31 am revealed R14 lying in bed, yelling inaudible words. Observation on 3/15/2025 at 5:29 pm revealed R14 was yelling out help repeatedly. The staff was passing dinner trays to other residents. In an interview on 3/15/2025 at 5:43 pm, the Regional Nurse Consultant confirmed that R14 only had a Level I PASRR, and a PASRR Level II had not been applied for. 4. Review of the medical record for R294 revealed the resident was admitted with the diagnoses of, but not limited to, major depressive disorder, anxiety disorder, and bipolar disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission MDS dated [DATE] revealed Section A (Identification Information) documented the resident had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Patterns) revealed a Brief Interview For Mental Status score of 14 (indicating little to no cognitive impairment). Section I (Active Diagnoses) documented diagnoses of anxiety disorder, depression, and bipolar disorder. Review of R294's medication regime revealed the resident was prescribed citalopram 30 mg, one tablet by mouth daily (a medication used to treat depression), and quetiapine fumarate 50 mg, one tablet by mouth two times a day for bipolar disorder. Review of R294's PASRR Level I assessment dated [DATE] revealed R5 did not have a primary diagnosis of dementia, did not have a terminal illness, and did not have a diagnosis of a serious mental illness or mental disorder. Review of R294's EHR revealed a diagnosis of bipolar disorder that was initiated on 4/2/2024 with no indication that a PASRR Level II was applied for on behalf of R294. Review of the Behavioral Monitoring document for R294 revealed that the resident exhibited behavioral symptoms two of 31 days in January 2025 (1/19/2025 and 1/27/2025) and four of 28 days in February (2/4/2025, 2/10/2025, 2/11/2025, and 2/12/2025). Review of the facility-provided list of residents with Level II PASRR within the facility revealed that R294's name was not listed. In an interview on 3/15/2025 at 5:43 pm, the Regional Nurse Consultant confirmed that R294 only had a Level I PASRR, and a PASRR Level II had not been applied for.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914 Based on observations, staff interviews, resident interviews, record review, and review of the facility's policies titled, Activity of Daily Living (ADLs) and Residents Rights, the facility failed to ensure three of five residents (R) (R8, R84, and R294) sampled for ADL care received care and services for ADLs. The deficient practice had the potential to place R8, R84, and R294 at risk for unmet needs and a diminished quality of life. Findings include: Review of the facility's policy titled, Activity of Daily Living (ADLs), revised 3/1/2023, revealed the Policy section included The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. bathing, dressing, grooming, and oral care. Review of the facility's policy titled, Resident Rights, revised 2/1/2025, revealed the section titled Resident Rights included . 5. Self-determination. The resident has the right to and the facility must promote and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. 1. Record review for R8 revealed diagnoses including, but not limited to, essential hypertension chronic pain, scoliosis, quadriplegia, and muscle wasting. Review of R8's Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Pattern) documented a Brief Interview For Mental Status (BIMS) score of 8 (indicating the resident had severe cognitive impairment). Section GG (Functional Abilities and Goals) documented that R8 had impairment on each side and required assistance with ADLs. Review of R8's care plan revealed a Focus area of Resident has an ADL self-care performance deficit related to activity intolerance, impaired balance, limited mobility. Interventions included that the resident was total dependent on one to two person staff for bathing/showering as needed or as required and required substantial to maximal assistance for personal hygiene and care. Observation on 3/14/2025 at 10:05 am revealed R8 had a moderate amount of facial hair visible under her chin, and her hair appeared disheveled and unkempt. In an interview on 3/14/2025 at 10:05 am, R8 revealed she had not had a shower in a month and that her hair needed to be washed. Observation on 3/15/2025 at 11:14 am revealed R8 continued to have a moderate amount of facial hair visible under her chin, and her hair appeared disheveled and unkempt. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/15/2025 at 11:23 am, Certified Nurse Aide (CNA) AA revealed that she worked with R8 quite a bit and had not given the resident a shower since she has been working with the resident in the past month. She stated that R8 was given a bed bath instead of the shower because R8 required a shower bed transport, and the bed would not fit through the shower room door. In an interview on 3/15/2025 at 11:30 am, CNA BB revealed that residents who require a shower bed were taken to the shower room on Unit Three. CNA BB stated the shower bed was a little larger than the door frame, however, it would fit through the door after maneuvering the bed around into the door and shower stall. In an interview on 3/15/2025 at 11:45 am, CNA DD revealed that she was responsible for the care of R8 on 3/14/2025 when the resident was scheduled for her shower. CNA DD confirmed that R8 had not received a shower as scheduled and that it had been a while since the resident had been to the shower room. In an interview on 3/15/2025 at 11:50 am, Licensed Practical Nurse (LPN) CC revealed that R8's scheduled shower days were Monday, Wednesday, and Friday on the day shift. LPN CC confirmed R8 had not received a shower as scheduled, and there was no documentation of R8 refusing a shower or personal hygiene. LPN CC verified that R8 had visible facial hair on her chin and stated it needed to be removed. 2. Record review for R84 revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease, Type 2 diabetes mellitus, weakness, and retention of urine. Review of R84's Admission MDS assessment dated [DATE] revealed Section C(Cognitive Patterns) documented a BIMS of 11 (indicating moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented R84 was dependent for showering/bathing self and required substantial to maximal assistance with personal hygiene. Review of R84's care plan revealed a Focus area of Resident needs assistance with grooming, bathing, and personal hygiene related to self-care impairment. Interventions included the resident was dependent for bathing, dressing, and nail care. Observation on 3/14/2025 at 8:45 am revealed R84 was lying in bed with visible facial hair on the chin, and the resident's hair appeared disheveled and unkempt. Observation on 3/15/2025 at 9:30 am revealed R84 continued to have visible facial hair on the chin, and the resident's fingernails had a brown substance on the nail beds. Observation on 3/16/2025 at 8:00 am revealed R84 continued to have visible facial hair on the chin, and the resident's fingernails had a brown substance on the nail beds. 3. Record review for R294 revealed diagnoses of, but not limited to, pulmonary embolism, hypothyroidism, major depressive disorder, anxiety disorder, and generalized muscle weakness. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R294's Quarterly MDS assessment dated [DATE] revealed Section C(Cognitive Patterns) documented a BIMS of 14 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented that R294 required substantial to moderate assistance for showering/bathing self and partial to moderate assistance with personal hygiene. Review of R294's care plan revealed a Focus area of Resident needs assist with grooming, bathing, and personal hygiene related to self-care impairment. Interventions included the resident required limited assistance with bathing and dressing and supervision with personal hygiene. Observation on 3/14/2025 at 9:00 am revealed R294 was sitting in a wheelchair in her room. Her hair appeared greasy and unkempt, and her fingernails had visible brown substance underneath the nail beds. Observation on 3/14/2025 at 4:30 pm revealed R294's hair continued to appear greasy and unkempt, and her nails continued to have a brown substance underneath the nail beds. Observation on 3/15/2025 at 8:00 am revealed R294 sitting up in a wheelchair at her bedside wearing the same clothing she had worn the day before. Her hair appeared greasy and unkempt, and her nails continued to have a brown substance underneath the nail beds. Observation on 3/15/2025 at 3:00 pm revealed that R294 continued to wear the same clothing from the previous observation, and there had been no change in the resident's hygiene since the survey entrance. In an interview on 3/15/2025 at 3:20 pm, R294 revealed that the staff had not offered her any assistance with showering. Observation on 3/16/2025 at 8:00 am revealed that R294 continued to wear the same clothes and had greasy, unkempt hair, and her nails still had a brown substance on the nailbeds. In an interview on 3/16/2025 at 12:30 pm, the Director of Nursing (DON) revealed her expectation was for staff to provide showers and ADL care to residents as scheduled and document any refusal of care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41165 Based on observation, staff interviews, record review, and review of the facility's policy titled, Pharmacy Services, the facility failed to ensure that medication was obtained from the pharmacy in a timely manner for one of five residents (R) (R17) observed for medication administration. Findings include: Review of the facility's policy titled, Pharmacy Services, revised 3/1/2025, revealed the Policy section included It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. The Compliance Guidelines section included, 1. The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. Review of the clinical record revealed R17 had diagnoses including, but not limited to, essential (primary) hypertension, metabolic encephalopathy, tachycardia, unspecified, and anxiety disorder. Review of R17's Physician's Orders revealed orders dated 2/3/2025 that included metoprolol extended release (ER) 50 milligrams (mg), one by mouth in the morning for hypertension (high blood pressure), and diltiazem ER 120 mg, one capsule by mouth in the morning for hypertension. Observation on 3/15/202 at 9:18 am, during medication administration, with Registered Nurse (RN) EE revealed R17's metoprolol ER 50 mg and diltiazem 120 mg ER were not available in the medication cart. Observation on 3/15/2025 at 9:35 am revealed RN EE asked Licensed Practical Nurse (LPN) GG to obtain the missing medications from the 'overflow.' LPN GG returned with the metoprolol ER 50 mg. In an interview on 3/15/2025 at 9:53 am, LPN GG stated the diltiazem 120 mg ER was not available in the facility. She stated the facility did not have a backup pharmacy provider. She further stated that she would notify the facility's pharmacy, and the pharmacy would arrange for the provision of the medication. She stated she was unsure of the time the medication would be delivered, but it would be at least an hour and would not arrive in time to administer to R17 as ordered. In an interview on 3/15/2025 at 10:00 am, the Director of Nursing (DON) stated she was aware medications were not being reordered in a timely manner. She stated that the nurse should reorder the medication from the pharmacy when the pill cards reach the blue mark on the packet to ensure the timely delivery of the medication. The DON confirmed the facility failed to ensure R17's medications were available for timely administration as ordered by the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115044	A. Building B. Wing	03/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azalea Health Center by Harborview	1600 Anthony Road Augusta, GA 30904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 41165 Based on observation, staff interviews, record review, and review of the facility's policy titled, Medication Administration, the facility failed to ensure a medication error rate of less than five percent. There were 27 opportunities with 10 medication errors for one of four residents (R) (R17) observed for medication administration. The medication error rate was 37.04 percent. Findings include: Review of the facility's policy titled Medication Administration, revised 6/1/2024, revealed the Policy Explanation and Compliance Guidelines section included. 10. Ensure that the six rights of medication administration are followed: g. Right Resident, h. Right Drug, i.Right Dosage, j. Right Route, k. Right Time, l. Right Documentation . The Example guidelines for Medication Administration section included, Medication timing (excludes insulin): . BID (two times a day) 9 am, 9 pm, QD (every day) 9:00 am. Review of the facility-provided document titled Medication Times revealed that medications ordered daily were to be administered at 9:00 am, and medications ordered to be administered two times daily were to be administered at 9:00 am and 6:00 pm. Review of R17's clinical record revealed diagnoses including, but not limited to, essential hypertension, metabolic encephalopathy, tachycardia, and anxiety disorder. Review of R17's Physician's Orders revealed the orders included diltiazem extended release (ER) 120 milligrams (mg) one in the morning for hypertension (HTN), escitalopram oxalate 20 mg one daily for depression, folic acid 1 mg one a day for supplement, metoprolol succinate extended release (ER) 50 mg one in the morning for HTN, oxybutynin chloride 2.5 mg one in the morning for over-active bladder, Risperdal 0.5mg one in the morning for schizophrenia, Trelegy Ellipta aerosol inhaler, one puff daily for chronic obstructive pulmonary disease (COPD), vitamin D-3 one daily for supplement, Colace 100mg one every morning and bedtime for constipation, and Dulera inhalation aerosol two puffs every morning and bedtime for COPD. Review of R17's Medication Administration Record (MAR) dated 3/2025 revealed all medications ordered to be given once daily or every morning were scheduled to be administered at 9:00 am. During medication administration observation on 3/15/2025 at 10:43 am, Registered Nurse (RN) EE administered R17's morning medications at 10:43 am. The diltiazem ER 120 mg was not available. In an interview on 3/15/2025 at 10:00 am, the Director of Nursing (DON) stated that the morning medication administration time was 9:00 am. She stated she would notify the physician of the medication that was unavailable and of the medications being administered late. In an interview on 3/15/2025 at 10:15 am, RN EE stated she was aware that R17's medications were late and had not been administered on time. (continued on next page)

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	115044	A. Building B. Wing	03/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/16/2025 at 3:20 pm, the DON stated that it was her expectation for medications to be given one hour before or after the scheduled time. The DON confirmed the facility failed to administer medications in a timely manner.

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	115044	A. Building B. Wing	03/16/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 41165 Based on observations, staff interviews, record review, and review of the facility policies titled Medication Administration and Pharmacy Services, the facility failed to ensure that one of five residents (R) (R17) observed during medication administration observations was free from significant medication errors. Findings include: A review of the facility policy titled Medication Administration, revised 6/1/2024, revealed the Policy Explanation and Compliance Guidelines section included . 10. Ensure that the six rights of medication administration are followed: e. Right time. 12. Compare medication source with MAR (medication administration record) to verify resident name, medication name, form, dose, route, and time. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. Review of the facility's policy titled, Pharmacy Services, revised 3/1/2025, revealed the Policy section included It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. The Compliance Guidelines section included, 1. The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. Review of the facility-provided document titled, Medication Times, revealed that medications ordered daily were to be administered at 9:00 am, and medications ordered to be administered two times daily were to be administered at 9:00 am and 6:00 pm. Review of the clinical record revealed R17 had diagnoses including, but not limited to, essential (primary) hypertension, metabolic encephalopathy, tachycardia, unspecified, and anxiety disorder. Review of R17's Physician's Orders revealed an order dated 2/3/2025 for diltiazem ER 120 mg, one capsule by mouth in the morning, for hypertension. Review of R17's Medication Administration Record (MAR) revealed the 3/15/2025 9:00 section for diltiazem 120 mg ER was coded as 4. The Chart Codes on the MAR indicated 4 was Other/See Nurse Notes. Review of R17's Progress Notes revealed an entry dated 3/15/2025 at 4:22 pm of Resident's diltiazem ER 120 mg available. Writer called and informed (Physician's name). New order received to give diltiazem ER 120 mg x 1 (one time). BP (blood pressure) 148/70. Medication given per order. Resident informed of above information, and she acknowledged understanding of information given. During medication pass observation on 3/15/2025 at 10:43 am, RN EE administered R17's medications. Further observation revealed the diltiazem 120 mg ER was not administered at 10:43 am. RN EE confirmed that the diltiazem 120 ER 120 mg was not available for administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/15/2025 at 9:20 am, Licensed Practical Nurse (LPN) GG stated she would notify the physician and pharmacy of the missing medication. She further stated that the medication may not be available for at least one hour. She confirmed the medication was ordered to be administered at 9:00 am and should be administered within one hour of the scheduled time. In an interview on 3/15/2025 at 10:00 am, the Director of Nursing (DON) confirmed that the morning medication administration time was at 9:00 am and stated medications should be administered within one hour before or after 9:00 am. She stated she was aware that R17's diltiazem 120 mg ER was unavailable in the facility and would inform the physician. In an interview on 3/16/2025 at 3:20 pm, the DON stated that it was her expectation for medications to be available and administered one hour before or after the scheduled time. The DON confirmed the facility administered R17's morning dose of diltiazem 120 mg ER after 4:00 pm on 3/15/2025.