

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER New Horizons Habersham		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Habersham Terrace Gardens Demorest, GA 30535	

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50803</p> <p>Based on staff interview, record review, and review of the facility's policy titled, Advance Directives, the facility failed to provide written information to the resident and/or representative regarding the right to accept or refuse medical or surgical treatment for one of 30 sampled residents (R) (R3) reviewed for advance directives. This failure had the potential to deny R3 and/or representatives the opportunity to have choices and preferences with health care decisions and to formulate an Advance Directives.</p> <p>Findings include:</p> <p>Review of the facility's undated policy titled Advance Directives under the Purpose statement revealed, To establish guidelines for complying with state and federal law related to an individual's wishes and personal beliefs regarding the provision of health care at the end of life or when incapacitated. Under the section titled Advance Directive for Healthcare revealed, A written document, voluntarily executed, to make one's wishes regarding their own health care known.</p> <p>Review of R3's Electronic Medical Record (EMR) revealed R3 was admitted to the facility with diagnoses that included but was not limited to dementia, mental disorder due to known physiological condition, and unspecified intellectual disabilities.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed, Section C (Cognitive Pattern), a Brief Interview for Mental Status (BIMS) indicated R3 was rarely or never understood.</p> <p>Review of R3's EMR revealed a Do Not Resuscitate Order for Resident without Decision Making Capacity dated 4/11/1994. Further review of the document revealed that it did not include or show a signed acknowledgement of receipt or evidence that the facility provided R3 and/or responsible party with written information pertaining to their right to accept or refuse medical and/or surgical treatment.</p> <p>Interview on 12/11/2024 at 11:52 am with Licensed Practical Nurse (LPN) DD confirmed R3 did not have an Advance Directive Checklist in the clinical record and that the Do Not Resuscitate Order for Resident without Decision Making Capacity was the only evidence of an Advance Directive in R3's file.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50803</p> <p>Based on observations, staff and resident interviews, and record review, the facility failed to develop a comprehensive person-centered care plan related to language barrier communication devices and three facility acquired pressure ulcers for one out of 30 sampled residents (R) (R57). This deficient practice had the potential to affect R57's health and safety.</p> <p>Findings include:</p> <p>Review of R57's Electronic Medical Record (EMR) revealed R57 was admitted to the facility on [DATE] with diagnoses that included but was not limited to moderate Alzheimer's dementia, acute inflammatory demyelinating polyneuropathy, functional quadriplegia, generalized weakness, and three facility acquired pressure ulcers (foot anterior right, foot anterior left, sacrum reopened pressure injury).</p> <p>Review of R57's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed, Section B (Hearing, Speech, and Vision), R57 was usually understood and usually understands as it relates to communication; Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) of 9, which indicated R57 had moderate cognitive impairment; Section GG, (Functional Abilities and Goals), revealed R57 was dependent on a helper for assistance with activities of daily living (ADLs) and mobility; Section M (Skin Conditions), revealed R57 was at risk of pressure ulcers and had two unstageable pressure ulcers with suspected deep tissue injury.</p> <p>Review of R57's care plan dated 7/30/2024 indicated a focus of Cognitive/Communication Impairment with Goals that included the resident will be able to make simple decisions and communicate needs; Interventions included but not limited to all staff will ask simple, direct questions and provide simple direct information. There were no care plan interventions related to R57's language barrier and methods for R57 to communicate his needs.</p> <p>Further review of R57's care plan dated 7/30/2024 indicated a focus of Skin Integrity with Goals that included the resident will have no pressure areas, skin tears, or bruises. Interventions included but not limited to assisting R57 with diet and assessing skin integrity as needed. There were no care plan interventions related to R57's three facility-acquired pressure ulcers.</p> <p>Review of R57's Physician's Orders included but was not limited to a pain assessment every shift, acetaminophen 650 milligrams (mg) every six hours as needed, wound care daily, and Speech Therapy to eval and treat.</p> <p>Observation on 12/10/2024 at 9:48 am revealed R57 speaking only in spanish using a live translator. The translator stated that it was difficult to understand R57 and translate his words due to audio and the connection.</p> <p>Observation on 12/10/2024 at 12:19 pm in the dining room revealed, R57 sitting at a table with no communication device noted in sight.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 12/11/2024 at 2:17 pm in R57's room revealed, R57 was difficult to understand using a translator.</p> <p>Observation on 12/12/2024 at 12:02 pm revealed, Registered Nurse (RN) FF entering R57's room without a translator device.</p> <p>Interview on 12/10/2024 at 9:48 am with Licensed Practical Nurse (LPN) AA revealed that she was an agency nurse and bilingual (Spanish and English), who worked with R57 sometimes. She stated that there was a tablet kept at the nurses' station with a live translator function.</p> <p>Interview on 12/12/2024 at 2:03 pm with Certified Nursing Assistants (CNA) GG revealed that she uses the translator device to communicate with R57 throughout the day and also uses LPN AA who was sometimes there during the week. She stated that they learn his needs based on experience of his needs and if the translator was not present, she uses nonverbal demonstrations to communicate. When asked if she feels like staff meet the resident's needs, she stated that they do the best they can in the situation. She further stated that sometimes it was difficult to understand him because they need to use the translator.</p> <p>Interview on 12/12/2024 at 3:10 pm with R57 using a Spanish-speaking surveyor to translate on the phone revealed that there was a staff member that speaks Spanish but when she was not there, he does his best with the little English he knows. He stated that most staff treat him with respect, but he also feels like some staff ignore him since he cannot speak English. He further stated that there was no device that he used to translate his words to staff; he has a phone that he could possibly use but it was dead. When asked if staff communicate with him frequently with the tablet, he stated no.</p> <p>Interview on 12/12/2024 at 3:33 pm with CNA CC and CNA EE revealed that there should be interventions regarding R57's pressure ulcers in the care plan. When asked how they know how to care for R57's pressure ulcers, they stated that they rely on shift reports. They further stated that they sometimes use the translator device kept at the nurses' station,</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 12/12/2024 at 3:56 pm revealed she also develops the care plans. She stated that a lot of care plan interventions are already built in based on diagnoses unless they need to be more specific as needed. When asked if she agrees that R57 needs care planned interventions for communication devices and for the facility acquired pressure ulcer care, she confirmed that the translator was key and agreed that it should be a listed intervention. She confirmed that the care plan would be the tool to get an understanding of each resident and their needs. It was revealed, a focus that addressed the facility acquired pressure ulcers, language barrier and methods of communication was added on 12/12/2024.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50524</p> <p>Based on observations, staff interviews, record review, and review of the facility's policy titled Nebulizer Machine Cleaning, the facility failed to prevent the spread of infections by not cleaning, changing or covering nebulizer equipment for one of five residents (R) (R21) receiving nebulization treatments.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Nebulizer Machine Cleaning dated 7/1/2023 revealed, I. Purpose: To promote and maintain infection control when utilizing nebulizer machines .III. Policy: Nebulizer tubing will be changed once weekly and as needed (prn). Nebulizer filters must be washed or changed once weekly and prn.</p> <p>Review of Electronic Medical Records (EMR) revealed R21 was admitted with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD) and asthma.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed, Section C (Cognitive Patterns): a Brief Interview of Mental Status (BIMS) of 14 which indicated R21 had intact cognition, Section I (Active Diagnosis): COPD and asthma.</p> <p>Review of R21's care plan dated 8/4/2023 included but not limited to Problem: COPD, Emphysema, Asthma. Goal: Resident will be free of respiratory infections and exacerbations through next review period. Intervention: Nebulization treatment PRN.</p> <p>Review of R21's Physician's Orders dated 9/19/2024 revealed, orders that included but not limited to: PROVENTIL 2.5 milligram (mg) /3 milliliters (mL) (0.083%) nebulizer solution 2.5 mg for acute cough every six hours PRN for wheezing.</p> <p>Observation on 12/10/2024 at 11:17 am revealed nebulizer face masks and equipment in drawer of R21's bedside table. The masks and equipment were not covered in bags. One face mask was dated 11/19 and the other face mask had 11/5 written on it.</p> <p>Observation on 12/10/2024 at 4:26 pm revealed nebulizer face masks and equipment in drawer of R21's bedside table. The masks and equipment were not covered in bags. One face mask was dated 11/19 and the other face mask had 11/5 written on it.</p> <p>Observation on 12/11/2024 at 9:38 am revealed nebulizer face masks and equipment in drawer of R21's bedside table. The masks and equipment were not covered in bags. One face mask was dated 11/19 and the other face mask had 11/5 written on it.</p> <p>Observation on 12/11/2024 at 2:38 pm revealed nebulizer face masks and equipment in drawer of R21's bedside table. The masks and equipment were not covered in bags. One face mask was dated 11/19 and the other face mask had 11/5 written on it.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility's document titled .Administrations of albuterol (PROVENTIL) 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg revealed, nebulization was administered to R21 up to five weeks after the 11/5 date written on the nebulization face mask and up to three weeks after the 11/19 date written on the nebulization face mask that read:</p> <p>Given: 2.5 mg: nebulization on 12/2/2024; Given: 2.5 mg: nebulization on 11/23/2024; Given: 2.5 mg: nebulization on 11/14/2024; Given: 2.5 mg: nebulization on 11/12/2024; Given: 2.5 mg: nebulization on 11/6/2024; Given: 2.5 mg: nebulization on 11/5/2024 at 9:00 pm and</p> <p>Given: 2.5 mg: nebulization on 11/5/2024 at 8:00 am.</p> <p>Interview on 12/11/2024 at 2:43 pm with Licensed Practical Nurse (LPN) HH confirmed the face masks in the drawer of R21's bedside table were not covered and had dates 11/19 and 11/5 on them. She stated the face masks should be covered in a bag and that the masks and nebulization tubing should be changed each week. She confirmed the masks and tubing were not changed each week and the dates on the tubing were correct. She stated the last time she worked on that hall was two weeks ago. LPN HH revealed, she had administered nebulization to R21 with the same face masks and tubing in R21's bedside drawer. She stated she did not change the face mask or the tubing before administering the nebulization. LPN HH further stated if the face masks, tubing and equipment were not cleaned weekly, soiled, and not covered in a bag, it could lead to infection for R21 because the items would be contaminated when they were placed in the drawer or on any surfaces that were not clean. She stated that nebulization equipment should be changed weekly because it made them free from dust, germs and keep them patent from solutions used for nebulization treatment which could harbor infection.</p> <p>Interview on 12/11/2024 at 2:52 pm with the Unit Manager (UM) revealed her expectation was for the equipment for nebulization, including the face masks and tubing were to be changed each Tuesday night by the night staff. She stated weekly cleaning of the nebulizer machine and changing of the equipment would reduce bacteria and infection for R21. She stated if the nebulization masks and equipment were not changed at least weekly or placed on dirty surfaces, they could accumulate dust and bacteria, and the outcome could lead to infections for the resident.</p> <p>Interview on 12/11/2024 at 3:38 pm with the Director of Nursing (DON) revealed, her expectations were for the nebulization masks and equipment to be placed in a bag when not in use and for the equipment to be changed weekly. The DON stated when the face mask and equipment were placed on dirty surfaces such as in the drawer of a resident's bedside table the outcome would be the resident could get sick or get an infection.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50524</p> <p>Based on staff interviews and record reviews, the facility failed to maintain communication between the facility and the dialysis center for one of one resident (R) R19 reviewed for dialysis. This deficiency had the potential to cause complications related to dialysis and diminished quality of life for R19.</p> <p>Findings include:</p> <p>Review of Electronic Medical Records (EMR) revealed R19 admitted with a diagnosis that included but not limited to End Stage Renal Disease (ESRD) on dialysis.</p> <p>Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed, Section C (Cognitive Patterns) revealed, a Brief Interview of Mental Status (BIMS) of 3 which indicated R19 was cognitively impaired; Section O (Special Treatments) revealed, R19 received dialysis.</p> <p>Review of R19's care plan dated 9/20/2023 revealed, Problem: Renal Failure with Dialysis with Goal of: Resident will be free of secondary infections through next review period that included, Interventions: encourage compliance with diet/fluid restrictions as ordered, monitor and record BP as ordered, DO NOT use arm with shunt to take BP, monitor shunt site for signs and symptoms (s/s) of infection, report substantial weight gain/loss to MD as ordered, administer medications related to condition of renal failure/dialysis as ordered, and monitor labs as ordered.</p> <p>Review of facility's document titled Dialysis (# of days) order dated 9/21/2023 revealed, R19 had dialysis three times weekly.</p> <p>Review of facility's document titled Long Term Care Facility Outpatient Dialysis Services Care Coordination Agreement revealed contract agreement between the dialysis center [name of dialysis center] and the facility.</p> <p>Review of Physician's Progress Note dated 9/19/2023 revealed, Plan: R19 had outpatient hemodialysis secured at [name of dialysis center] on Tuesdays, Thursdays, Saturdays (TTS).</p> <p>Review of facility's documents revealed, there was no evidence of documentation regarding communication between the facility and the dialysis center.</p> <p>Interview on 12/11/2024 at 1:04 pm with Licensed Practical Nurse (LPN) HH revealed, the facility had no documented communication between the nurses at the facility and the nurses at the dialysis center. She stated the nurses at the facility do not send documentation of vital signs or any information to the dialysis center when the resident goes to dialysis and the dialysis center does not communicate with the facility regarding R19's dialysis when R19 completes dialysis. LPN HH stated, the facility and the dialysis center nurses do not communicate through phone calls either. LPN HH stated, whenever there is no communication between the facility and the dialysis center the outcome would be a disjoint in care because if something happened with R19 the nurses at the facility would not know what was done at the dialysis center and the dialysis center would not know what happened with R19 at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 12/11/2024 at 2:52 pm with Unit Manager (UM) confirmed there was no communication between the facility and the dialysis center. She stated when there was no communication between the facility and the dialysis center the outcome would be negative for the resident.</p> <p>Interview on 12/11/2024 at 3:38 pm with Director of Nursing (DON) revealed her expectation was for the facility to have a document sent with the resident to dialysis and a document sent from the dialysis center to the facility. The DON stated it would improve the communication between the facility and the dialysis center. She confirmed that at present, the facility did not have documentation of communication between nursing staff at the dialysis center and the facility. She stated the outcome would be a bad outcome for the resident when important information was not communicated between the facility and the dialysis center because the resident could miss out on important treatments and care. She further stated if something bad happened at dialysis and the nurses at the facility did not know about it the facility would not know what to treat and the resident could miss out on important care.</p> <p>A dialysis policy was requested from the facility but was not provided prior to exit.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50524</p> <p>Based on observations, resident and staff interviews, record review, and review of the facility's policy titled, Infection Prevention and Control-Hand Hygiene, the facility failed to wash/sanitize hands during a wound treatment for one of two residents (R) (R38) reviewed for pressure ulcers. This deficient practice had the potential to result in complications of the wound and further impair the resident's skin integrity.</p> <p>Findings include:</p> <p>Review of facility's policy titled Infection Prevention and Control dated 7/1/2023 revealed, I. Purpose: To establish guidelines for healthcare providers and staff to perform hand hygiene . III. Policy A. Hand Washing and Hand Antisepsis . 4. Alcohol-based hand sanitizer (hospital approved with at least 60% alcohol) may be substituted for hand washing with soap and running water in the following circumstances: a. Hands are not visibly soiled. b Before and after patient contact (includes any contact with environment/equipment). c. After contact with a source that is likely to be contaminated. d. After removing gloves.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE] revealed, Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) of 12 which indicated R38 had intact cognition; Section M (Skin Condition) revealed, R38 had one or more unhealed pressure ulcer (s) at stage one or higher.</p> <p>Review of R38's care plan dated 10/30/2024 revealed a care plan that included, Problem: Wound Care Description: Wound to coccyx will not deteriorate over the next two weeks, Goal: Optimal wound healing without complications over the next weeks, Intervention: Perform wound care as ordered by physician.</p> <p>Review of R38's Physician's Orders dated 11/13/2024 revealed, Wound Care Pressure injury coccyx, clean wound with: (Never Use Peroxide) Wound Cleanser. Specific wound care instructions: Cleanse area, pat dry, apply skin prep to peri wound and pack wound with Dakins solution gauze loosely and cover with a protective dressing. Change twice a day.</p> <p>Observation on 12/12/2024 at 10:57 am during wound care treatment of the of coccyx for R38 revealed, Licensed Practical Nurse (LPN) HH removed soiled pair of gloves and put on clean pair of gloves without sanitizing her hands between changing gloves. During the observation, the Unit Manager (UM) came in the room and saw LPN HH removed soiled pair of gloves and put on a clean pair of gloves without sanitizing her hands.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/12/2024 at 11:39 am with LPN HH confirmed she did not sanitize her hands after she removed the soiled pair of gloves and before putting on another pair of clean gloves. She stated infection prevention was paramount. She stated hand washing or hand sanitization should be done before, during and after resident contact. She further stated that she should have sanitized her hands after she removed the soiled pair of gloves, and she did not. She stated hands were to be sanitized before putting on clean gloves to get rid of germs and prevent infection to the residents. She stated that germs from her hands when she removed the soiled gloves could have been transferred to her clean gloves because she did not sanitize her hands, and this could cause infection to R38's wound.</p> <p>Interview on 12/12/2024 at 12:33 pm with the UM confirmed LPN HH did not sanitize her hands after she removed a soiled pair of gloves and before putting on a pair of clean gloves during wound care. She stated the outcome could lead to the spread of infection to the wound and to R38.</p> <p>Interview on 12/12/2024 at 7:17 pm with Director of Nursing (DON) revealed, her expectations were for the staff to sanitize their hands after removing gloves and before putting on a new pair of gloves. She stated when hands are not sanitized between glove change, the outcome would be problems with the residents' care and problems for the staff if the staff come in contact with contaminated substances from the residents and the residents come in contact with contaminated substances from the staff. She stated the residents could get an infection or there could be worsening of a wound if it occurs during wound care.</p>		