STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115090	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brown Health and Rehabilitation	545 Cook Street Royston, GA 30662

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 12679 Based on interviews, record review, and review of the facility's policy titled, Abuse Prohibition--Reporting and Investigating, the facility failed to complete a thorough investigation for two of two sampled Residents (R) (R48 and R82) reviewed for abuse. Specifically, there was no evidence the facility interviewed R48 the victim, other staff, or residents regarding the allegations of potential sexual abuse as a part of the facility's investigations. Findings include: Review of the facility's policy titled, Abuse Prohibition--Reporting and Investigating dated 12/29/2023 under the section titled, Guidelines indicated . Interviews will be conducted of pertinent parties. Written signed statements from any involved parties will be obtained if possible or a witnessed, signed interview would be an appropriate alternative. Information regarding the event will be gathered from the suspect, person making the accusations, patient involved, reliable patients who may have witnessed the incident, and any other persons who may have witnessed the incident, and any other persons who may have credible, pertinent information . All investigative information will be kept on file in a secured location. All information gathered is confidential in nature . Review of an undated document provided by the facility titled, Face Sheet indicated R82 was admitted with a diagnosis of dementia. Review of a document provided by the facility titled, Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/26/2024, indicated R82 had a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating severely impaired cognition. The assessment indicated the resident wandered and was ambulatory. Review of a document provided by the facility titled Face Sheet indicated R48 was admitted with a diagnosis of Parkinson's disease. Review of a document provided by the facility titled, Admission MDS, with an ARD of 1/25/2024, indicated R48 had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident had no behaviors such as hallucinations or delusions. The assessment indicated the resident used a wheelchair and required substantial to maximum assistance from staff for activities of daily living. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a file provided by the facility (referred to as the facility's investigation of a 3/6/2024 incident), dated 3/14/2024, indicated R82 was observed to kiss R48 on the cheek. To determine consent and competency of R48, the facility completed another BIMS and the resident scored a six out of 15, which revealed severe cognitive impairment. Both R48 and R82 were separated. According to the facility's investigation, R82 attempted to enter the room of R48 and was redirected. The investigation indicated R48 was transferred to the opposite side of the building. The facility could not substantiate abuse. There was no evidence the facility interviewed other staff regarding the allegations of potential sexual abuse. In addition, there was no evidence R48, the victim, was interviewed as part of the facility's investigation. Review of a file provided by the facility (referred to as the facility's investigation of a 3/18/2024 incident) dated 3/26/2024 indicated a staff member was attending to R48, while she was in a wheelchair and out in the hallway. The investigation revealed R82 leaned over R48 and kissed her cheek. Staff immediately removed R82 from R48. According to the facility's investigation, R82 was upset he could not pursue a relationship with R48. R82 was sent to a local hospital for a psychiatric evaluation and returned back to the facility three days later. Facility-wide training with staff occurred and the facility implemented 15-minute checks for R82. The investigation revealed R48 was to be monitored by the staff. The facility could not substantiate abuse. There was no evidence the facility interviewed other staff regarding this allegation of potential sexual abuse. In addition, there was no evidence R48, the victim, was interviewed as part of the facility's investigations. The facility also failed to ensure residents were interviewed as part of the facility's investigation. Review of R82's and R48's clinical records revealed there were no staff witness statements documented for the incidents dated 3/6/2024 and on 3/18/2024. During an interview on 4/2/2024 at 5:29 pm, the Administrator stated she did not collect a statement from R48 since the resident had a low Brief Interview for Mental Status (BIMS) score. The Administrator stated the staff who witnessed the two incidents between R48 and R82, were in the clinical records.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interviews, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to complete and electronically transmit a Discharge Minimum Data Set (MDS) assessment to CMS's (Centers for Medicare and Medicaid Services) Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system for two of two residents (R) (R35 and R80) reviewed for discharge to home. Findings include: Review of the RAI Manual, dated 10/1/2019, indicated, There are three types of discharges: two are OBRA [Omnibus Budget Reconciliation Act] required-return anticipated and return not anticipated; the third is Medicare required-Part A PPS [Prospective Payment System] Discharge. A Discharge assessment is required with all three types of discharges . Any of the following situations warrant a Discharge assessment . Resident is discharged from the facility to a private residence . Discharge Assessment - return not anticipated. 1. Review of an undated document provided by the facility titled, Face Sheet indicated R35 was admitted to the facility on [DATE] and was discharged home on 12/21/2023. Review of a document provided by the facility titled, Nursing Home Part A PPS Discharge MDS with an assessment reference date (ARD) of 12/20/2023, indicated R35 ended Medicare skilled nursing care. There was no evidence of a discharge assessment completed which would indicate R35 was discharged from the facility to home and would not return to the facility. 2. Review of an undated document provided by the facility titled, Face Sheet indicated R80 was admitted to the facility on [DATE] and was discharged home on 11/27/2023. Review of a document provided by the facility titled, Nursing Home Part A PPS Discharge MDS, with an ARD of 11/26/2023, indicated R80 ended Medicare skilled nursing care. There was no evidence of a discharge assessment completed which would indicate R80 was discharged to home and would not return to the facility. During an interview on 4/3/2024 at 2:55 pm, the MDS Coordinator confirmed R35 and R80 should have had an OBRA discharge MDS assessment to indicate the two residents were discharged and not returning to the facility. During an interview on 4/4/2024 at 8:53 am, the Administrator and Director of Nursing stated it was their expectation that all mandatory MDS assessments be completed and transmitted per RAI requirements.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 12679 Based on interviews, record review, and review of facility's policy titled, Patient's Plan of Care, the facility failed to update a Care Plan for one Resident (R) (R31) when a pacemaker monitoring device was provided to the facility and failed to ensure one (R1) was invited to participate in the quarterly care plan meeting. These failures had the potential for R31 not to receive necessary care and services for a pacemaker monitoring device and R1 not to be involved in decisions affecting care in the facility. The sample size was 41 residents. Findings include: Review of the facility policy titled, Patient's Plan of Care, dated 12/29/2023, revealed The patient's care plan should be reviewed . and revised based on changing goals, preferences, and needs of the patient and in response to current interventions. The comprehensive care plan should also be updated as ongoing clinical assessments identify changes. The policy also documented, The center will provide the patient and/or patient's representative with advance notice of care planning conferences to enable patient/patient representative participation at a time the patient/patient representative is available to participate, in person or via phone call/video conferencing . 1. Review of R31's undated Face Sheet, located in the electronic medical record (EMR) under the Face Sheet' tab, revealed R31 was admitted with diagnoses including sick sinus syndrome, left bundle branch block, and presence of a cardiac pacemaker. Review of R31's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/28/2024 and located in the MDS tab of the EMR, revealed a Brief Interview of Mental Status (BIMS) score of 99, which indicated severe cognitive impairment. R31's diagnoses included heart failure and hypertension. Review of the Care Plan tab in the EMR under the focus area for anticoagulant related to left bundle branch block, sick sinus syndrome and pacemaker, included interventions initiated on 2/16/2024 for administering medications and watch for signs of bleeding. The Care Plan lacked interventions about the device to monitor the pacemaker. During an observation on 4/2/2024 at 9:15 am in R31's room, on a table located against the wall opposite the bed a device was plugged into the wall. The label on the device listed the (Name of the remote management system). There was a phone number for assistance label on top of monitoring device, plugged into wall socket and green light on in the bottom right corner of the device. During an interview on 4/4/2024 at 10:05 am, Licensed Practical Nurse (LPN)2, who was providing care for R31, stated she did not know what the device did or anything about the purpose of the device located in R31's room and confirmed the resident's Care Plan lacked documentation of the device. During an interview on 4/4/2024 at 12:34 pm, Registered Nurse (RN)1 verbalized the Care Plan for R31 should have been updated when the device was brought into the facility and staff should have occasionally confirmed the signal was being sent to the cardiologist office. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2024 at 1:30 pm, the Assistant Director of Nursing (ADON) explained the device was brought to the facility after a cardiology appointment by FM2, it was a remote monitor, and the only requirement was to be plugged into the wall. The ADON confirmed the remote monitoring device for the pacemaker should have been updated on R31's Care Plan when it was brought into the facility. During an interview on 4/4/2024 at 1:18 pm, the Director of Nursing (DON) confirmed information about the monitoring device was not included on R31's Care Plan, and once the monitoring device came into the facility it should have been added to the Care Plan. 2. Review of a document provided by the facility titled, Face Sheet indicated R1 was admitted to the facility with a diagnosis of a traumatic head injury. Review of a document provided by the facility titled, Care Plan, dated 8/31/2020, indicated R1 had short- and long-term memory problems. Review of a document provided by the facility titled, Care Plan Conference, dated 10/24/2023, indicated the family member of R1 was invited to participate in his care conference and did not attend. The document failed to indicate if R1 was invited to participate in his quarterly care conference. Review of a document provided by the facility titled, quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 12/20/2023, indicated R1 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicated led the resident was moderately cognitively impaired. Review of a document provided by the facility titled, Care Plan Conference dated 1/23/2024 indicated the family of R1 was invited to participate in his care conference and did not attend. The document failed to indicate if R1 was invited to participate in his quarterly care conference. During an interview on 4/2/2024 at 9:18 am, R1 stated he did not get invited to his quarterly care conferences. During an interview on 4/3/2024 at 1:11 pm, the Social Services Director (SSD) stated the MDS Coordinator would send out invitations to the residents' representatives on a quarterly basis and would always invite the residents. The SSD did not invite the resident to attend the Care Plan Conference. During an interview on 4/3/2024 at 2:14 pm, the MDS Coordinator stated all the resident representatives were sent invitations. The MDS Coordinator stated the SSD would invite the residents to their quarterly care plan meetings. The MDS Coordinator did not invite the resident to attend the Care Plan Conference. During an interview on 4/4/2024 at 4:52 pm, the Director of Nursing (DON) stated her expectation was for the residents and their family members to be invited to quarterly care conferences and the facility does send out invitations. 39540

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on observations, staff interviews, record review, and review of the facility's policy titled, Using A Portable Lifting Machine, the facility failed to ensure a mechanical lift sling was inspected for damage and defects after laundering for one out of five residents (R) (R13) reviewed for falls. The deficient practice caused R13 to fall from a mechanical lift sling because of a broken strap while being transferred from his motorized wheelchair to the bed. Findings include: Review of the facility's policy titled, Using A Portable Lifting Machine, dated 12/29/2023, provided by the facility, revealed, Various manual and/or electric mechanical lifts may be used by this center. Manufacturer recommendations for use should be followed. Review of the manufacturer guidelines titled, Liko (Trademark) Soft Original High Back Sling, Mod. 26 Instructions for Use, dated 12/11/2013, provided by the facility, revealed Care and Maintenance of Liko Slings . Check the Sling after Washing. All points are inspected with regard to wear and damage Fabric, Straps, Seams, Suspension loops, Buckles (where applicable) . Do not use damaged slings. Protocol for periodic inspection can be used as guidance as to which parts are extra important to check for each sling model. Slings in polyester fabric have a longer lifetime than slings in net polyester. The handles on certain slings are intended for steering. Too heavy a load on the handles can result in the sling breaking. Review of R13's undated Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed R13 was admitted to the facility on [DATE] with diagnoses of cerebral palsy (CP) and morbid obesity. Review of R13's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/17/2023 located in the EMR under the MDS tab, revealed R13 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The assessment indicated R13's functional status as being dependent on staff for transfers, and he used a motorized wheelchair. Review of R13's Care Plan, dated 10/6/2023, located in the EMR under the Care Plan tab, indicated R13 fell on [DATE] with an intervention on 10/2/2023 of 911 call [sic], MD [physician] notified, Sent to ER [emergency room], Neuro [neurological] check and an intervention on 10/6/2023 of Slings evaluated and blue sling appropriate for use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R13's Nursing Progress Notes, dated 10/2/2023, located in the EMR under the Progress Notes tab, indicated 0305 [3:05 AM]-Staff was putting resident to bed when strap on lift seat [sling] broke and resident fell to floor with legs still in lift seat. Back was lying across leg of lift with head on floor. Lift lowered and sling removed. Resident rolled off leg of lift onto floor. Pillow under head, No Loc [loss of consciousness]. Resident c/o [complained of] pain to back. Able to MAEW [move all extremities well]. 0359 [3:59 AM] 911 notified. 0401 [4:01 AM]-Dr [doctor] and on call notified 0402 [4:02 AM]-Neuro check WNL [within normal limits]. 0410 [4:10 AM]-EMS [emergency medical services] here. Awaiting additional personel [sic]. 0430 [4:30 AM]-Resident to [hospital] via stretcher. 0431 [4:31] AM-Report called to RN [registered nurse] at [hospital]. During an interview on 4/2/2024 at 11:01 am, R13 stated on 10/2/2023, three-night shift staff--two Certified Nursing Aides (CNAs) and one RN--were in the process of transferring him from the motorized wheelchair to his bed when the upper right strap of the sling ripped and broke. His head fell to the floor, but his legs stayed in the sling. R13 also stated he had pain in his neck and back, he was sent to the hospital, and he had no injuries. During an interview on 4/2/2024 at 3:06 pm, the Administrator stated R13 fell from the mechanical lift when the right upper strap broke when three staff were moving him from the wheelchair to the bed on 10/2/2023. The Administrator also stated R13 was sent to the hospital because he complained of pain but did not suffer any injuries. The Administrator indicated the cause of the broken sling could not be determined; however, the investigation revealed the laundry staff did not document that mechanical lift slings were inspected for defects or damage prior to putting them back in circulation on the floor prior to R13's fall. The Administrator confirmed no other incidents had occurred before or after R13's fall but she removed those slings and ordered new slings for all the residents. During an interview on 4/2/2024 at 3:17 pm, the Housekeeping Supervisor stated the laundry staff washed and hung the mechanical lift slings to dry then sent them to floor or stored them in storage bins but did not check them for damage or defects or document it until after R13's fall on 10/2/2023. The Housekeeping Supervisor also stated laundry staff now inspect every sling after they were laundered, and they documented the inspection on the Mechanical Lift Inspection Log. During an interview on 4/3/2024 at 11:54 am, Laundry Aide 1 stated that after the mechanical lift slings were laundered, they were inspected for damage, and they documented it on the sling log, but that process did not begin until after R13's incident last year. Laundry Aide 1 also stated if the slings were damaged, they removed the sling and gave it to the Housekeeping Supervisor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 28604 Based on observation, interview, record review, and review of the facility's policy titled, Standard Patient Room Cleaning, the facility failed to ensure prevention of spread of infection by using foam protectors in disrepair over bed rails that created an uncleanable surface for four of four Residents (R) (R19, R22, R10, and R13) reviewed for side rail use. This deficient practice had the potential for the foam covers on the side rails to harbor bacteria and spread infection to the residents. Findings include: Review of the facility's policy titled, Standard Patient Room Cleaning, dated January 2024, revealed 5. DISINFECT: . b. Patient zone: Using the same microfiber cloth and enhanced disinfectant, clean and disinfect surfaces in the patient's zone (i.e., over bed table, bed rails, bedside table, phone, call light cord). 1. Review of R22's undated Face Sheet, located in the electronic medical record (EMR) under the Face Sheet tab, revealed R22 was admitted with diagnoses including rheumatoid arthritis and chronic pain syndrome. Review of the Care Plan tab in R22's EMR revealed an intervention initiated 7/14/2023 to apply side rails to the bed. The Care Plan lacked documentation of reason indicating a need to pad the side rails. During an observation on 4/2/2024 at 1:56 pm in R22's room, bilateral 1/4 side rails attached to the upper frame of the resident's bed were covered with a gray foam padding and secured with duct tape. During an interview on 4/3/2024 at 3:31 pm, the Director of Nursing (DON) expressed a lack of understanding of the concern for the uncleanable surface of the foam on the side rails, stating it was just their germs. During an observation on 4/4/2024 at 2:19 pm, the foam padding on the R22's bed rails was cracked and peeling, exposing porous areas of the foam. During an interview on 4/4/2024 at 11:21 am, in R22's room, R22 verbalized they did not know the reason for the foam padding on the rails on the bed and the foam had been in place since the admission in June 2023. During an interview on 4/4/2024 at 12:48 pm, the Maintenance Director explained a work request was placed in the TELS (building maintenance documentation system) system to pad the resident's bed rails. He acquired the foam from Ace Hardware (same foam used to apply insulation to the outside of pipes), cut it to size, and secured it with tape to the bed rails. During an interview on 4/5/2024 at 11:10 am, the Infection Preventionist (IP) confirmed the foam was not cleanable due to the porous texture and residents or staff could infect or reinfect themselves during contact with the foam due to reservoirs for bacteria in the texture of the foam. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R19's Face Sheet, located in the EMR under the Face Sheet tab, revealed R19 was admitted with diagnoses including Alzheimer's disease and unspecified lack of coordination. Review of the Care Plan tab in R19's EMR revealed an intervention initiated 2/5/2023 to apply side rails to the bed. The Care Plan lacked documentation of reason indicating a need to pad the side rails. During an observation on 4/2/2024 at 1:56 pm in R19's room, bilateral side rails attached to the upper frame of the resident's bed were covered with a gray foam and secured with black tape. During an observation on 4/4/2024 at 2:19 pm, the foam padding on R19's bed rails was cracked, pitted, and part peeled off exposing porous areas of foam. During an interview on 4/4/2024 at 12:48 pm, the Maintenance Director explained a work request was placed in the TELS system to pad the resident's bed rails. He acquired the foam from Ace Hardware (same foam used to apply insulation to the outside of pipes), cut it to size, and secured it with tape to the bed rails. During an interview on 4/5/2024 at 11:10 am, the IP confirmed the foam was not cleanable due to the porous texture and residents or staff could infect or reinfect themselves during contact with the foam due to reservoirs for bacteria in the texture of the foam. 3. Review of R10's undated Face Sheet located in the EMR under the Face Sheet tab revealed R10 was admitted with diagnoses of amnesia and difficulty walking. Review of R10's Care Plan, revised 4/4/2024, located in the EMR under the Care Plan tab, indicated a problem of Skin breakdown: at risk for/actual and an intervention to Continue padded rails related to history of bruising. Observations in R10's room on 4/2/2024 at 9:36 am and 4/4/2024 at 9:22 am revealed R10 lying in bed with two side rails elevated at the top of the bed with gray foam covering the top of the side rail, secured with gray tape. During an interview on 4/4/2024 at 12:48 pm, the Maintenance Director revealed the nurses submitted a work order for the foam padding for the side rails, which he ordered and picked up from (Name of Store) Hardware, then secured it to the side rails with duct tape. During an interview on 4/5/2024 at 11:10 am, the IP confirmed the foam was not cleanable due to the porous texture and residents or staff could infect or reinfect themselves during contact with the foam due to reservoirs for bacteria in the texture of the foam. 4. Review of R12's undated Face Sheet, located in the EMR under the Face Sheet tab, revealed R12 was admitted with diagnoses that included dementia and transient cerebral ischemic attack (stroke). Review of R12's Care Plan, revised 4/4/2024 and located in the EMR under the Care Plan tab, revealed a problem of Skin breakdown: at risk for/actual and an intervention to Continue padded side rail on left per patient preference. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations in R12's room on 4/2/2024 at 11:35 am and 4/3/2024 at 8:39 am revealed R12 was lying in bed with two side rails raised at the top of the bed with a dark gray foam covering the top of the left side rail, secured with black tape at the top and bottom of the rail. During an interview on 4/3/2024 at 8:39 am, R12 stated she did not know when or why the foam was applied to the side rail. During an interview on 4/4/2024 at 12:30 pm, Registered Nurse (RN) 1 stated the foam was applied to the bed rails to prevent skin tears or bruises on the resident's arms due to her fragile skin. During an interview on 4/4/2024 at 12:48 pm, the Maintenance Director revealed the nurses submitted a work order for the foam padding for the side rails which he ordered and picked up from (Name of Store) Hardware, then secured it to the side rails with duct tape. During an interview on 4/5/2024 at 11:10 am, the IP confirmed the foam was not cleanable due to the porous texture and residents or staff could infect or reinfect themselves during contact with the foam due to reservoirs for bacteria in the texture of the foam. 39540

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 39540 Based on observation, interview, and record review, the facility failed to ensure staff were informed or educated about the remote cardiac monitor's purpose for one of one Resident (R) (R 31) with a pacemaker monitor. The deficient practice had the potential to place R31 at risk of not receiving necessary care and monitoring for cardiac instability. Findings include: Review of the Facility Assessment, dated 3/6/2024, revealed Education is conducted on our L.E.A.D. platform which is assigned monthly by (Name of Company) and on an as needed basis for individuals and groups. L.E.A.D. assignments are conducted based on QAPI processes and annual education requirements for regulatory purposes. Other training needs are addressed through On-boarding and orientation-Annua/Skills Fair (completed in May 2023), Safety Boot Camp, Webinars, Staff Meetings, Huddles and (Name of Company). Notifications. (Name of Company) consultants conduct education during site visits and via Zoom meetings. Outside education is offered through GHCA, AHCA, Healthcare Coalitions and (Name of Company) training and meetings off-site. The Facility Assessment did not identify cardiac pacemaker monitoring equipment or staff training needed for use of the device. Review of the undated Face Sheet, located in the electronic medical record (EMR) under the Face Sheet tab, revealed R31 was admitted with diagnoses including sick sinus syndrome, left bundle branch block, and presence of a cardiac pacemaker. Review of R31's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/28/2024 and located in the EMR under the MDS tab, revealed a Brief Interview of Mental Status (BIMS) score of 99, which indicated severe cognitive impairment. R31's diagnoses included heart failure and hypertension. Review of the Care Plan tab in the EMR under the focus area for anticoagulant related to left bundle branch block, sick sinus syndrome and pacemaker, included interventions initiated on 2/16/2024 for administering medications and watch for signs of bleeding and lacked interventions about the device to monitor the pacemaker. During an observation on 4/2/2024 at 9:15 am, in R31's room, on a table located against the wall opposite the bed a device was plugged into the wall. The label on the device was (Name of the remote management system). There was a phone number for assistance label on top of monitoring device, plugged into wall socket and green light on in the bottom right corner of the device. During an interview on 4/2/2024 at 9:59 am, R31's Family Member (FM)1 explained the device was a monitor that sent information about the heart rhythm and pacemaker to the cardiologist's office for evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115090	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brown Health and Rehabilitation	545 Cook Street Royston, GA 30662

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2024 at 10:05 am, Licensed Practical Nurse (LPN)2, who was providing care for R31, stated she did not know what the device did or anything about the purpose of the device located in R31's room. During an interview on 4/4/2024 at 1:30 pm, the Assistant Director of Nursing (ADON) explained the device was brought to the facility after a cardiology appointment, it was a remote monitor, and the only requirement was to be plugged into the wall. During an interview on 4/5/2024 at 1:55 pm, R31's FM2 explained during the visit with the cardiologist and R31 in December 2023, the device was provided to monitor the pacemaker due to the battery being very low (implanted in 2016). The cardiologist's office would notify the facility if there were issues with the battery or cardiac rhythm. FM2 brought the device to the facility to monitor R31's cardiac stability. During an interview on 4/5/2024 at 9:17 am, Licensed Practical Nurse (LPN)3 confirmed FM2 brought the device into the facility to monitor the pacemaker of R31 to set up for monitoring. LPN3 plugged in the device and called the customer service number to set up the monitor. The responsibility of the facility was to be sure the device was plugged in, green light on in the bottom right corner, and placed in the resident room. LPN3 stated since the device was already set up, she did not communicate information about the device to any other staff. During an interview on 4/5/2024 at 12:23 pm, the Director of Nursing (DON) verbalized staff development and training was performed as a group project involving the DON, ADON, supervisors, and other staff as needed. The DON confirmed no education was provided for the device in R31's room for monitoring the cardiac health of the resident when the device was brought into the facility, but training should have been done to ensure all staff could provide the necessary care for the monitor.