STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115129	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nurse Care of Buckhead	2920 Pharr Court South NW Atlanta, GA 30305

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and a review of the facility's policies titled Assistance with Meals, the facility failed to provide a dignified existence for three of 106 sampled residents (R) (R187, R159, and R108) related to exposed catheter bags for R187 and R159, and during meals for R108. This deficient practice had the potential to negatively impact the residents' sense of self-worth and overall well-being. Findings included: 1. The policy regarding the Foley catheter bag was requested from the facility, and it was not provided by the exit date of this survey. A review of the facility's electronic medical records (EMR) revealed that R187 was re-admitted to the facility on [DATE] with a diagnosis including, but not limited to, urinary retention. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that R187 presented with a Brief Interview of Mental Status (BIMS) score of 15, which indicated R187 was cognitively intact; had an active diagnosis of Neurogenic bladder and Obstructive Uropathy; and had an indwelling catheter. A review of the care plan dated 2/13/2025 documented that R187 had an Indwelling Catheter related (r/t) Neurogenic bladder with a goal that R187 would remain free from catheter-related trauma through the next review date. A review of the physician orders dated 2/22/2025 the following orders for R187:* Foley cath (on admission) 16fr/10cc. Change monthly, once a day every 30 days (s).* Catheter strap on at all times, on every shift.* Change Foley/Suprapubic catheter with occlusion or removal as needed for occlusion or removal.* Clean around Foley/suprapubic catheter with soap and water every shift. During an observation on 5/27/2025 at 11:15 am, R187's Foley catheter bag was attached to the bedrail, and it was not covered with a privacy bag. During an observation on 5/27/2025 at 4:15 pm, R187's Foley catheter bag was attached to the bedrail and was not covered with a privacy bag. During an observation on 5/28/2025 at 9:35 am, R187's Foley catheter bag was attached to the bedrail, and it was not covered with a privacy bag. During an interview on 5/28/2025 at 9:37 am, Licensed Practical Nurse (LPN) DD revealed that R187's Foley catheter bag was not covered with a privacy bag. She stated the catheter bag should be covered because it was a dignity issue. She further stated R187 could be uncomfortable when it was not covered, and the bag should be covered at all times for the resident's privacy. During an interview on 5/28/2025 at 9:39 am, Certified Medication Assistant Technician (CMAT) RRR confirmed that R187's foley catheter bag was not covered. She stated the catheter bag should be covered for the resident's privacy because it was a dignity issue. During an interview on 5/28/2025 at 10:07 am, Certified Nursing Assistant (CNA) BB confirmed the catheter bag was uncovered. She stated the bag should be covered for the resident to have dignity. She stated that if the bag was not covered, it would mess with the resident's confidence, and they would not enjoy being out and about because people would see it. She stated the resident would feel like their business is being exposed, and they would not feel good about it, even if they were in their room, because when the room door was opened, everyone who passed or went into the room would see it. During an interview on 6/2/2025 at 1:08 pm, the Director of Nursing (DON) stated that she expected that the Foley catheter bags would be covered to maintain the residents' privacy. The policy regarding the Foley catheter bag was requested by the facility, and it was not provided. 2. A review of the EMR revealed that R159 was re-admitted to the facility on [DATE] with a diagnosis including, but not limited to, neurogenic bladder. A review of the Medicare 5-Day MDS assessment dated [DATE] documented that R159 presented with a BIMS of 14, which indicated R159 had intact cognition; had an active diagnosis of neurogenic bladder, and had an indwelling catheter. A review of the care plan dated 11/26/2024 documented that R159 was at high risk for infection related to the complications associated with an indwelling catheter. A goal was for R159 to remain free from catheter-related trauma through the review date. Interventions included positioning the catheter bag and tubing below the level of the bladder; placing the drainage bag in a privacy bag. A review of the physician's orders dated 2/22/2025 documented included but not limited to: Change Foley Catheter every month and as needed (PRN) every night shift every 30 days. During an observation on 5/27/2025 at 11:18 am revealed that R159's Foley catheter bag was attached to the bedrail and not covered with a privacy bag. R159's bed was the first bed to be seen on entering the room, and the Foley catheter bag was hanging on the right side of the bed and visible from the entrance of the room door, and when the room door was opened. During an observation on 5/27/2025 at 4:20 pm, R159's Foley catheter bag was observed attached to the bedrail and not covered with a privacy bag. R159's bed was the first bed to be seen on entering the room, and the Foley catheter bag was hanging on the right side of the bed and visible from the entrance of the room door, and

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policies titled Self-Administration of Medication and Administering Medications, the facility failed to assess one of 106 sampled residents (R) (R2) for self-administration of medications. Findings included: A review of the facility's policy titled Self-Administration of Medication, dated April 2022, under section titled General Guidelines, number one documented, A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician and approved by the Interdisciplinary Care Plan Team. A review of the facility's policy titled, Administering Medications, revised April 2019, under section titled Policy Interpretation and Implementation, number 27 documented, Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. A review of R2's electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE] with a diagnosis of, but not limited to, Alzheimer's Disease. A review of R2's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R2 presented with a Brief Interview for Mental Status (BIMS) score of 15, indicating that R2 was cognitively intact, and that R2 was ordered an antidepressant, opioid, hypoglycemic, and anticonvulsant. A review of R2's care plan with a revision date of 5/8/2025 indicated a focus on using antidepressant medication related to the diagnosis of depression. Goals included that R2 would be free from adverse reactions related to antidepressant therapy. Intervention included, but was not limited to, giving R2 antidepressant medications as ordered by the physician. A review of R2's care plan with a revision date of 2/18/2025 revealed that R2 uses anti-anxiety medications related to anxiety disorder. Goals included that R2 would be free from adverse reactions related to anti-anxiety therapy. An intervention included, but was not limited to, giving R2 anti-anxiety medications as ordered by the physician. A review of R2's physician orders included but was not limited to an order dated 3/14/2025 for Cymbalta oral capsule delayed release particles 30 mg with directions to take one capsule by mouth one time a day for depression, an order dated 3/31/2025 for lamotrigine oral tablet 100mg with directions to take one tablet by mouth two times a day for anticonvulsant, an order dated 1/21/2025 for mirtazapine oral tablet 15 mg with directions to take one tablet by mouth at bedtime, and an order dated 11/26/2024 for pregabalin oral capsule 75 mg with directions to take one capsule by mouth two times a day for neuropathy. Further review of R2's physician orders revealed no order for self-administration of medication. A review of R2's EMR revealed no assessment for self-administration of medication. During an observation and interview on 5/27/2025 at 11:55 am with R2 revealed three pills in a medication cup on her bed that she was actively taking. When asked if she normally administers her own medication, she stated yes and that the nurse will give her the pills, and she will take the pills at her own pace due to problems swallowing. During an observation on 5/29/2025 at 9:12 am, R2 was observed with three pills at her bedside that she was actively taking. Certified Medication Aide Technician (CMAT) SS was observed to walk into R2's room and quickly exit the room. During an interview with R2 at this time, she stated that the staff had taken her pills away. During an interview on 5/29/2025 at 9:20 am, CMAT SS stated that she has worked at the facility for two years and knows the residents on this floor well. CMAT SS confirmed she took the pills from R2's room and discarded them. She stated she checked on the roommate and saw the pills at R2's bedside and removed them because they should not be there. When asked why she removed them from the room, CMAT SS stated that medications should not be left at the bedside. When asked what kind of pills those were, she stated that they may have been part of the evening medications. During an interview on 6/6/2025 8:43 am, the Director of Nursing (DON) confirmed that R2 does not have an assessment for self-administering medications and will need to get one completed. She stated that her expectation for self-administering medications is to first determine if the resident is cognitively intact, then conduct an assessment for self-administration, have a physician order, education with the resident, and establish parameters for regular check-ins and documentation. The DON further stated that potential negative outcomes would depend on the medications.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record reviews, and a review of the facility's policy titled Residents' Rights, the facility failed to honor the resident rights for one of 25 sampled residents (R) (R12) related to the choice to be transferred out of bed daily. This failure had the potential to cause a decrease in the residents' mental and emotional progress. Findings included: A review of the facility's policy titled Resident Rights dated 10/8/2022 revealed that all activities and interactions with residents by any staff, temporary agency staff, or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident, goals, preferences, and choices. A review of the electronic medical record (EMR) revealed that R12 was admitted on [DATE] with diagnoses that included bipolar disorder, schizoaffective disorder, morbid obesity, anxiety disorder, drug-induced subacute dyskinesia, and drug-induced secondary Parkinsonism. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that R12 presented with a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive deficits; R12 very rarely suffers from social isolation; that R12 exhibited no behavior; that R12 had lower extremity impairment on both sides, and uses a wheelchair; and that R12 was ordered antipsychotic, antiplatelet, and anticonvulsant medications. A review of the care plan dated 4/4/2025 revealed that R12 was at risk for altered mood or behavior related to the diagnosis of schizoaffective disorder, bipolar disorder, anxiety disorder, and insomnia. It was noted that R12 would have improved mood state, happier, no signs or symptoms of depression, anxiety, or sadness through the review date. The interventions included administering medications as ordered, monitoring and documenting for side effects and effectiveness, behavioral health consults as needed (psycho-geriatric team, psychiatrist, etc.), and educating the resident regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, and maintenance. During an observation on 5/27/2025 at 12:19 pm, R12 was lying in bed, staring at the ceiling. He stated that he would like to get out of bed every day, but they get him up once a week whenever they can due to the Hoyer and short staff and due to his weight. He stated that he mostly stays in bed and gets very few visits from staff, but they come whenever he rings for help. R12 stated that he is from Kentucky but likes being here in Georgia because this is where his wife is from, and she passed away, and being here makes him feel close to her when he feels sad. He stated that he would like to do activities or some kind of recreation with other people. During an observation on 5/28/2025 at 11:01 am, R12 was lying in bed watching TV. He stated that he informed the Certified Nursing Assistant (CNA) that he would like to get out of bed today, but was told that they were short-staffed and so she couldn't get him up. R12 stated that he understands and is just grateful to be able to stay here so he can feel close to his wife. During an interview on 5/29/2025 at 2:00 pm, CNA FF revealed that she was not the regular CNA for R12 but was assigned to his care that day. CNA FF stated that she is aware that R12 likes to get out of bed daily, but stated that sometimes it is difficult because of staffing, and he requires a Hoyer lift and requires two staff members for transfer. She stated, I'm not saying that it is right, but that is how it is here sometimes. During an interview on 5/30/2025 at 1:00 pm, the Activities Director (AD) revealed that she has been working in the facility for a little over a year now. She stated, We do an admission assessment on each resident when they get admitted and get their preference and try to put a plan together that best suits the individual. Initially, he was a little depressed and did not want to do anything. But then he was moved to another floor and is now more verbal. He's my one-on-one, and he does say he would like to get up, but when they are short-staffed, they don't get him up. When he is in the room, we talk about sports and family, and I offered him games, but he refuses. He consistently verbalizes he wants to get out of bed to socialize, but is unable to, due to not getting out of bed. I do know that he wants to be in the group, but can't when they don't get him out of bed. I bring him bingo bucks, but he can't come down to use them because he hasn't gotten out of bed. He wants to come out of his room. AD stated that for residents who do not leave the room to attend activities, she goes around and offers one-on-one activities they may like and gives them bingo bucks, so they are able to buy snacks. She also stated that this administration has further cut the activities budget, and so she is unable to buy things for the residents that she used to buy before. During an observation on 5/30/2025 at 1:00 pm, R12 was lying in bed watching TV. He again stated that he would like to get out of bed, but stated that he is aware that they were short-staffed, so he didn't ask today. R12 stated, It's okay because I know they're doing their best, but it would be nice to attend the activities downstairs. During an interview on 5/30/2025 at 2:18

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F 0568 Level of Harm - Potential for minimal harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on resident and family interviews, record review, staff interviews, and review of the facility policy titled Resident Rights Policy, the facility failed to provide quarterly resident trust fund statements to 2 of 2 residents (R) R36 and R148 who have a resident account in the facility and are cognitively intact. Findings included: A review of the facility policy titled Resident Rights Policy with a revised date of 10/8/2022 documented that each resident has the right to be treated with dignity and respect as it relates to Protection/Management of personal funds and Accounting and Records of Personal Funds. During the Resident Council interview on 5/28/2025 at 2:30 pm, the residents revealed they are only aware of their Personal Funds account balances if they ask. It was revealed in the meeting that they used to get quarterly statements years ago, but not anymore. The residents' council agreed that they do not receive quarterly statements. During an interview on 6/2/2025 at 1:45 pm, R36 revealed she has not received her quarterly statements. During a phone interview on 5/31/2025 at 1:18 pm, the representative of R148 revealed there is a lack of response from the facility, and she has not received quarterly statements from the facility. During an interview on 6/5/2025 at 5:30 pm, the Interim Business Office Manager (BOM) revealed she has been in this position since April 2025 and that she will sometimes work remotely because she is the regional BOM. She revealed that if a resident wants funds, the receptionist gives out the funds at any time, 24 hrs a day. She further revealed the assistant BOM is solely responsible for giving out the quarterly statements, but since she is on vacation, she is unsure of how she actually makes an account of how the resident receives it. The BOM stated there are no documents that show the residents received their quarterly statements. During an interview on 6/5/2025 at 5:30 pm, the Regional Medicaid Specialist revealed she has not mailed any quarterly statements. She confirmed that the last statements should have been mailed out in March 2025, so the next ones should go out at the end of June 2025. Furthermore, she revealed there is no record of quarterly statements given to the residents from the previous BOM. They are not sure of what happened to the records.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** AMENDEDBased on record review, staff interviews, and review of the facility policy titled Advance Directives, the facility failed to ensure one of 106 sampled residents (R) (R48) Advance Directives was completed and followed up on. Findings included: A review of the facility policy titled Advance Directives dated April 2022 documented that a resident's choice about Advance Directives will be respected. Prior to or upon admission, the Care Plan Team will ask residents/their family members about the existence of any Advance Directives. A review of the electronic medical records (EMR) revealed that R48 was admitted to the facility on [DATE] with diagnoses including, but not limited to, medically complex conditions, vascular dementia, moderate, with agitation, hypertension, non-Alzheimer's dementia, depression (other than bipolar), bipolar disorder, and schizophrenia. A review of the annual Minimal Data Set (MDS) assessment dated [DATE] revealed that R48 had a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. A review of R48's care plans dated 5/22/2025 indicated a focus on the Resident/family desire for full code status. Goals indicated that R48 desires will be met through the next review date. Interventions indicated to follow facility protocol for FULL CODE status. A review of R48's physician orders dated 5/22/2025 revealed a code status of full code. A review of the physician orders for life-sustaining treatment (POLST) in the electronic health record (EHR) reveals that it was blank and has no signatures on it. During a phone interview on 5/30/2025 at 2:13 pm, the family member of R48 revealed that no one from the facility has called her or spoken with her about Advanced Directives for her mother. She further stated she has not been able to speak to anyone regarding the admission paperwork from the facility. During an interview on 6/6/2025 at 8:15 am, the Social Services Director (SSD) revealed that the process for getting Advance Directives from residents and families begins when the resident first admits to the facility. They ask the family if the hospital explained to them the process of Advance Directives. If they do have Advance Directives on admissions, the facility Admissions Coordinator will ask for the documentation and will upload it in the system under Advance Directives. A POLST is completed with the resident if they are of sound mind. If the resident is not of sound mind, they will attempt to get the responsible party to come in to discuss. They will automatically be Full Code until then. The SSD confirmed the POLST was blank for R48 and that the family had not been reached to come in and sign it. She further revealed that it was not typical to only have one attempt, and they need to make more attempts to reach that family member. During an interview on 6/6/2025 at 12:06 pm, the Director of Nursing (DON) revealed she expects the Advance Directive to be completed timely which depends on being able to get confirmation from the families. The DON further revealed that the SSD typically completes the POLST. Turn-around time is usually within the same day.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled Change in a Resident's Condition or Status, the facility failed to notify the responsible party and attending physician about a change in residents' condition for two of 106 sampled residents (R) (R371 and R170). Specifically, the facility failed to notify R371's responsible party and attending physician following a fall and failed to notify R170's responsible party of a change in condition. Findings included: A review of the policy titled Change in a Resident's Condition or Status with a revised date of February 2021 revealed that the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and /or status. The nurse will notify the resident's attending physician or physician on call when there has been an accident or incident involving the resident. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: the resident is involved in any accident or incident that results in an injury, including injuries of an unknown source, or it is necessary to transfer the resident to a hospital/treatment center. 1. A review of R371's electronic medical record (EMR) revealed he was admitted to the facility on [DATE] and discharged from the facility on 10/31/2024. Pertinent diagnoses during his residence at the facility included, but were not limited to, history of falling, unsteadiness on feet, muscle weakness, other abnormalities of gait and mobility, fracture of unspecified part of neck of left femur, and fall on same level from slipping, tripping, and stumbling without subsequent striking against object. A review of R371's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates R371 was cognitively intact. A review of a final summary facility investigation dated 7/14/2024 revealed, It has been determined by the IDT (Interdisciplinary Team) that [R371's] fracture had occurred when he fell from his room on 7/3/2024. [Certified Nursing Assistant (CNA) CCC] had reported to the charge nurse [Licensed Practical Nurse (LPN) DDD] that [R371] had fallen. However, [LPN DDD] did not document or assess [R371] in a timely manner. On 7/5/2024, [R371] complained of left leg pain. Orders were obtained to get an X-ray of the left hip and leg area. An X-ray was obtained, and the results revealed a fractured left femur. Family and MD notified of results. Orders received to send [R371] to ER. [R371] was scheduled for surgery on the left femur. [R371] will be returning to the facility. Investigation also revealed that [LPN DDD] failed to follow facility policies regarding incidents/falls. [LPN DDD] failed to assess and document [R371's] incident after it was reported to her. Due to these reasons, [LPN DDD] was terminated from her position at Nurse Care of Buckhead. [CNA CCC] received education on not getting a resident off the floor until the nurse assessed them after a fall. Care plan reviewed and updated. No further incidents noted at this time. A review of R371's EMR revealed no documentation on the day of the fall or any evidence of notifications to R371's responsible party or physician regarding the fall that occurred on 7/3/2024. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/2025 at 9:27 am, the Human Resources Director confirmed that LPN DDD was terminated on 7/8/2025 for violating company policy/procedure and is not eligible for rehire. During a phone interview on 6/7/2025 at 11:30 am, CNA CCC revealed that R371 always tried to get up and go back and forth to the restroom without asking. He noticed the resident on the floor, picked the resident off the floor, and then went to the nurses' station to report it to the nurse. He told the nurse that the resident fell, and she said ‘Alright.’ He stated that the nurse did not make any sudden moves to assess the resident after he reported the fall. During an interview on 6/6/2025 at 9:26 am, the Director of Nursing (DON) revealed that R371 resided at the facility prior to her working at the facility. The DON stated that when a resident falls, there should be an immediate physical assessment, neuro assessment, pain assessment, vitals taken, notification to the physician and family, documentation, follow-up, X-ray, and other interventions as indicated, such as hospitalization. The DON confirmed that, according to the facts, the nurse did not assess the resident following the fall. The DON further confirmed that the charge nurse should have assessed immediately following the fall, and a notification to the physician and responsible party should have been made. The DON stated that potential negative outcomes of not meeting these expectations following a resident's fall could result in injuries they are not aware of. 2. A review of the EMR revealed that R170 was admitted to the facility on [DATE] with diagnoses of, but not limited to, unspecified dementia, unspecified severity, with agitation, acquired absence of left leg above knee, other acute osteomyelitis, left ankle and foot and acquired absence of right leg above knee. A guardian was listed on the face sheet as the Emergency Contact and the responsible party contact. A review of the most recent quarterly MDS assessment dated [DATE], revealed that R170 presented with a BIMS score of three, indicating that R170 has severe cognitive impairment; that R170 was dependent on staff for transfers, toileting, and personal hygiene; and that R170 was assessed as having one fall with injury. Falls were triggered as an area of concern on the Care Area Assessment Summary (CAAS). A review of the care plan last updated 2/7/2025, revealed that R170 is at risk for falls. Interventions to be implemented included frequent rounding for observation, anticipating and meeting the resident's needs. A review of the nursing note dated 8/6/2024 revealed that R170 was sitting on her Geri chair within sight of the nursing station when she tumbled over and hit her forehead on the floor. Staff rushed to her side and assisted her off the floor to a sitting position. There was a hematoma on the side where her head landed on the floor, and blood was coming from her forehead. Emergency 911 was called immediately to transfer the resident to an acute care hospital for further evaluation. There was no documentation that the primary contact listed on the face sheet was notified. A review of a nursing note dated 3/5/2025 revealed that R170 fell out of the Geri chair. The nurse assessed the resident for pain and injury. R170 stated that her head hurt on her forehead. The CNA reported to the nurse that the resident jumped out of the Geri chair and hit her head on the bed rail. The nurse practitioner was notified and ordered for R170 to be sent to an acute care hospital. There was no documentation that the primary contact listed on the face sheet was notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the EMR revealed no documentation that R170's guardian was notified about the change in condition. During an interview on 5/30/2025 at 4:12 pm, the DON discussed regarding notification of change to R170's guardian regarding the falls that occurred on 3/25/2025 and 8/6/2025. DON confirmed that R170's guardian was not notified when the falls occurred. She revealed that she expects staff to make every effort to contact family and document each attempt if not successful in reaching the family. She revealed that she expects staff to assess and evaluate every fall. During an interview on 6/2/2025 at 11:00 am, CNA AA revealed that she is familiar with R170 and worked on the third floor on 3/5/2025 when R170 jumped out of the Geri chair and fell. She revealed that R170 was sitting on her Geri chair when she reached out to grab R170’s brief to change her in a split second, R170 fell out of the chair. She stated that she had notified the nurse, and R170 was evaluated. She stated that she could not tell if the resident was taken to the hospital because it was at the end of her shift. During an interview on 6/3/2025 at 9:15 am, the Administrator revealed that he expects staff to complete an incident report, notify the DON and investigate every incident as well as abuse, and notify the family. He stated that in the case of an injury of unknown origin, the staff are expected to notify him, and he will make a report to the state. He stated that they have a clinical meeting every morning to discuss incidents and take appropriate action.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, record review, and review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, the facility failed to ensure that allegations and investigations of abuse, including injuries of unknown source, were reported timely to the State Survey Agency (SSA) for one of five sampled residents (R) (R128) reviewed for abuse. Findings included:A review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised September 2022, was conducted, and under section titled Policy Interpretation and Implementation, subsection titled Follow-Up Report, number one documented, Within five (5) business days of the incident, the administrator will provide a follow-up investigation report.A review of R128's electronic medical record (EMR) revealed he was admitted to the facility on [DATE], and his pertinent diagnoses included but were not limited to aphasia following nontraumatic intracerebral hemorrhage, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side, and generalized muscle weakness.A review of R128's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of four, indicating R128 had severe cognitive impairment.A review of the facility report dated 2/11/2025 regarding an allegation of abuse from Certified Nursing Assistant (CNA) TTTT to R128. A review of the follow-up report revealed a submission date of 4/24/2025.During an interview with R128 on 6/3/2025 at 10:54 am, the resident stated that there was a staff member who punched him in the head a few months ago. When asked if the staff member was still working at the facility, he stated no.During an interview on 6/3/2025 at 9:27 am, the Human Resources Director revealed that the alleged perpetrator, CNA TTTT, was terminated on 2/17/2025 for resident abuse and is not eligible for rehire.During an interview on 6/6/2025 at 9:49 am, the Director of Nursing (DON) confirmed that the follow-up report was submitted after the five-day window. The DON stated it is possible that this delay in reporting was due to the recent turnover of administrators. She further stated that she was not the DON during this time.During an interview on 6/6/2025 at 11:11 am, the Administrator revealed he started working at the facility on 4/22/2025 and was not working at the facility during the time of the alleged abuse. He confirmed the date of the initial report being submitted on 2/11/2025 and the follow-up report being submitted on 4/24/2025. He further stated that this incident was identified when he was hired as not having a five-day report and needed one completed.

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, record review, and review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, the facility failed to ensure that allegations of abuse, including injuries of unknown source, were thoroughly investigated for two of five sampled residents (R) (R128 and R379) reviewed for abuse. Findings included: 1. A review of the policy titled Reporting and Investigating, revised September 2022, revealed that the individual conducting the investigation, as a minimum, documents the investigation completely and thoroughly. A review of the electronic medical record (EMR) revealed R128 was admitted to the facility on [DATE] with pertinent diagnoses including but not limited to aphasia following nontraumatic intracerebral hemorrhage, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the left non-dominant side, and generalized muscle weakness. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R128 presented with a Brief Interview for Mental Status (BIMS) score of four, indicating R128 had severe cognitive impairment. A review of the facility report dated 2/11/2025 revealed an allegation of abuse from Certified Nursing Assistant (CNA) TTTT to R128. A review of the follow-up report dated 4/24/2025 documented no specific interviews but concluded the allegation of abuse as unsubstantiated. A review of the facility investigation provided by the facility on 5/28/2025 revealed no written statements regarding the investigation. During an interview on 6/3/2025 at 9:27 am, the Human Resources Director revealed that the alleged perpetrator, CNA TTTT, was terminated on 2/17/2025 for resident abuse and is not eligible for rehire. During an interview on 6/3/2025 at 10:54 am, R128 stated that there was a staff member who punched him in the head a few months ago. When asked if the staff member was still working at the facility, he stated no. During an interview on 6/05/2025 at 10:02 am, Certified Medication Aide Technician (CMAT) GGG revealed she has worked at the facility for six months. She recalled a few months ago when she heard that R128 alleged that the CNA that night punched him in the face. She further stated that she has not seen the CNA since then. During an interview on 6/6/2025 at 11:11 am, the Administrator revealed he had started working at the facility on 4/22/2025 and was not working at the facility during the time of the alleged abuse. He stated that if the evidence of the statements is not in there, they should be. He further stated that there should be statements in the folder, including police notes. He expects all the evidence of investigations, including statements, to be put into one folder. 2. A review of the facility's policy titled Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property with no review date, revealed that all suspected cases of abuse or misappropriation of a resident's property will be fully investigated by the Administrator, Abuse Coordinator, or designee.The findings will be reported to the appropriate governing agencies.Interview the person reporting the allegation.Ensure resident safety is not jeopardized and physically assess the resident.Secure the area, if indicated.Notify the physician, resident representative, Administrator, and DON immediately. Interview all associates, residents, and family members involved.Ensure confidentiality.File a report with government agencies.Suspend the associate pending investigation.Continue the investigation to determine if other residents may be at risk for similar occurrences. If similar residents are at risk, appropriate measures /changes will be implemented.Track resolutions to ensure future safety for the residents.If a family member, a center visitor, a consultant, volunteer staff, a family friend, or other individual is implicated, request that they leave the center with instructions that they will be contacted by the Center Administrator.Involuntary seclusions - this is to be used as the last restrictive approach for the minimum amount of time for resident protection and is to be done according to the resident's needs and not for staff convenience. A review of EMR revealed that R379 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses, which included, but were not limited to, encounters for other orthopedic aftercare, orthopedic surgery (except major joint replacement or spinal surgery). fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing, muscle weakness (generalized), other abnormalities of gait and mobility. unspecified lack of coordination. A review of R379's quarterly MDS assessment dated [DATE] revealed that a BIMS indicated the resident has memory problems for short and long term and was unable to complete the cognitive interview. A review of the Care Plan dated 2/17/2025 revealed that R379 had a focus area of risk for falls related to Actual fall and ER evaluation. A

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, record review and review of the facility policy titled Coordination- Pre-admission Screening and Resident Review (PASARR) Program and MDS Error Correction, the facility failed to ensure that the Minimum Data Set (MDS) assessment was accurate for four of 106 sampled residents (R) (R12, R104, R117 and R33, and 133). Findings included: A review of the undated facility policy titled Coordination Pre-admission Screening and Resident Review (PASARR) Program revealed that the facility will coordinate assessments with the PASARR program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and efforts. Coordination includes incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a residence assessment, care planning, and transitions of care. A review of the facility policy titled MDS Error Correction dated June 2025 revealed that if an error is discovered after the encoding and editing, then correct the error. For minor errors, correct the record. A major error is one that inaccurately reflects the resident's clinical status and/or may result in an inappropriate plan of care. For major errors: correct the original assessment to reflect the resident's status as of the original assessment reference date and submit the record; and perform a new significant change in status (if this has occurred) or a new significant correction to a prior assessment with a new observation period and assessment reference date. 1. A review of the electronic medical record for R12 revealed that he was admitted on [DATE] with diagnoses that include bipolar disorder, schizoaffective disorder, morbid obesity, anxiety disorder drug drug-induced subacute dyskinesia, and drug-induced secondary parkinsonism. PASARR II observed in R12 miscellaneous records revealed an accepted PASARR II document dated 8/20/2024. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed A Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive deficits. Section A of the MDS revealed that the R12 PASARR II assessment indicated No. Section D revealed that R12 very rarely suffers from social isolation. Section E reveals no behavior exhibited. Section GG revealed lower extremities impairment on both sides, wheelchair, dependent with lower body dressing, showers, and toilet hygiene. Section N reveals antipsychotic, antiplatelet, and anticonvulsant medication use. A review of the residence care plan dated 4/4/2025, revealed a focus area stating, at risk for altered mood or behavior related to diagnosis of schizoaffective disorder, bipolar disorder, anxiety disorder, and insomnia. Outcome documented, will have improved mood state, happier, no signs or symptoms of depression, anxiety, or sadness through the review date. The interventions included administer medications as ordered, monitor/ document for side effects and effectiveness. Behavioral health consults as needed (psycho-geriatric team, psychiatrist, etc.) and educate the resident regarding expectations of treatment, concerns with side effects, potential adverse effects, evaluation, and maintenance. Focus area revealed, has an Activities of Daily Living (ADL) self-care performance deficit, personal assistance myself except for. The outcome states, Residents' needs will be met. The interventions include Assist with ADLs as needed, Physical Therapy/ Occupational Therapy (PT/ OT) evaluation and treatment as per Physician (MD) orders. A review of the Physician's orders revealed Abilify oral tablet 10 milligrams (mg), HCL 100 mg, Depakote delayed release 500 mg one tablet daily, and Depakote 500 mg given four tablets by mouth at bedtime for schizoaffective disorder. 2. A review of the EMR revealed that R104 was admitted to the facility on [DATE] with diagnoses that include dementia with agitation, paranoid schizophrenia, major depressive disorder, hallucinations, and cognitive communication deficit. A review of R104 admission MDS assessment dated [DATE] revealed a BIMS score of 11, indicating minimal cognitive deficits revealed that the R104 PASARR II assessment indicated No. A review of R104 care plan, revised on 6/6/2025, revealed a focused area stating, has diagnosis of paranoid schizophrenia, brief psychotic disorder, hallucinations, and problem related to social environment. Level II. Outcome revealed, will have fewer episodes of behaviors through the review date. Interventions included administering medications as ordered. Monitor/document for side effects and effectiveness, anticipate and meet needs, approach in a calm manner, document behaviors and resident response to interventions. Focus area states, diagnosis of paranoid schizophrenia, hallucinations, and brief psychotic disorder. Outcome reveals, will remain free of drug-related complications, including movement disorder, discomfort, hypertension, Constipation, or cognitive impairment to review date. Interventions include administer medications as ordered. Monitor/ document for side effects and effectiveness, observe for hypotension, tardive dyskinesia, excessive sedation, or AMS; promptly report such to the MD, observe for signs of

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, record review and review of the facility's policy titled, Coordination-Pre-admission Screening and Resident Review (PASARR) Program, the facility failed to coordinate/ incorporate PASARR recommendations into for four of four resident (R) (R12, R104, R117, and R33) assessment, care planning and transitions of care. This failure had the potential to cause duplication of services and failure to provide the services necessary for individuals with mental disorders, intellectual disability, or a related condition for level two residents. Findings included: A review of the undated facility policy titled Coordination Pre-admission Screening and Resident Review (PASARR) Program revealed that the facility will coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and efforts. Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a residence assessment, care planning, and transitions of care. 1. A review of the electronic medical record (EMR) records for R12 revealed that he was admitted on [DATE] with diagnoses that include bipolar disorder, schizoaffective disorder, morbid obesity, anxiety disorder, induced subacute dyskinesia, and drug-induced secondary parkinsonism. A review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed A Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive deficits. Section A of the MDS revealed that R12's PASARR II assessment indicated No. Section D revealed that R12 very rarely suffers from social isolation. Section E reveals no behavior exhibited. Section GG revealed lower extremities impairment on both sides, wheelchair, dependent with lower body dressing, showers, and toilet hygiene. Section N reveals antipsychotic, antiplatelet, and anticonvulsant medication use. A review of the care plan dated 4/4/2025 revealed that R12 was at risk for altered mood or behavior related to the diagnosis of schizoaffective disorder, bipolar disorder, anxiety disorder, and insomnia, and that R12 would have an improved mood state, happier, with no signs or symptoms of depression, anxiety, or sadness through the review date. The interventions included administering medications as ordered, monitoring/documenting for side effects, and assessing effectiveness. Behavioral health consults as needed (psycho-geriatric team, psychiatrist, etc.) and educate the resident regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, and maintenance. Focus area revealed, has an Activities of Daily Living (ADL) self-care performance deficit, personal assistance myself except for. The outcome states, Residents' needs will be met. The interventions include assisting R12 with ADL care as needed, Physical Therapy/ Occupational Therapy (PT/ OT) evaluation and treatment as per MD orders. A review of the physician orders revealed Abilify oral tablet 10 milligrams (mg), HCL 100 mg, Depakote delayed release 500 mg, give one tablet daily, and Depakote 500 mg, give four tablets by mouth at bedtime for schizoaffective disorder. A review of the PASARR II recommendations, dated 8/20/2024 revealed, There's diagnosis of bipolar disorder and he's been taking psychotropic medications consistent with such diagnosis, to include two psychotropics; for this reason and due to onset of major stressors and possibility of extended stay, specialized mental health services are recommended during stay. Specifically, psychiatric care for assessment and medication monitoring, individual counseling for adjustment and coping and other emotional support and the development of an individualized care plan, one incorporating his needs and preferences for improved and sustained health stability, behavioral and physical, behavioral health monitoring is recommended. Follow up with the outpatient psychiatric provider is recommended. Initial observation and interview on 5/27/2025 at 12:19 pm with R12 revealed him lying in bed staring at the ceiling. R12 stated that he would like to get out of bed every day, but they get him up once a week whenever they can due to the Hoyer and short staff and due to his weight. He stated that he mostly stays in bed and gets very few visits from staff, but they come whenever he rings for help. R12 stated that he is from Kentucky but likes being here in Georgia because this is where his wife is from, and she passed away, and being here makes me feel close to her when I feel sad. R12 further stated that they would like to do activities or some kind of recreation with other people. During an observation on 5/28/2025 at 11:01 am, R12 was lying in bed watching TV. He stated that he informed the Certified Nursing Assistant (CNA) that he would like to get out of bed today, but was told that they were short-staffed and so she couldn't get him up. R12 stated that he understands and is just grateful to be able to stay here so he can be close to his wife. 2. A review of the facilities' admission records R104 revealed that R104 was admitted to the facility on [DATE] with diagnoses

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** null null null Based on observations, interviews, record review, and review of facility policy titled Care Plan, the facility failed to develop or implement a comprehensive care plan for six of 106 sampled residents (R) (R49, R87, R96, R109, R80, and R180) related to dialysis for R49 and 87; related to Post Traumatic Stress Disorder (PTSD) for R96; related to activities of Daily Living (ADL) care for R109; related to pain management for R80; and related to positioning for R180. On 6/3/2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, the DON, and Regional Director of Clinical Operations (RDCO) were informed of the Immediate Jeopardy (IJ) for F656, F698, and F835 on 6/3/2025 at 11:14 am. The noncompliance related to the IJ was identified to have existed on 5/6/2025. An Acceptable IJ Removal Plan was received on 6/5/2025 related to Comprehensive Care Plans, C.F.R. 483. 21; Dialysis, C.F.R. 483.25(l); and Administration, C.F.R. 483.70. Based on observations, record reviews, interviews, and a review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice were removed on 6/5/2025. Findings included: A review of the facility's policy titled Care Plan dated August 2022 documented: Intent: It is the policy of the facility to create Care Plans in accordance with State and Federal regulations. Procedure: Each resident admitted to the nursing home facility shall have a plan of care. The plan of care must consist of: a. Physician's orders, diagnosis, medical history, physical exam, and rehabilitative or restorative potential. Resident care plan means a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, with participation from other facility staff and the resident or his or her designee or legal representative, which includes a comprehensive assessment of the needs of an individual resident, the type and frequency of services required to provide the necessary care for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, a list of services provided within or outside the facility to meet those needs, and an explanation of service goals. The facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. At the resident's option, every effort must be made to include the resident and family or responsible party, including a private duty nurse or nursing assistant, in the development, implementation, maintenance, and evaluation of the resident's plan of care. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. A review of the electronic medical record (EMR) revealed that R49 was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, hypertensive chronic kidney disease with stage 5 chronic kidney disease, end-stage renal disease, major depressive disorder, and anxiety disorder. A review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R49 had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognitive impairment. A review of R49's care plan was initiated on 11/1/2022 with a focus on diagnoses of end-stage renal disease, bilateral kidney cancer, nephrectomy, and receiving dialysis. The interventions included, but were not limited to, encouraging R49 to go for the scheduled dialysis appointments. It was noted on 5/19/2025 that R49 was admitted to the Intensive Care Unit (ICU) in an acute care hospital for monitoring. A review of the care plan dated 3/5/2021 revealed that R49 was at risk of experiencing adverse reactions and altered psychosocial wellbeing related to transportation issues with dialysis transportation. The outcome was that R49 would be free from increased signs and symptoms of adverse reactions related to issues with dialysis transportation through the next review. Interventions included contacting the transportation [NAME] and the standing order supervisor for the inquiry or complaint number. Ensure an alternative dialysis time option is available for the residents. A review of the EMR discharge note revealed that R49 was sent to the hospital on 5/19/2025, after exhibiting symptoms of shortness of breath and elevated potassium levels. It was noted on 5/19/2025 that R49 was admitted to ICU for monitoring. R49 was admitted from 5/20/25 through 5/22/2025, and again from 5/25/2025 through 5/27/2025, for complications related to missed dialysis, including severe hyperkalemia and volume overload. During an interview conducted on 6/4/2025 at 9:17 am, Dialysis Facility Administrator ZZZZ confirmed and provided the dates missed for chair appointments for residents R49 missed seven out of twelve dialysis treatments on 6/7/2025, 6/9/2025, 6/19/2025, 6/21/2025, 6/23/2025, 6/26/2025, and 6/28/2025. R49 was sent to the hospital on 6/19/2025, after displaying symptoms of shortness of breath and elevated potassium levels. 2. A review of the EMR revealed that R87 was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus without complications, chronic pulmonary edema, essential (primary) hypertension, anemia in chronic kidney disease, other hyperlipidemia, hyperkalemia end end-stage renal disease, and dependence on renal dialysis. A review of a Quarterly MDS assessment dated [DATE] revealed R87 had a BIMS score of 15, indicating Intact cognitive function. A review of the care plan created on 2/16/2023 indicated that R87 needed hemodialysis related to end-stage renal failure. Interventions included hemodialysis on Tuesdays, Thursdays, and Saturdays, and if R87 missed dialysis, an attempt would be made to secure alternative transportation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nurse Care of Buckhead	2920 Pharr Court South NW Atlanta, GA 30305

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/28/25 at 12:57 pm, Dialysis Facility Administrator (FA) YYYY and the Social Worker disclosed that R87 was hospitalized due to missing two consecutive treatments. It was shared that the facility confirmed the missed appointments were due to transportation issues and to be seen three times a week. The FA YYYY explained that the dialysis doctor contacted the facility and ordered R87 to be sent to the hospital for treatment. The previous transportation company was canceled, and the facility began using its own. The current transportation company operates only with one truck. 3. A review of the EMR revealed that R96 was admitted to the facility on [DATE] with a diagnosis that included, but was not limited to, PTSD. A review of the admission MDS dated [DATE] documented that R96 presented with a BIMS score of one, which indicated R96 had severe cognitive impairment and had an active diagnosis of PTSD. A review of the care plan in the EMR revealed there was no active, comprehensive care plan for PTSD. During an interview on 6/2/2025 at 12:09 pm, MDS Coordinator KKK confirmed there was no care plan for R96's diagnosis of PTSD. She stated that the nursing staff, as well as herself and the other MDS Coordinators, were responsible for developing the comprehensive care plan related to the PTSD care area, and that it was not done. She further stated that if there was no care plan for PTSD, R96 was at risk for not receiving the appropriate care. During an interview on 6/2/2025 at 1:08 pm, the DON revealed she confirmed there was no comprehensive care plan for PTSD for R96. She stated that the responsibility for ensuring there was a care plan developed for R96's PTSD was a collaborative effort between the MDS coordinators and the nursing department. She further stated it was important for a comprehensive care plan to include a plan of care for the diagnosis of PTSD to ensure that R96 received appropriate services to manage his condition. During an interview on 6/5/2025 at 12:14 pm, the Assistant Director of Nursing (ADON) revealed that R96 could be missing out on care that he should be receiving for his condition since there was no comprehensive care plan. She stated that R96 would need various interventions related to that diagnosis. 4. A review of the facility's admission records revealed that R109 was admitted to the facility on [DATE] with diagnoses that included restlessness and agitation, major depressive disorder, fall on same level, dysphagia, aphasia, atherosclerotic heart disease of native coronary artery without angina pectoris, cerebral ischemia, muscle weakness (generalized), and history of falling. A review of the Quarterly MDS dated [DATE] revealed that R109 presented with a BIMS score of nine, indicating moderate cognitive decline; had impairment on one side; that R109 required a wheelchair for mobility; required partial/ moderate assistance with toileting and upper body dressing; required substantial/ maximal assistance with lower body; and that R109 was ordered antipsychotic, antidepressant, and antiplatelet medications. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R109 care plan revised on 4/15/2025, revealed a focus area stating that R109 has an Activities of Daily Living (ADL) self-care performance deficit related to limited mobility, history of Cerebral Vascular Accident (CVA).” Outcome revealed that R109 will improve the current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene through the review date. Interventions include to promote dignity by ensuring privacy, toilet use: require one person staff participation to use toilet, transfer: require two person staff participation with transfers, bed mobility: require two person staff participation to reposition and turn in bed, bathing: check nail length and clean on bath day and as necessary, report any changes or necessity for trimming to the nurse, bathing: is totally dependent on staff to provide a bath and as necessary, bathing: provide with a sponge bath when a full bath or shower cannot be tolerated, personal hygiene/oral care: require one person staff participation with personal hygiene and oral care, dressing: require one person staff participation to dress and eating: require supervision and setup help with meals. A review of the Physician's orders revealed the use of Seroquel oral tablet 100 milligrams (mg) (quetiapine fumarate) give one tablet by mouth at bedtime, Seroquel oral tablet 50 mg (quetiapine fumarate) give 50 mg by mouth one time a day, sertraline hcl oral tablet 100 mg (sertraline hcl) give one tablet by mouth one time a day. During an observation/ interview on 5/27/25 at 11:53 am, R109 was observed sitting on his bed. Left-sided weakness was observed with contracture of the left hand. All fingernails on both hands were long, with black substances underneath each nail. R109 stated that he had asked for help sometime this year and still has not gotten it. He stated that he has asked the staff to cut his nails on more than one occasion, but no one has done it. R109 stated that his nails keep breaking. He said, “I don't want them to break because it hurts when it breaks.” He stated that he has difficulty opening his closet and drawers due to the long fingernails. During a second observation on 5/29/2025 at 10:36 am with R109 revealed his fingernails had not been cut, cleaned, or filed. He revealed that his Certified Nursing Assistant (CNA) had been in to bring him supplies earlier. He stated that sometimes they take a long time to come to him, so he does the best he can to provide his own self-care. During an observation on 5/30/2025 at 12:42 pm, R109 revealed his fingernails still had not been cut, cleaned, or filed. R109 stated he is still waiting for someone to cut them for him. He further stated that if he were able, he would have cut them himself by now. During an interview on 5/30/2025 at 1:30 pm with CNA FF revealed that she has been working in the facility for about three years and is familiar with the resident, but stated that she is normally not his aide. She added that she is his aide just for today. CNA FF stated that CNAs do not cut fingernails, activities usually do nails, we don't do nails. We can clean them but not clip them, and I have never seen a nail file in this facility. During a fourth observation on 6/2/2025 at 9:01 am with R109 revealed himself lying in bed holding his fingers. He stated that still no one has come to cut them and doesn't want them to break while he is sleeping. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. A review of the facility's admission record for R80 revealed that she was admitted to the facility on [DATE] with diagnoses that include insomnia, pyoderma gangrenosum, personal history of other venous thrombosis and embolism, paresthesia of skin, non-pressure chronic ulcer of other parts of right lower leg limited to breakdown of skin and lymphedema. A review of the Quarterly MDS assessment dated [DATE] revealed that R80 presented with a BIMS score of 15, indicating that R80 is cognitively intact; presented with lower extremities impairment on both sides that require the use of a wheelchair for mobility; required substantial/ maximal assistance with toileting, partial/ moderate assistance with showers, upper body dressing and personal hygiene; that R80 was dependent with lower body activities of care; received scheduled pain medication for occasional pain that does not interfere with activities; and was ordered anticoagulant, opioid and diuretic medication. A review of R80 care plan revised on 4/4/2025 revealed a focus area of Pain medication Therapy (opioid), both PRN and routine, also to be given prior to wound care. Outcome revealed, will be free of any discomfort or adverse side effects from pain medication through the review date. Interventions include, Administer medication as ordered, review (FREQ) for pain medication efficacy. assess whether pain intensity acceptable to resident, no treatment regimen or change in regimen required; Controlled adequately by therapeutic regimen no treatment regimen or change in regimen required but continue to monitor closely; Controlled when therapeutic regimen followed, but not always followed as ordered; Therapeutic regimen followed, but pain control not adequate, changes required. A review of the physician's orders revealed oxycodone HCL tablet 5 milligram (mg), give 5 mg by mouth before wound care, and oxycodone HCL tablet 5 mg, give 5 mg by mouth every six hours for pain. Pain: Assess pain level. Initial and score every shift and as needed. 0=No Pain/1-4=Mild Pain/ 5-7=Moderate Pain/ 8-10=Excruciating pain, every shift for pain monitoring. Treatment: cleanse the right posterior calf with wound cleanser/ normal saline (WC/NS). Apply alginate and wrap with kerlix, cleanse the left posterior calf with WC/NS. Apply alginate and wrap with kerlix. During an interview on 5/27/2025 at 2:44 pm, R80 revealed that her wound is doing better now, and they are giving me my medication, but I have reported them because they sometimes refuse to give me my pain medication. I constantly ask them why they are refusing to give me my medication, and they told me that they don't think I need it. The last time I had to tell them I'm gonna snitch on them to the state if they don't give it to me, and so they have been giving it to me lately. R80 stated that she sometimes refuses her treatment because she is in so much pain, because the nurse refuses to administer her pain medication. A review of R80 medication administration records for several days during the months of August 2024, September 2024, March 2025, and May 2025 revealed missing signatures on the Medication Administration Record (MAR). A review of the nurse's notes dated 8/6/2024 revealed medication out of stock. A review of the nurse's notes dated 11/10/2024 revealed medication not administered, waiting for pharmacy delivery, phone call to pharmacy and MD. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the nurse's notes dated 11/11/2024 revealed oxycodone HCL tablet 5 mg give 5 mg before wound care every Monday, Wednesday, and Friday for wound care to be given before wound care Med on order. A review of the nurse's notes dated 5/5/2025 revealed Medication is on order. A review of the nurse's notes dated 5/28/2025 revealed oxycodone HCL tablet 5 mg give 5 mg by mouth every six hours for pain. Awaiting pharmacy. A review of the nurse's notes dated 5/31/2025 revealed oxycodone HCL tablet 5 mg give 5 mg by mouth every six hours for pain, unavailable. During an interview on 6/5/2025 at 11:54 am, Licensed Practical Nurse (LPN) EE stated, “I do part-time, and I do a cart audit before I leave each day I'm here and reorder medication as needed. If I hear a resident say they did not get their medication, I do a grievance, and it goes to the DON. I have not heard anything about residents' missing medications.” During an interview on 6/5/2025 at 12:07 pm with Certified Medication Aide (CMA) NNN revealed that she has been working in the facility for about a year and a half and has always worked on the third floor in the hall in question. CMA NNN admitted to having had instances where residents run out of medications, and it is not in the cart. She stated that if the patient does not have medication, I call the pharmacy and reorder it. Once the pharmacy is notified, then you let the nurse know and document in progress notes what was said. ” During an interview on 6/2/2025 at 1:08 pm, the DON stated, Medications for the residents are reordered by faxing the order to the pharmacy or by calling the pharmacy.” She stated that the main fax machine was at the front desk, and the nurse is required to fax the paper script to the pharmacy for reordering the medications. The DON also stated that for pain medications, it's a different process. A script is needed, and it has to be signed by the doctor and sent to the pharmacy.” The DON stated that the nurse is to follow up with the pharmacy, which will give a code or a number to remove the medication from the pyxis if available, and if the medication is not in the pyxis, the resident is offered an alternative until the medication is received. DON stated that the nurses on the units are responsible for ordering and reordering the medications in a timely manner before the stock is completely out. She stated that the medications are to be ordered within a week of them finishing, so the pharmacist has enough time to send the medication. She confirmed that there were gaps in the MAR for some residents who did not receive their pain medication and stated that, if it's not documented, it was not done. My expectation from the nurses if there is a problem where the fax and the pyxis system are down, they should notify me, and I will get in contact with the pharmacy regarding the medication.” 5. A review of the EMR revealed that R180 was admitted on [DATE] with diagnoses including but not limited to dysphagia following nontraumatic intracerebral hemorrhage, tracheostomy, respiratory failure, and morbid obesity. BIMS score of 99 due to dysphagia. A review of the care plan revealed no focus, outcome, or interventions for R180 in regards to positioning/repositioning to preserve skin integrity and promote movement of extremities. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was completed on 5/29/2025 at 9:05 am with a family member of R180, who revealed he visits on weekends due to his work schedule. He is concerned with her sitting in urine and feces for long periods of time. She is not getting physical therapy anymore due to her insurance, per the therapy team. She is not getting up out of bed due to staffing. She only lies in bed, which makes him concerned about her skin breaking down. He makes her medical decisions when they contact him. He has not been invited to any of her care conferences since she was admitted . He was not aware of, nor had he reviewed, a document called a care plan. An interview was completed on 6/5/2025 at 4:08 pm with DON, who confirmed R180 did not have a task in the medical record to prompt staff to position R180 frequently and document in this area. During the interview, the DON added the task that stated, turn and re-position frequently, as tolerated for comfort and pressure relief when in bed. DON confirmed that the current care plan for R180 did not include a focus and interventions for frequent repositioning. The facility implemented the following actions to remove the IJ: 1. Education for Licensed Nurses: The licensed nurses, to include the administrative nurses of the DON, ADON, the MDS Nurses, and the Unit Manager (UM), were educated on 6/3/2025 by the RDCO on completing comprehensive care plans related to dialysis and dialysis transportation. New hire orientation for licensed nurses will encompass training to ensure care plans are implemented for patients, including dialysis and dialysis transportation. Staff Education: 37 of 40 licensed nurses have been educated so far. No licensed nurses will work until the education on this care plan implementation has been completed. 2. Root Cause Analysis: On 6/3/2025, the [NAME] President of Operations (VPO), the Administrator, the Assistant Administrator, the DON, the RDCO, and the Medical Director (MD) discussed the root cause of F656. The center's administration identified the root cause of this issue as the facility did not have a dedicated dialysis transport provider, nor consistent follow-up if transportation failed to arrive to transport the resident. 3. Audit of Current Dialysis Care Plans: A 100% audit of all current dialysis care plans has been reviewed to ensure accuracy of the information and care plan implementation. 4. Systemic Change in Practice Plan: Weekly, the MDS nurses, the DON, the ADON, and the UM will hold a meeting to review all care plans for which MDS assessments have been recently completed to ensure dialysis and dialysis transportation have been addressed and to ensure care plans are implemented promptly. An Ad Hoc QAPI Meeting was held at 4:30 pm on 6/4/2025, which included the Administrator, Assistant Administrator, MD, DON, RDCO, and VPO. Citation F656 was discussed, along with its root cause, a corrective action plan, education, and systemic changes in practice necessary to remove the immediacy and correct the deficiency. 5. Based on the steps above, the facility alleged that the immediacy was removed on 6/5/2025. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Verified on 6/6/2025 by interview with the Administrator and the RDCO. The sign-in sheet was reviewed, and the contents of the education provided were confirmed. Education was provided on 6/3/2025. Interviews were conducted on 6/6/2025 through 6/8/2025 with the following employees and revealed that they received education and were able to provide appropriate answers related to the in-service: 6/6/2025 at 1:57 pm with Certified Medication Administration Technician (CMAT) ZZZ; 6/6/2025 at 2:02 pm with Licensed Practical Nurse (LPN) LLLL; 6/6/2025 at 2:07 pm with LPN MMMM; 6/6/2025 at 2:12 pm with LPN ZZ; 6/6/2025 at 2:17 pm with LPN NNNN; 6/6/2025 at 2:22 pm with LPN OOOO; 6/6/2025 at 2:27 pm with LPN DD; 6/6/2025 at 2:32 pm with LPN PPPP; 6/6/2025 at 2:37 pm with LPN QQQQ; 6/6/2025 at 2:42 pm with LPN RRRR; 6/6/2025 at 2:47 pm with LPN EE; 6/6/2025 at 2:52 pm with LPN SSSS; 6/6/2025 at 2:57 pm with LPN YYY; 6/6/2025 at 3:02 pm with LPN WW, 6/6/2025 at 3:07 pm with LPN OOO; 6/6/2025 at 3:12 pm with LPN TTTT; 6/6/2025 at 3:27 pm with the ADON; 6/6/2025 at 3:32 pm with the DON; 6/7/2025 at 12:03 pm with LPN KK; 6/7/2025 at 12:10 pm with LPN UUUU; 6/7/2025 at 12:12 pm with CMAT RRR; and 6/7/2025 at 12:30 pm with CMAT BBB. 2. Verified by interview on 6/6/2025 with the Administrator and the RDCO that a meeting was held on 6/3/2025 to discuss the root cause analysis. The sign-in sheet and confirmation email from the attendees were reviewed and confirmed. The contents of the root cause analysis, which were provided to the participants, were reviewed and verified. 3. Verified on 6/6/2025 by interview with the Administrator and the RDCO that the residents’ care plans were updated to reflect transport arrangements for dialysis. 4. Verified by interview on 6/6/2025 with the Administrator and the RDCA that there will be a weekly meeting with the MDS, DON, ADON, and the UM to review all care plans that MDS assessments have been recently completed to ensure dialysis and dialysis transportation have been addressed and to ensure care plans are implemented promptly. Verified by interview on 6/6/2025 with the Administrator and the RDCO that an Ad Hoc meeting was held on 6/4/2025 at 4:30 pm to discuss the root cause, a corrective action plan, education, and systemic changes in practice necessary to remove the immediacy and correct the deficiency. The sign-in sheet and confirmation email from the attendees were reviewed and confirmed. The contents of the root cause analysis, which were provided to the participants, were reviewed and verified. 5. Based on the information in the AOC, it was determined that the immediacy was removed on 6/5/2025.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and review of the facility's policy titled Care Plan, the facility failed to revise care plans for three of 106 sampled residents (R) (R96, R214, and R159) regarding denture care for R96, regarding diabetes mellitus for R214, and related to for midline dressing for R159. Findings included:A review of the facility's policy titled Care Plan dated August 2022 documented that it is the policy of the facility to create Care Plans in accordance with State and Federal regulations. Each resident admitted to the nursing home facility shall have a plan of care. The plan of care must consist of physician's orders, diagnosis, medical history, physical exam, and rehabilitative or restorative potential. A review of the facility's Electronic Medical Records (EMR) revealed that R214 was admitted to the facility on [DATE] with diagnosis included but not limited to type 2 diabetes mellitus, R159 was re-admitted to the facility on [DATE] with diagnosis included but not limited to sepsis and R96 was admitted to the facility on [DATE] with diagnosis included but not limited to Alzheimer's disease.Review of the admission Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview of Mental Status (BIMS) of 01 which indicated R96 had severe cognitive impairment. Review of the Medicare - 5 Day Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview of Mental Status (BIMS) of 13 which suggested R214 had intact cognition, Section I (Diagnoses) diabetes mellitus.Review of the Medicare 5- Day Minimum Data Set (MDS) dated [DATE] documented Section C(Cognition) Brief Interview of Mental Status (BIMS) of 14 which indicated R159 had intact cognition.Review of the facility's care plans revealed no evidence of revised care plans for R96 related to denture care, R214 related to diabetes mellitus and R159 related to midline care. Interview on 6/2/2025 at 11:01 am with Licensed Practical Nurse (LPN) YYY revealed she stated she started working at the facility one week ago. She stated the MDS does care plans. She stated she had not done nor updated care plans since working at the facility. She further stated that she would speak with the supervisor to find out how to proceed if something new comes up that needs to go in the care plan.Interview on 6/2/2025 at 11:09 am with LPN DD revealed she started working at the facility since February 2025. She stated the nurses did the baseline care plan when the residents were admitted but the nurses do not update care plans.Interview on 6/2/2025 at 12:09 pm with MDS Coordinator KKK revealed she confirmed there was no care plan for R96 related to denture care, R214 related to diabetes mellitus and R159 related to midline care. She stated the nursing staff as well as herself and the other MDS coordinators were responsible to ensure the care plans were updated and it was not done. She further stated if the care plans were not revised the residents would not get the appropriate care they should receive.Interview on 6/2/2025 at 1:08 pm with the Director of Nursing (DON) revealed she confirmed there was no care plan for R96 related to denture care, R214 related to diabetes mellitus and R159 related to midline care. She stated there should be care plans for the care areas and there were not. She stated the responsibility for ensuring care plans were revised was a collaborative effort between the MDS and nursing. She further stated it was important for the care plans to be revised to ensure the residents received services to manage their medical conditions. Interview on 6/5/2025 at 12:14 pm with the Assistant Director of Nursing (ADON) revealed she stated the care plans should be revised and updated for the residents. She stated that the residents could be missing out on care that they should be receiving if the care areas were not documented in the care plans. She stated that the residents would need various interventions and if it was not documented in the care plans, they would miss out on care they should receive.

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F 0689 Level of Harm - 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** Based on observations, staff and resident interviews, and review of the facility's policies titled Falls and Fall Risk, Managing and Self-Administration of Medication”, the facility failed to provide an environment free of accident hazards for three of 106 sampled residents (R) (R371, R14, and R159) related to failing to conduct a fall risk assessment and implement fall interventions after a fall that resulted in a major injury for R371 and failed to secure medications at the bedside for R14 and R159. Harm was identified as having occurred on 7/3/2024, when R371 had not been assessed after a fall, resulting in a delay in diagnosis and treatment for a left displaced femoral neck fracture and a closed left hip fracture. Findings included: 1. A review of the facility's policy titled, Falls and Fall Risk, Managing, with a revised date of March 2018, revealed that Based on previous evaluations and current date, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. A review of the electronic medical record (EMR) revealed that R371 was admitted to the facility on [DATE] and discharged from the facility on 10/31/2024. Pertinent diagnoses during his residence at the facility included, but were not limited to, history of falling, unsteadiness on feet, muscle weakness, other abnormalities of gait and mobility, fracture of unspecified part of neck of left femur, and fall on same level from slipping, tripping, and stumbling without subsequent striking against object. A review of R371's discharge Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates R371 was cognitively intact; that R371 displayed no rejection of care; that R371 required supervision during a sit-to-stand transfer; required supervision (touching assistance) to walk ten feet; and that R371 had an indwelling catheter. A review of R371's care plan dated 9/14/2023 documented that R371 was at high risk for falls related to deconditioning and being unaware of safety needs. Goals included that R371 would be free of falls. Interventions included, but were not limited to, encouraging the resident to call for assistance before transferring self-unassisted and maintaining a clear pathway free of obstacles. A review of a nurse's note dated 6/30/2024 documented, PAR [Patients at risk] Review for Falls: IDT [interdisciplinary team] met to discuss falls. PAR review for fall. The resident experienced falls on 6/22/24. The resident was assisted to the bathroom by two staff members. The resident stated he was trying to get his wallet when he fell into the tub. The resident continued to be impulsive. Staff assisted the resident off the floor. It was documented that there were “No injuries noted.” The family and physician were notified of the incident. The new intervention included the completion of a fall screening. Staff were reeducated on not leaving residents unattended while in the bathroom. R371 remained on Weekly PAR Review. Last fall: 5/4/2024, 5/17/2024, and 6/20/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nurse Care of Buckhead	2920 Pharr Court South NW Atlanta, GA 30305

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the nurse's notes in R371's EMR revealed no documentation on 7/3/2024, the day of the fall that resulted in injury. A review of a nurse's note dated 7/5/2024 in R371's Unrevealed that at approximately 12:00 pm on 7/5/2024, R371 complained of pain in the left thigh and knee. The resident was asked what had happened, and he stated he had fallen a few days prior. It was documented that the resident had a history of falls. The resident voiced no other concerns, and upon assessment, there were no bruising or open areas noted at the time of the reported incident. The Nurse Practitioner (NP) was notified and ordered an x-ray and as-needed (prn) pain medication. A review of a nurse's note dated 7/5/2024 in R371's EMR documented an acute visit note by the NP that she was called by nursing staff with a report that R371 was complaining of left leg and knee pain due to a recent fall. On her arrival at the facility, R371 was assessed for pain and injury and stated that he had sustained a fall three days ago while he was trying to go into the restroom. It was documented that R371 stated that he tripped over his Foley catheter because it was too long. The NP assessed R371’s leg and knee; the resident flinched when his leg was touched or raised. It was documented that R371 stated that his pain level was seven out of ten with movement. Verbal orders were given to staff for a view x-ray of R371's left leg and knee, and instructions to staff to continue to assist R371 with ADL care as needed and continue pain management. A review of a radiology report dated 7/7/2024 in R371's EMR documented an acute left femoral neck fracture. A review of a nurse's note dated 7/8/2024 in R371's EMR documented a phone encounter signed by the NP that the X-Ray results showed left femur fracture. Verbal order given to send patient out to hospital for further evaluation and treatment. Under Assessment, the NP documented ICD codes of Abnormal x-ray of femur, Femur fracture, left, and Fall with injury. A review of a nurse’s note dated 7/8/2024 in R371's EMR documented, Writer received X-ray results, NP notified of results and writer was given an order to send to (emergency room) for evaluation/treatment (related to) X-ray results; 911 was notified and resident to be sent to hospital, report was given to hospital that this resident is impulsive and has a (history) of falls - he was (complaining of) pain and on call (physician) was notified and x-ray order was obtained; daughter made aware of transfer; and (R371) aware that he is going to the hospital, all safety measures are in place, will continue with (plan of care). A review of a hospital Discharge summary dated [DATE] documented that R371 was admitted to the hospital on [DATE] and discharged on 7/12/2024. Under section titled Discharge Diagnoses, a left displaced femoral neck fracture and a closed left hip fracture were documented. Section titled Care Timeline revealed an arthroplasty, hip, bipolar was performed on 7/9/2024. A review of an undated Witness Statement Form, Certified Nursing Assistant (CNA) CCC stated that he observed [R371] on the floor from tripping over his cat. bag. I helped him into the wheelchair and back into bed, and he replied that he was okay. This occurred on 7/3/2024. I let the nurse on duty know at the time it was [Licensed Practical Nurse (LPN) DDD], this occurred around 11:45 am.” (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of an Employee Counseling Form dated 7/11/2024 revealed LPN DDD was terminated with details that stated, Resident fell on 7/3/2024 and was reported to [LPN DDD] by a CNA on duty. The nurse did not report the fall or do a risk assessment pertaining to the fall. The fall resulted in injury. When the nurse was questioned, she stated she did not recall a fall. A review of a final summary dated 7/14/2024 of the facility reported incident documented a conclusion that documented that it was determined by the Interdisciplinary Team (IDT) team that [R371's] fracture had occurred when he fell from his room on 7/3/2024. [CNA CCC] had reported to the charge nurse [LPN DDD] that [R371] had fallen. However, [LPN DDD] did not document or assess [R371] . On 7/5/2024, [R371] complained of left leg pain. Orders were obtained to get an X-ray of the left hip and leg area. An X-ray was obtained, and results revealed a fractured left femur. Family and (physician were notified of the results. Orders received to send [R371] to ER. [R371] was scheduled for surgery for left femur fracture. [R371] will be returning to the facility. Investigation also revealed that [LPN DDD] failed to follow facility policies regarding incidents/falls. [LPN DDD] failed to assess and document [R371's] incident after it was reported to her. Due to these reasons, [LPN DDD] was terminated from her position at the facility. [CNA CCC] received education on not getting a resident off the floor until the nurse assessed them after a fall. During an interview on 6/3/2025 at 9:27 am, the Human Resources Director confirmed that LPN DDD was terminated on 7/8/2025 for violating company policy/procedure and is not eligible for rehire. During a phone interview on 6/7/2025 at 11:30 am, CNA CCC revealed that R371 always tried to get up and go back and forth to the restroom without asking. He noticed the resident on the floor, picked the resident off the floor, and then went to the nurses' station to report it to the nurse. He told the nurse that the resident fell, and that the nurse said, “Okay.” He stated that the nurse did not make any sudden moves to assess the resident after he reported the fall. During an interview on 6/6/2025 at 9:26 am, the Director of Nursing (DON) revealed R371 resided at the facility before she sated working at the facility. The DON stated that when a resident falls, there should be an immediate physical assessment, neuro assessment, pain assessment, vitals taken, notification to the physician and family, documentation, follow-up, X-ray, and other interventions as indicated, such as hospitalization. The DON confirmed that, according to the facts, the nurse did not assess the resident following the fall. The DON confirmed that she does not see any care plan interventions regarding tripping over his catheter bag. The DON further confirmed that the CNA should not have moved the resident before the resident was assessed, and the charge nurse should have assessed immediately following the fall. The DON stated that potential negative outcomes of not meeting these expectations following a resident's fall could result in injuries they are not aware of. 2. A review of the facility's policy titled Self-Administration of Medication, dated April 2022, under section titled General Guidelines, number one documented, A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician and approved by the Interdisciplinary Care Plan Team. A review of R14's EMR revealed R14 was admitted to the facility on [DATE] with pertinent diagnoses that included osteoarthritis, asthma, rheumatoid arthritis, and cognitive communication deficit. A review of R14's quarterly MDS assessment dated [DATE] revealed a BIMS of 15, indicating R14 was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of R14's physician orders revealed no order for an inhaler or any topical medications. Additionally, there was no order for self-administration of medications. A review of R14's EMR revealed no assessment for self-administration of medications. During an observation on 5/27/2025 at 11:00 am of R14's bedside table revealed a pill bottle with an unknown opaque substance inside and a name on the bottle that is not R14's or any responsible party listed in R14's EMR. Further observation revealed an inhaler on the bedside table. An interview with R14 during this time revealed that she uses the inhaler often, sometimes two to three times a day. When asked about the pill bottle, she stated there is some eczema medication inside. During an observation on 5/28/2025 at 5:49 pm of R14's bedside table revealed the same pill bottle with opaque substance and the inhaler. During an observation on 5/29/2025 at 9:45 am of R14's bedside table revealed the same pill bottle with opaque substance and the inhaler. During an interview on 5/29/2025 at 9:48 am with Certified Medication Aide Technician (CMAT) SS revealed that R14 does not use an inhaler or any topical medications according to R14's physician orders. She further confirmed these medications should not be at the bedside and that all of R14's medications should be administered through the facility staff. She further confirmed that they can only give what the physician prescribed. During an interview on 6/6/2025 at 8:59 am with the DON confirmed that the pill bottle with opaque substance and the inhaler should not be kept at R14's bedside, and they need to do an assessment for self-administration. The DON confirmed she does not see any order for creams and confirmed the pill bottle was something the facility probably did not know anything about and possibly the family brought in. The DON further confirmed she does not see an order for an inhaler and stated that family possibly brought that in as well. 3. A review of the facility's policy titled Self-Administration of Medication dated April 2022 documented Policy: The purpose of this procedure is to establish uniform guidelines concerning the self-administration of drugs. General Guidelines: 1. A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician and approved by the Interdisciplinary Care Plan Team. A review of the facility's Electronic Medical Records (EMR) documented R159 was re-admitted to the facility on [DATE] with a diagnosis of, but not limited to, major depressive disorder. A review of the Medicare 5-Day MDS dated [DATE] documented that R159 presented with a BIMS score of 14, which indicated R159 had intact cognition, and presented with a diagnosis of major depressive disorder. A review of the care plan documented no evidence of a care plan for self-administration of medication. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Physician's Orders documented no evidence of physicians' orders for self-administration of medication. A review of the facility's documents revealed no evidence of approval of medication self-administration by the interdisciplinary team. An observation on 5/27/2025 at 2:40 pm revealed one bottle of vitamin C 500 milligram (mg) tablets, one bottle of vitamin D3 Softgels, and one bottle of vitamin E Softgels in a container on R159's bedside table. During an interview at this time, R159 stated the tablets belonged to her and she took them whenever she wanted to take them. An observation on 5/28/2025 at 9:46 am revealed one bottle of vitamin C 500 milligram (mg) tablets, one bottle of vitamin D3 Softgels, and one bottle of vitamin E Softgels in a container on R159's bedside table. During an interview at this time, R159 stated she had had the tablets for weeks and had been taking them whenever she wanted to take them. During an interview on 5/28/2025 at 9:48 am, Licensed Practical Nurse (LPN) DD revealed she confirmed there was one bottle of vitamin C 500 mg tablets, one bottle of vitamin D3 Softgels, and one bottle of vitamin E Softgels in a container on R159's bedside table. LPN DD stated she did not know the tablets were there at R159's bedside. She stated R159 should not have the medications at her bedside without the nurses' knowledge, and that she was the regular nurse on this unit, and she was not aware of the medications at R159's bedside. LPN DD stated the doctor should be aware of it and order the medications if R159 were to get them. She also stated R159 was not ordered for self-administration of medications, and there was no process in place for her to self-administer medication. She further stated the tablets may interact with other medications she was taking, interact with medications given by the nurses at the facility, and worst-case scenario, she may have a negative reaction to the medications. During an interview on 5/31/2025 at 10:47 am, CNA QQQ revealed that she stated the residents should not have medications at the bedside. She stated she would let the nurse know because R159 may take more than what she should be taking if the nurse was giving her the same medications. During an interview on 6/2/2025 at 1:08 pm, the DON revealed her expectations were for the residents not to have medications at the bedside. She stated that the nurses need to manage the residents' medications to know what medications are being given by the facility. She stated the nurses were to follow up with the medical doctor to see if the doctor wanted the resident to receive those medications and go through the process of allowing the resident to have the medication. The DON stated the process involved physicians' orders, the IDT allowing self-administration of medications, and it be care was planned, and that process was not in place.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interviews, record review, and review of the facility's policy titled Food and Nutrition Services, the facility failed to serve the correct diet for one of 11 residents (R) (R2) ordered to receive a puree diet. Findings included: A review of the facility's policy titled Food and Nutrition Services with a revised date of October 2017 revealed that food and nutrition services will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. If an incorrect meal is provided to a resident or a meal does not appear palatable, nursing staff will report it to the food service manager so that a new food tray can be issued. A review of R2's electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE], and pertinent diagnoses included, but were not limited to, Alzheimer's Disease. A review of R2's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R2 had a Brief Interview for Mental Status (BIMS) score of 15, indicating R2 was cognitively intact; R2 displayed no rejection of care; R2 was independent with eating; and R2 was on a therapeutic diet. A review of R2's care plan revealed a focus initiated on 5/30/2025 that R2 has a swallowing problem related to dysphagia, as evidenced by a puree diet. Goals documented that R2 will have no choking episodes when eating through the review date. Interventions included but were not limited to R2's diet to be followed as prescribed, puree diet, and to refer to a speech therapist for swallowing evaluation. A review of the physician orders dated 5/27/2025 revealed that R2 was ordered a puree/dysphagia puree diet, mechanical soft with pureed meats texture, and thin liquid consistency. During an observation on 5/27/2025 at 11:55 am, R2 was observed to be edentulous (to have no teeth). R2 stated she was in the process of trying to get dental work done. R2 stated she has a swallowing difficulty in her esophagus, but that the kitchen sends her food she cannot consume, including corned beef and chicken salad. She revealed she has been at the facility for four years. During an observation on 5/27/2025 at 1:18 pm, R2 was eating her lunch, which consisted of chicken on a bone and a roll. R2 stated that her lunch was difficult for her to chew. A review of her lunch meal ticket documented Only magic cup, mighty shake, milk, mashed potatoes, and pureed cream of chicken soup for every meal. R2 further stated she was not given the magic cup or mighty shake indicated on her meal ticket. She stated that sometimes those items are given on her tray and sometimes not. During an interview on 5/28/2025 at 5:31 pm, R2 stated that she had some grits and a waffle for breakfast. During an interview on 5/29/25 at 9:12 am, R2 stated that she did not want her breakfast. An observation during this time revealed that the breakfast tray and meal ticket for R2 were in the food warmer. A review of her meal ticket documented, No sausage. Only magic cup, mighty shake, milk, mashed potatoes, and pureed cream of chicken soup for every meal. Observation of the meal on the plate consisted of two whole waffles, a few pieces of whole bacon, and grits. During an interview on 5/29/2025 at 9:20 am, Certified Medication Aide Technician (CMAT) SS revealed that R2 receives a regular diet. When asked to confirm her diet on the EMR, she confirmed the resident is indicated to receive a puree and mechanical soft diet. She further confirmed that the regular breakfast tray she was served was not the puree diet she should have received. During an interview on 6/6/2025 at 8:50 am, the Director of Nursing (DON) confirmed R2's puree dysphagia diet that started 5/27/2025. When told of the observations of R2's meals, the DON stated that those diets should not have been served to her unless she requested them. The DON further confirmed R2 is edentulous (has no teeth). The DON stated that she expects the diets served to the residents to be correct, and potential negative outcomes of not meeting those expectations can lead to some consumption challenges.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record reviews, and review of the facility's policy titled Pain and Administering Medications, the facility failed to ensure that one of 106 sampled residents (R) (R80) received her pain medication in a timely manner. Findings included: A review of the facilities policy titled Pain with a revised date of October 2022, revealed that the nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated, for example, wound care, ambulation, or repositioning. The staff and physician will evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, as well as how pain may be contributing to complications such as gait disturbances, social isolation, and falls. With input from the resident to the extent possible, the physician and staff will establish goals of pain treatment, for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep. A review of the facilities policy titled Administering Medications with a revised date of April 2019 revealed that medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: Enhancing optimal therapeutic effort of the medication; Preventing potential medication or food interactions; and Honoring resident choices and preferences, consistent with his or her care plan. If a dosage is believed to be inappropriate or excessive for a resident or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician, or the facilities medical director to discuss the concerns. A review of the facility's admission record for R80 revealed that she was admitted to the facility on [DATE] with diagnoses that include insomnia, pyoderma gangrenosum, personal history of other venous thrombosis and embolism, paresthesia of skin, non-pressure chronic ulcer of the other part of right lower leg, limited to breakdown of skin, and lymphedema. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive decline. Section GG indicated lower extremities impairment on both sides, the need for use of a wheelchair, substantial/ maximal assistance required with toileting, partial/ moderate assistance with showers, upper body dressing, and personal hygiene. It also indicated that R80 is dependent on lower-body activities of care; anticoagulants R80 receive scheduled pain medication for occasional pain that does not interfere with activities, indicated no swallowing issues, section L indicated no dental issues, section N indicated the use of anticoagulant, opioid and diuretic and indicated that physical therapy was started on 8/24/2024 and ended on 9/7/2024, it also indicated that R80 was offered immunizations but declined. A review of R80 care plan revised on 4/4/2025 revealed a focus area of Pain medication Therapy (opioid), both PRN and routine, also to be given prior to wound care. Outcome revealed, will be free of any discomfort or adverse side effects from pain medication through the review date. Interventions include: Administer medication as ordered, observe any black box warnings and follow as indicated, review (FREQ) for pain medication efficacy. assess whether pain intensity acceptable to resident, no treatment regimen or change in regimen required; Controlled adequately by therapeutic regimen no treatment regimen or change in regimen required but continue to monitor closely; Controlled when therapeutic regimen followed, but not always followed as ordered; Therapeutic regimen followed, but pain control not adequate, changes required. Focus area stated, has an Activities of Daily Living (ADL) self-care performance deficit r/t Limited Mobility, pain. Outcome stated, The resident will have her basic ADL and functional mobility needs met via staff AEB her being clean and dressed appropriately. Interventions include, Observe for any changes in the resident's abilities to do her ADL's and mobility, provide assistance as needed (PRN), provide assistance with bathing, provide assistance with personal hygiene, provide physical assistance with dressing, PT/OT evaluation and treatment as per MD orders, encourage the resident to use bell to call for assistance as needed, skin inspection: The resident requires skin inspection every week and PRN. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. A review of the physician orders revealed oxycodone HCL tablet 5 milligram (mg) given 5 mg by mouth before wound care; oxycodone HCL tablet 5 mg given 5 mg by mouth every six hours for pain. Pain: Assess pain level. Initial and score every shift, and as needed. 0=No Pain/1-4=Mild Pain/ 5-7=Moderate Pain/ 8-10=Excruciating pain, every shift for pain monitoring. Treatment: cleanse the right posterior calf with wound

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure services were provided in accordance with professional standards of practice for two of seven residents (R) (R49 and R87) who are dependent on dialysis three times weekly for end-stage renal disease (ESRD) received reliable transportation to attend life-sustaining dialysis treatments. This failure resulted in missed dialysis sessions and avoidable hospitalizations due to volume overload and severe hyperkalemia. On 6/3/2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, the DON, and Regional Director of Clinical Operations (RDCO) were informed of the Immediate Jeopardy (IJ) for F656, F698, and F835 on 6/3/2025 at 11:14 am. The noncompliance related to the IJ was identified to have existed on 5/6/2025. An Acceptable IJ Removal Plan was received on 6/5/2025 related to Comprehensive Care Plans, C.F.R. 483.21; Dialysis, C.F.R. 483.25(l); and Administration, C.F.R. 483.70. Based on observations, record reviews, interviews, and a review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice were removed on 6/5/2025. Findings included: 1. A review of the electronic medical record (EMR) revealed that R49 was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, hypertensive chronic kidney disease with stage 5 chronic kidney disease, end-stage renal disease, major depressive disorder, and anxiety disorder. A review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R49 had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognitive impairment. A review of R49 Physician's Orders revealed an order dated 10/24/2023 for the resident to receive dialysis services at 11:15 am on Tuesday, Thursday, and Saturday. A review of R49 care plan date initiated on 3/5/2021 revealed a focus category of resident is at risk to experience adverse reactions and altered psychosocial wellbeing r/t transportation issues w/ dialysis transportation. The outcome was for R49 will be free from increased s/s of adverse reactions r/t issues w/ dialysis transportation thru the next review. Interventions Contact Transportation [NAME] QA and Standing Order Supervisor for inquiry/complaint number. Ensure an alternate dialysis time option for resident. A review of R49 medical record discharge note R49 was sent to the hospital on 5/19/2025, after exhibiting symptoms of shortness of breath and elevated potassium levels. It was noted on 5/19/2025 that R49 was admitted to ICU for monitoring. R49 was admitted from 5/20/25 through 5/22/2025, and again from 5/25/2025 through 5/27/2025, for complications related to missed dialysis, including severe hyperkalemia and volume overload (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nurse Care of Buckhead	2920 Pharr Court South NW Atlanta, GA 30305

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. A review of the EMR revealed that R87 was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus without complications, chronic pulmonary edema, essential (primary) hypertension, anemia in chronic kidney disease, other hyperlipidemia, hyperkalemia end end-stage renal disease, and dependence on renal dialysis. A review of a Quarterly MDS assessment dated [DATE] revealed R87 had a BIMS score of 15, indicating Intact cognitive function. A review of R87's physician's orders revealed an order dated 5/28/2025 for the resident to receive dialysis services at 11:15 am on Tuesday, Thursday, and Saturday. A review of R87 care plan date initiated on 2/16/2023 revealed a focus category of resident needs hemodialysis related to end-stage renal failure. Risk for missing dialysis due to refusals/transportation issues. The outcome for R87 will have no s/sx of complications from dialysis through the review date. Interventions If R87 misses dialysis: 3. Attempt to secure other means for transportation. A review of R87 hospital discharge diagnoses dated 5/17/2025 at 10:57 am revealed hyperkalemia due to diminished renal excretion due to missed hemodialysis. On 5/28/2025 at 12:17 pm, R87 confirmed that he had missed a dialysis appointment again on 5/27/2025 and stated that over the past weeks, he believed he had missed dialysis at least three times or more. A review of the nursing progress notes dated 5/19/ 2025 at 8:30 pm revealed R87 complained of mild pain and cramps in the left arm. Recorded vital signs were as follows: Blood Pressure was 135/82; Heart Rate was 90 BPM (beats per minute); Respiratory Rate was 18 breaths per minute; Temperature was 98.2 degrees Fahrenheit (F); and Oxygen Saturation was 98% (percent). R87's sister requested a hospital evaluation. A physician's order was received. At 11:00 pm, R87 was transported to an acute care hospital via stretcher, accompanied by two paramedics. Interview on 5/28/25 at 12:57 pm, the Dialysis Facility Administrator (FA) YYYY confirmed that R87 completed appointments scheduled in May on the 3rd, 13th, 22nd, and 24th. The social worker disclosed that R87 was hospitalized due to missing two consecutive treatments. It was shared that the facility confirmed the missed appointments were due to transportation issues and to be seen three times a week. The FA YYYY explained that the dialysis doctor contacted the facility and ordered R87 to be sent to the hospital for treatment. Additionally, FA YYYY confirmed that the facility discounted R87's transportation on May 6th. The previous transportation company was canceled, and the facility began using its own. The current transportation company operates only with one truck. FA YYYY further explained that she has called the facility at least two to three times regarding R87 appointments, yet it seems that no one is concerned about ensuring he attends them. During an interview on 5/29/2025, at 1:35 pm with the Social Worker (SW) LLL, it was confirmed that the social work department is not responsible for dialysis transportation, but rather it is the responsibility of the nursing department and/or the Director of Nursing. During an interview on 5/29/2025 at 1:47 pm with the Director of Nursing (DON), it was confirmed that she acknowledged her awareness of residents missing their appointments and she did not conduct any scheduling of transportation. (continued on next page)

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Nurse Care of Buckhead	2920 Pharr Court South NW Atlanta, GA 30305

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5/29/2025 at 2:02 pm with the Assistant Director of Nursing (ADON), she revealed she had no role in coordinating dialysis transportation. She occasionally verified that the previous central supply clerk scheduled appointments. She expressed that the current system is inadequate, leading to missed appointments for residents. During an interview with the Administrator on 5/30/2025 at 10:12 am, he acknowledged that the central supply clerk was responsible for coordinating dialysis transportation. The Administrator also admitted that he was unaware multiple residents had been hospitalized in May due to missed dialysis treatments and stated that the nursing team had not informed him. Furthermore, the Administrator was unable to confirm that the transportation barrier was discussed in QAPI. On 6/2/2025, at 1:05 PM, an interview with the Administrator and the Administrator's Assistant confirmed that residents R49 and R87 were both utilizing state state-funded (Medicaid) transportation company. Per Administrator Assistance, the state-funded transportation company has a history of being difficult, the appointment process is antiquated, and appointments must be arranged through phone calls, faxes, and/or emails. The Administrator's Assistant disclosed that the facility is required to carry out these tasks, and the Central Supply clerk (CSC) was initially responsible for this. However, the Central Supply clerk transitioned from the role of Certified Nurse Assistant (CNA) on 4/28/2025 but left the facility as the CSC on May 21, 2025. The Administrator Assistant confirmed she assumed these responsibilities after his termination, but just returned from her vacation, having departed on May 24, 2025, and returned on May 31, 2025. Both individuals indicated that there is no proactive plan in place to prevent missed appointments; they simply wait to see if state state-funded transportation company arrives on the date of the appointment. If not, they contact their brokerage transportation company, but confirmed that sometimes they are not able to accommodate the residents due to the short notice, so they call the physician. Interview on 6/2/2025 at 3:56 pm with the Medical Director confirmed her awareness of the hospitalization of both residents. She emphasized the importance of arranging transportation, ensuring access is ready, and providing necessary medications. She expressed concern that even one missed appointment per month is a significant issue and should be viewed as a red flag for the facility's operations. Interview conducted on 6/4/2025 at 9:17 am, with Dialysis Facility Administrator ZZZZ, who confirmed and provided the dates missed for chair appointments for residents R49 and R87. Resident R87 failed to attend seven out of twelve scheduled dialysis treatments on 6/6/2025, 6/8/2025, 6/10/2025, 6/15/2025, 6/17/2025, 6/20/2025, and 6/27/2025. Consequently, after missing two consecutive treatments, the dialysis physician directed the facility to transfer the resident to the hospital on 6/15/2025 for emergency dialysis. Similarly, Resident R49 missed seven out of twelve dialysis treatments on 6/7/2025, 6/9/2025, 6/19/2025, 6/21/2025, 6/23/2025, 6/26/2025, and 6/28/2025. R49 was sent to the hospital on 6/19/2025, after displaying symptoms of shortness of breath and elevated potassium levels. FA ZZZZ indicated that the dialysis physician had to recommend sending residents to the hospital, and although the dialysis service has initiated and coordinated transportation for R87, as per our agreement, the facility remains responsible for these actions. The facility implemented the following actions to remove the IJ: (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Administration Education: The RDCO educated the Administrator, Assistant Administrator, and DON on 6/3/2025, ensuring reliable transportation services for dialysis residents. Transportation aides and licensed nursing staff were educated on the importance of scheduling appointments, follow-up of appointments, and preparing residents for their required dialysis treatments. No licensed nurses will work until the education on this care plan implementation has been completed. 2. Root Cause Analysis: On 6/3/2025, the [NAME] President of Operations (VPO), the Administrator, Assistant Administrator, the DON, the RDCO, and the Medical Director (MD) discussed the root cause of F698. The center's administration identified the root cause of this issue as the facility did not have a dedicated dialysis transport provider, nor consistent follow-up if transportation failed to arrive to transport the resident. 3. Audit of Current Dialysis Residents: A 100% audit of all current dialysis resident records has been initiated to determine if reliable transportation to and from dialysis appointments is available. 4. Systemic Change in Practice Plan: DON, the ADON, the Administrator, the Assistant Administrator, and the Transportation Aide will hold a weekly meeting to review all dialysis transportation schedules. Any scheduling conflicts or changes in scheduling companies will be addressed to ensure timely dialysis appointments. 5. Ad Hoc Quality Assurance Performance Improvement (QAPI) Meeting: An Ad Hoc QAPI Meeting was held at 4:30 pm on 6/4/2025, which included the Administrator, Assistant Administrator, the MD, the DON, the RDCO, and the VPO. Citation F698 was discussed, along with its root cause, a corrective action plan, education, and systemic changes in practice necessary to remove the immediacy and correct the deficiency. 6. Based on the steps above, the facility alleged that the immediacy was removed on 6/5/2025. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: 1. Verified on 6/6/2025 by interview with the Administrator and the RDCO. The sign-in sheet was reviewed, and the contents of the education provided were confirmed. Education was provided on 6/3/2025. Interviews were conducted on 6/6/2025 through 6/8/2025 with the following employees and revealed that they received education and were able to provide appropriate answers related to the in-service: 6/6/2025 at 1:57 pm with Certified Medication Administration Technician (CMAT) ZZZ; 6/6/2025 at 2:02 pm with Licensed Practical Nurse (LPN) LLLL; 6/6/2025 at 2:07 pm with LPN MMMM; 6/6/2025 at 2:12 pm with LPN ZZ; 6/6/2025 at 2:17 pm with LPN NNNN; 6/6/2025 at 2:22 pm with LPN OOOO; 6/6/2025 at 2:27 pm with LPN DD; 6/6/2025 at 2:32 pm with LPN PPPP; 6/6/2025 at 2:37 pm with LPN QQQQ; 6/6/2025 at 2:42 pm with LPN RRRR; 6/6/2025 at 2:47 pm with LPN EE; 6/6/2025 at 2:52 pm with LPN SSSS; 6/6/2025 at 2:57 pm with LPN YYY; 6/6/2025 at 3:02 pm with LPN WW, 6/6/2025 at 3:07 pm with LPN OOO; 6/6/2025 at 3:12 pm with LPN TTTT; 6/6/2025 at 3:27 pm with the ADON; 6/6/2025 at 3:32 pm with the DON; 6/7/2025 at 12:03 pm with LPN KK; 6/7/2025 at 12:10 pm with LPN UUUU; 6/7/2025 at 12:12 pm with CMAT RRR; and 6/7/2025 at 12:30 pm with CMAT BBB. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Verified by interview on 6/6/2025 with the Administrator and the Director of Clinical Operations that a meeting was held on 6/3/2025 to discuss the root cause analysis. The sign-in sheet and confirmation email from the attendees were reviewed and confirmed. The contents of the root cause analysis, which were provided to the participants, were reviewed and verified. 3. Verified on 6/6/2025 by interview with the Administrator and the RDCO that the residents’ records were updated to reflect transport arrangements for dialysis. 4. Verified by interview on 6/6/2025 with the Administrator and the RDCO that there will be a weekly meeting with the MDS Coordinator, DON, ADON, and the Unit Managers (UMs) to review all care plans that MDS assessments have been recently completed to ensure dialysis and dialysis transportation have been addressed and to ensure care plans are implemented promptly. 5. Verified by interview on 6/6/2025 with the Administrator and the RDCO that an Ad Hoc meeting was held on 6/4/2025 at 4:30 pm to discuss the root cause, a corrective action plan, education, and systemic changes in practice necessary to remove the immediacy and correct the deficiency. The sign-in sheet and confirmation email from the attendees were reviewed and confirmed. The contents of the root cause analysis, which were provided to the participants, were reviewed and verified. 6. Based on the information in the AOC, it was determined that the immediacy was removed on 6/5/2025.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** AMENDED Based on staff interviews, resident interviews, and record review, the facility failed to ensure that routine and as-needed (PRN) medications were available for administration to three of 106 sampled residents (R) (R2, R55, and R394). This deficient practice had the potential to cause delays in physician-ordered medical interventions. Findings included: 1. A review of R2's electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE], and pertinent diagnoses included but were not limited to Alzheimer's Disease, chronic pain syndrome, sickle-cell disorder, and fusion of the spine in the cervical region. A review of R2's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15, which indicates R2 was cognitively intact, and that R2 was taking an antidepressant and an opioid medication. A review of R2's care plan, revised 5/8/2025, indicated a focus on R2 being at risk for pain/discomfort related to generalized pain and sickle cell. Goals included that R2's pain will be effectively managed through the next review date. Interventions included but were not limited to administering pain medication as ordered by the physician. A review of R2's care plan, revised 2/18/2025, indicated a focus of R2 on pain medication therapy related to a history of chronic pain. Goals included being free from any discomfort or adverse side effects from the pain medication reaction. Interventions included, but were not limited to, administering medication as ordered. A review of R2's Physician's Orders included, but was not limited to, an order dated 4/4/2025 for Percocet oral tablet 10-325 mg (milligram) (oxycodone with acetaminophen) with directions to give one tablet orally every six hours as needed for pain management related to chronic pain syndrome. A review of R2's April 2025 Medication Administration Record (MAR) revealed several gaps in Percocet administration. A review of R2's May 2025 MAR) revealed several gaps in Percocet administration. During an interview on 5/27/2025 at 11:55 am with R2 revealed that she had concerns about her pain medication not being reordered timely. R2 stated that her Percocet ran out last week causing her to not be able to have it for two days and thus being in more pain. She stated that she went to the Director of Nursing (DON) about this, and the DON said she would be on it. During an interview on 6/2/2025 at 1:08 pm, the DON stated that the nurses on the units are responsible for ordering and reordering the medications in time for the resident to receive it and not allow it to run out. The DON further stated that the medications are to be ordered within a week of the medication finishing, so that the pharmacist has enough time to send the medication before it is finished. She stated that medications for the residents are reordered by faxing or calling the pharmacy. She stated there is a new program that the facility is working on, which was just implemented one to two weeks ago, so that the facility could reorder medication through a link on the EMR directly into the pharmacy database. She stated that there is a fax machine in the medication rooms on each unit, but they are currently not operational. She stated that the main fax machine is located at the front desk, and the nurse is required to fax paper scripts to the pharmacy. The DON further stated there was no set schedule for the medications to be delivered to the facility. The DON further stated that she had instances where the residents ran out of medications, including pain medications. She confirmed that there were gaps in the MAR for some residents who did not receive their pain medication. She confirmed and acknowledged that these medications are PRN, and if the resident did not refuse or say they did not want it at that time, it is likely that the medication was not ordered timely and the facility was waiting on the pharmacy to send the medication and deliver it to the facility. She confirmed that this has happened on a few occasions where the residents did not receive their pain medications because the medications were not ordered timely. The DON confirmed that one resident who has been affected by this is R2. During a phone interview on 6/5/2025 at 6:45 pm, Pharmacy Tech EEE revealed that the facility can refill meds electronically from the EMR, by fax, or by phone. She stated that the pharmacy does not autofill for the facility, and that nurses have to request a refill for medications to be refilled. Pharmacy Tech EEE further stated that after re-ordering, medications are generally delivered to the facility within a 24-48-hour window or same day if they have it in stock. The pharmacy tries to advise nurses to refill medications two days in advance, so residents are not without their medications. 2. A review of R55's EMR revealed R55 was admitted to the facility on [DATE], and pertinent diagnoses included but were not limited to paroxysmal atrial fibrillation, chronic obstructive pulmonary disease (COPD), hypertension, osteoarthritis, and long-term use of anticoagulants. A review of R55's quarterly MDS assessment dated [DATE] revealed a BIMS of 15, which indicates R55 was cognitively intact, and that R55 was taking an anticoagulant, a

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, staff interviews, and review of the facility's policies titled Storage of Medications and Control of Drugs, the facility failed to remove expired items from the second and third floor medication rooms and the 200 and 300 hall medication carts. The facility also failed to have an open date on glucometer strips and failed to have all signatures on the 400 hall narcotic count sheets. This deficient practice had the potential to cause worsening of medical conditions for the residents. The facility's census was 212. Findings included: A review of the facility's policy titled Storage of Medications dated April 2022 documented Policy: Drugs and biologicals should be stored in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 3. No discontinued, outdated, or deteriorated drugs or biologicals are available for use in this Center. All such drugs are destroyed. A review of the facility's policy titled Control of Drugs dated April 2022 documented Policy Interpretation and Implementation: 7. Controlled drugs must be counted at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count. During an observation on 5/29/2025 at 1:29 pm revealed during review of the facility's medication room on the second floor with Licensed Practical Nurse (LPN) WW the following expired items were found: Nine boxes of Pilot COVID At Home Test which were expired 4/14/2025, one bag of 0.9% Sodium Chloride injection 250 milliliter (mls) which was expired 1/2025 and one bottle of aspirin 325 milligram (mg) tablets which was expired in 4/2025. During an observation on 5/29/2025 at 2:14 pm, during review of the facility's 200 hall back cart with LPN VVV revealed one bottle of aspirin 81 mg tablets with no expiration date was found. During an observation on 5/29/2025 at 2:30 pm, during review of the facility's 200 front hall cart with Certified Medication Assistant Technician (CMAT) WWW revealed one container of blood sugar strips with no open date, one bottle of acetaminophen 500 mg tablets with no expiration date and one bottle of Allergy 25 mg relief tablets with no expiration date. During an observation on 5/30/2025 at 5:13 pm, during review of the facility's 300 south side cart with CMAT XXX revealed one bottle of multi-vitamin dietary supplement tablets (bottle half full) with expiration date 4/2025, one bottle Cetirizine HCL 10 mg tabs with no expiration date and one bottle of Allergy relief 25 mg tabs with no expiration date. During an observation on 5/30/2025 at 5:40 pm, during review of the facility's third floor medication room with CMAT XXX revealed 36 boxes of COVID-19 Antigen test expired 10/31/2024, nine boxes of Pilot COVID-19 At-Home- Test expired 4/14/2025, and one box of COVID-19 Antigen Rapid Test expired 4/22/2025. During an observation on 5/30/2025 at 5:45 pm, during review of the 400 front hall cart narcotic count sheets revealed that there were missing signatures. The narcotic counts were correct. The missing signatures were noted for the following dates and shifts:4/1/2025 at 7:00 pm - 7:00 am (oncoming nurse)4/1/2025 at 7:00 am - 7:00 pm (outgoing nurse)4/2/2025 at 7:00 pm - 7:00 am (oncoming nurse)4/2/2025 at 7:00 am - 7:00 pm (outgoing nurse)4/3/2025 at 7:00 pm - 7:00 am (oncoming nurse)4/4/2025 at 7:00 am - 7:00 pm (outgoing nurse)4/4/2025 at 7:00 pm - 7:00 am (oncoming nurse)4/5/2025 at 7:00 pm - 7:00 am (outgoing nurse)4/5/2025 at 7:00 pm - 7:00 am (oncoming nurse)4/16/2025 at 7:00 am - 7:00 pm (outgoing nurse)4/16/2025 at 7:00 pm - 7:00 am (oncoming nurse)4/20/2025 at 7:00 pm - 7:00 am (outgoing nurse) 4/21/2025 at 7:00 am -7:00 pm (outgoing nurse)4/21/2025 at 7:00 pm -7:00 am (oncoming nurse)4/22/2025 at 7:00 pm - 7:00 am (outgoing nurse)4/22/2025 at 7:00 am -7:00 pm (oncoming nurse)4/23/2025 at 7:00 pm - 7:00 am (outgoing nurse)4/23/2025 at 7:00 am - 7:00 pm (oncoming nurse)5/1/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/1/2025 at 7:00 pm - 7:00 am (oncoming nurse)5/2/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/2/2025 at 7:00 pm - 7:00 am (outgoing nurse)5/3/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/3/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/16/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/16/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/22/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/22/2025 at 7:00 pm - 7:00 am (outgoing nurse)5/27/2025 at 7:00 pm - 7:00 am (outgoing nurse)5/28/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/28/2025 at 7:00 pm - 7:00 am (oncoming nurse)5/29/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/29/2025 at 7:00 am - 7:00 pm (oncoming nurse)5/30/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/30/2025 at 7:00 pm - 7:00 am (oncoming nurse)5/31/2025 at 7:00 am - 7:00 pm (outgoing nurse)5/31/2025 at 7:00 pm - 7:00 am (oncoming nurse) During an interview on 5/29/2025 at 1:29 pm, LPN WW revealed that the expired items should not be in the medication room. She stated the nurses could make the mistake of administering them to the residents, and the residents could have adverse reactions to the medications, which would be something bad for the residents. During an interview on 5/29/2025 at 2:14 pm, LPN VVV revealed that the nurses and CMATs

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and resident interviews, facility records, and review of facility policy titled Temperatures, the facility failed to provide meals that were prepared by methods that conserve nutritive value, flavor, and appearance, and provide meals that were palatable, attractive, and held at a safe and appetizing temperature. Specifically, the facility failed to ensure that food items served for breakfast were at or above 135 degrees Fahrenheit (F). These deficient practices had the potential to affect 207 of the 212 residents receiving an oral diet. Findings included: A review of the undated facility policy titled Temperatures revealed that All hot food items must be cooked to appropriate temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit (F). Food should be transported as quickly as possible to maintain the temperature for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures (i.e., hot/cold carts, pellet systems, insulated plate bases and domes, etc.). A review of the Georgia Department of Public Health Food Service Establishment Inspection report dated 12/3/2024 indicated compliance status No under section 3-1B. Food received at proper temperature, 5-1A. Proper cooking time and temperature, 5-1B. Proper reheating procedure for hot holding, and 6-1C. Proper cooling time and temperature. During an observation and interview on 5/27/2025 at 1:32 pm, Resident (R) 9 shared that the food delivered to the rooms is mostly cold, requires reheating, and is not covered. A tray was observed with food that was visible outside of the top cover. Review of resident Quarterly Minimum Data Set (MDS) Quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact and able to answer questions appropriately. During a breakfast meal service observation and the examination of the Steam Temperature Table were taken by the Assistant Dietary Manager GGGG conducted food temperature checks on 5/29/2025 at 7:26 am, revealed: Puree eggs, initially at 128 degrees F, were reheated and subsequently retested at 143 degrees F. Mechanical sausage, which started at 95 degrees F, was reheated and then retested at 155 degrees F. Omelet eggs, also beginning at 95 degrees F, were reheated and retested at 100 degrees F, followed by another retest at 147 degrees F. The waffle, initially at 103 degrees F, was reheated and retested at 146 degrees F. At the time of receiving the food, the temperature meal tray delivery to the residents had already begun. A review of sampled test breakfast tray on 5/29/2025, at 8:51 am, revealed test tray that was retrieved from Fourth floor cart food temperatures were not within professional guidelines as evidenced by the following: Omelet at 116-degree F, Grits at 114-degree F, and Oatmeal at 110-degree F. All temperatures were taken by the Dietary Manager and confirmed at time of observation. During an observation on 5/29/2025, at 8:56 am, on the third floor revealed that there was no bottom base to the plate warmer sitting in the cart; awaiting to be distributed. During an observation on 6/6/2025, at 1:11 pm, revealed that a food tray was being delivered to the second floor on top of a warmer storage cart without a bottom base plate warmer. During an interview on 5/28/2025, at 2:30 pm, members of the resident council meeting expressed that weekend food was cold and unsatisfactory, stating, You better have money and Uber because of extended wait times. During an interview on 6/3/2025, at 9:36 am, Dietary Aid (DA) IIII revealed that she was responsible for preparing breakfast and lunch. During the morning hours, breakfast is typically served with eggs, grits, oatmeal, and bread. Unfortunately, the steam table does not maintain the proper temperature; there seems to be an issue with the wells, as the bottom of the pan remains hot while the top surface does not. Many residents have reported that their food is cold, but the Certified Nurse Assistant or nurses often neglect to reheat and return the food to the kitchen to be replated, which sometimes forces me to ensure there is enough food available instead of relying on them to reheat it in the microwave on the floor. During an interview on 6/3/2025, at 09:56 am, DA JJJJ confirmed that he was responsible for the food carts' delivery to the floors, which involves notifying the nurse and initiating the sign-off process for the first cart. DA JJJJ explained that certain floors execute their distribution process differently from our established policy; they will not serve food to residents until all carts are present on the floor, while others will proceed differently. During an interview on 6/9/2025 at 2:02 pm, the Administrator stated that he was aware of complaints from residents regarding the food being served cold. Further interview indicated that he anticipated the residents' meals to be served hot according to their preferences, both when delivered to their rooms and in the dining room. The Administrator mentioned that he would assess the process, implement a Performance Improvement Plan (PIP), and investigate the necessary repairs for the various equipment

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, staff interviews, and reviews of the he facility policies titled General Food Preparation and Handling, Uniform Policy, and Food Brought in from the Outside, the facility failed to properly discard expired food and ensure that food items were labeled and dated in the kitchen refrigerator, freezer, dry storage, and emergency supply area. The facility also failed to maintain sanitary practices concerning hand hygiene, covering of hair with restraints, and up-to-date sanitizer test strips for dietary staff in the kitchen. These deficiencies had the potential to impact 207 out of the 212 residents who were on an oral diet. Findings included: A review of the undated policy titled General Food Preparation and Handling indicated in section Food Preparation-H. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact with prepared foods. A review of the undated policy titled Uniform Policy indicated that all employees will adhere to the Food & Nutrition policy on the proper wearing of a uniform required to work in the department. Dietary Aids and Floor Supervisor: hair nets. Cooks: hair nets or approved chef hats, in black. A review of the undated policy titled Food Brought in from Outside revealed that food or beverages should be labeled and dated to monitor for food safety. Food and beverages that have past the manufacturer's expiration date should be thrown away. During the kitchen initial brief tour conducted on 5/27/2025, at 9:53 am with the Dietary Manager (DM), it was observed upon entering that the Assistant Dietary Manager (ADM) GGGG was not wearing a beard net. DM confirmed during observation that all dietary staff should be wearing beard guards and hair restraints in the kitchen. Observation in the dry storage pantry revealed unlabeled and undated items, which included one 11.3 oz turkey gravy, two 14 oz chicken gravies, three 24 oz country gravies, seven 2.75 oz au jus gravy mixes, and 13 unlabeled silver packets as confirmed by the DM; seasonings from rice packets, along with two 24-oz lemonades, one of which had been opened, and an observation of one unlabeled and undated opened 5-pound bag of dry pasta. Furthermore, there were two 15-oz cans of white potatoes with an expiration date of December 2023. The Dietary Manager validated that all findings in the dry storage did not have an open or expiration date on items. The refrigerator revealed an unlabeled and undated opened 5-gallon container of pickles, along with 5 pounds of open cheese, which consisted of unwrapped yellowish slices of block cheese, and a one-gallon container of a brown liquid identified as onion soup, also without labels or dates. Furthermore, there was a 4-quart egg salad with an expiration date of 5/23/2025. The Dietary Manager verified all observations concerning the unlabeled and undated items and stated during the interview that she instructs staff to only indicate the date opened on packages. The freezer revealed there was one opened 5-pound bag of diced onions that was unlabeled, undated, with no expiration information, along with 32 prepared beverages, four 40-oz baby baker potatoes, four bags containing six bagels each, and four 5-pound bags of brown liquids identified as gravy. Additionally, two opened 5-pound bags of triangle hash brown were observed unwrapped and without labels. During an observation on 5/28/2025, at 4:42 pm in the kitchenette located on the fifth floor, multiple unlabeled and undated items were found in the residents' refrigerator. In the refrigerator, there were two bagged food items that were both unlabeled and undated food substances, along with one plastic container. During an observation on 5/28/2025 at 4:50 pm in the kitchenette located on the fourth floor, there was observed six unlabeled and undated brown paper bags were observed along with three plastic bags with an unknown food substance. Additionally, there were five 8-oz milk cartons with an expired date of 5/25/2025 (two cartons of skim milk and three cartons of whole milk). During an observation on 5/28/2025 at 5:00 pm, in the kitchenette located on the third floor, there was an unlabeled and undated box of pizza, a Styrofoam plate, and three plastic bags with food substance. There was also an expired box of chicken dated 5/27/2025. During an observation on 5/28/2025 at 5:08 pm in the kitchenette located on the second floor, there was an uncovered peanut butter and jelly sandwich with an expired date of 5/22/2025, two unlabeled and undated brown paper bags with an unknown food substance, and in the freezer was a 12-oz chicken roll box with an expired date of 3/3/2025. The Dietary manager confirmed this observation and stated that the kitchen staff was not responsible for the kitchenettes on the floors; that the CNAs and nursing staff are responsible. During an observation on 5/30/2025, at 8:10 am, ADM GGGG conducted a test of the sanitizing sink using Hydrion QT-40 test strips. The expiration date for the first test strip was expired with the date 6/1/2023, while the second attempt with a different set of test strips had expired on 5/1/2022. ADM GGGG confirmed that he was supposed to check the inventory, including the test strips, when the company was called to install the new system approximately two to three

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observations and staff interviews, the facility failed to ensure the outdoor garbage and refuse area was maintained in a sanitary manner, creating the potential for harboring pests and insects. The facility census was 212. Findings included: During an observation and interview were conducted on 5/27/2025, at 9:53 am, following the initial tour of the kitchen area. It was noted that the area surrounding the dumpster was littered with trash, discarded food, bedding, and various other debris. Additionally, the presence of gnats and flies was observed around the dumpster. During the interview with the Dietary Manager, it was clarified that the kitchen does not bear responsibility for the dumpster; it is the maintenance responsibility. She also mentioned that trash collection occurs on Mondays and Fridays. During an observation on 5/29/2025, at 7:13 am, the dumpster was observed with the presence of discarded food, a white plastic facility fixture, and a red broom lying in the debris. Additionally, gnats and flies were observed surrounding the dumpster. During an observation on 5/30/2025 at 8:00 am, the dumpster indicated the ongoing presence of discarded food, plastic facility fixtures, gloves lying on the ground, and debris scattered on the ground around the dumpster. During an interview conducted on 6/9/2025 at 8:37 am, the Maintenance Director confirmed that his department is responsible for the upkeep of the facility's grounds, which includes the area surrounding the dumpster. He also indicated that the housekeeping department is responsible for maintaining the cleanliness of the premises. The Maintenance Director acknowledged the presence of trash in the dumpster area, noting the existence of discarded food, debris, and the presence of both flies and gnats. He stated that his team will take action to resolve these issues and improve their efforts. The Maintenance mentioned that he has received verbal reporting of rodent sightings; however, he cannot personally confirm any such observations. During an interview on 6/9/2025 at 2:02 pm, the Administrator confirmed that the maintenance and housekeeping personnel are tasked with keeping the dumpster area clean and devoid of debris. The Administrator disclosed that he was aware of the presence of trash, debris, gloves, and discarded food, but he had communicated this to the staff. The Administrator further explained that pests and rodents could pose a risk due to the state of the dumpster, which might allow them to enter the building, although he is uncertain if there would be any actual risks.

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the Job Description for the Administrator and the Director of Nursing (DON), it was determined that the facility's Administration did not adequately address issues related to Dialysis and Transportation procedures. Furthermore, they failed to provide sufficient oversight and supervision related to dialysis transportation for two of seven residents (R) (R49 and R87). The facility administration failed to establish systems or offer administrative support to guarantee that residents receive the physician-ordered life-sustaining dialysis treatments. This oversight led to numerous missed dialysis appointments and subsequent hospitalizations. On 6/3/2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, the DON, and Regional Director of Clinical Operations (RDCO) were informed of the Immediate Jeopardy (IJ) for F656, F698, and F835 on 6/3/2025 at 11:14 am. The noncompliance related to the IJ was identified to have existed on 5/6/2025. An Acceptable IJ Removal Plan was received on 6/5/2025 related to Comprehensive Care Plans, C.F.R. 483.21; Dialysis, C.F.R. 483.25(l); and Administration, C.F.R. 483.70. Based on observations, record reviews, interviews, and a review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice were removed on 6/5/2025. Findings included: A review of the undated Administrator Job Description revealed it is the Administrator's job to lead and direct the overall operations of the facility in accordance with customer needs, government regulations, and company policies, with a focus on maintaining excellent care for the residents while achieving the facility's business objectives. A review of the undated Director of Nursing Job Description revealed it is the job of the DON to manage the overall operations of the Nursing Department in accordance with Company policies, standards of nursing practices, and governmental regulations so as to maintain excellent care of all residents' needs. 1. A review of the electronic medical record (EMR) revealed that R49 was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, hypertensive chronic kidney disease with stage 5 chronic kidney disease or end-stage renal disease, major depressive disorder, and anxiety disorder. A review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R49 had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognitive impairment. A review of R49 Physician's Orders revealed an order dated 10/24/2023 for the resident to receive dialysis services at 11:15 am on Tuesday, Thursday, and Saturday. A review of R49 care plan date initiated on 3/5/2021 revealed a focus category of the resident is at risk of experiencing adverse reactions and altered psychosocial wellbeing related to transportation issues with dialysis transportation. The outcome for R49 will be free from increased signs and symptoms of adverse reactions related to issues with dialysis transportation through the next review. Interventions included contacting transportation and the standing order supervisor for inquiry complaint number. Ensure an alternate dialysis time option for the resident. A review of R49's medical record discharge note, R49 was sent to the hospital on 5/19/2025, after exhibiting symptoms of shortness of breath and elevated potassium levels. It was noted on 5/19/2025 that R49 was admitted to the ICU for monitoring. R49 was admitted from 5/20/25 through 5/22/2025, and again from 5/25/2025 through 5/27/2025, for complications related to missed dialysis, including severe hyperkalemia and volume overload 2. A review of the EMR revealed that R87 was admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus without complications, chronic pulmonary edema, essential (primary) hypertension, anemia in chronic kidney disease, other hyperlipidemia, hyperkalemia, end-stage renal disease, and dependence on renal dialysis. A review of a Quarterly MDS assessment dated [DATE] revealed R87 had a BIMS score of 15, indicating intact cognitive function. A review of R87's physician's orders revealed an order dated 5/28/2025 for the resident to receive dialysis services at 11:15 am on Tuesday, Thursday, and Saturday. A review of R87 care plan date initiated on 2/16/2023 revealed a focus category of resident needs hemodialysis related to end-stage renal failure. Risk for missing dialysis due to refusals/transportation issues. The outcome for R87 will have no signs and symptoms of complications from dialysis through the review date. Interventions included that if R87 misses dialysis, the facility staff were to attempt to secure other means for transportation. A review of R87 hospital discharge diagnoses dated 5/17/2025 at 10:57 am revealed hyperkalemia due to diminished renal excretion due to missed hemodialysis

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on record review, staff interviews and review of the facility's policy titled Quality Assurance and Performance Improvement (QAPI) Program, the facility failed to develop and implement action plans; measure the success of actions and track performance; conduct at least one process Improvement Plan (PIP) and regularly review, analyze and act on data collected for three of 106 sampled residents (R) (R80, R2, R55, and R392) not receiving scheduled medications. Findings included: A review of the facility's policy titled Quality Assurance and Performance Improvement (QAPI) Program, revised February 2020, documented that the QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include tracking and measuring performance; establishing goals and thresholds for performance measurement; identifying and prioritizing quality deficiencies; systematically analyzing underlying causes of systemic quality deficiencies; developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. 1. A review of R80's medication administration record for several days during August 2024, September 2024, March 2025, and May 2025 revealed missing signatures on the Medication Administration Record (MAR). A review of the Nurses Notes (NN) dated 8/6/2024 revealed that medication was out of stock. A review of the NN dated 11/10/2024 revealed that medication not administered, waiting for pharmacy delivery, phone call to pharmacy and MD. A review of the NN dated 11/11/2024 revealed oxycodone HCL tablet given 5 mg by mouth before wound care every Monday, Wednesday, and Friday for wound care to be given before wound care Med on order. A review of the NN dated 5/5/2025 revealed Medication is on order. A review of the NN dated 5/28/2025 revealed oxycodone HCL tablet, give 5 mg by mouth every six hours for pain awaiting pharmacy. A review of the NN dated 5/31/2025 revealed oxycodone HCL tablet, given 5 mg by mouth every six hours for pain, was unavailable. 2. A review of R2's April 2025 MAR revealed several gaps in Percocet administration. A review of R2's May 2025 MAR revealed several gaps in Percocet administration. 3. A review of R55's January 2025 MAR revealed a four-day gap, a nine-day gap, and a five-day gap in her Percocet administration. A review of R55's February 2025 MAR revealed two five-day gaps and a six-day gap in her Percocet administration.A review of R55's May 2025 MAR revealed several holes in medication administrations for Eliquis and budesonide with the code of 13, indicating the medications were not administered. A review of R55's June 2025 MAR revealed budesonide, hydrocortisone, Zyrtec, and Eliquis with the code of 13, indicating the medications were not administered. 4. A review of R392's August 2024 MAR revealed holes in the MAR for ten doses consecutively from 8/6/2024 to 8/9/2024. A review of the QAPI minutes dated 5/2/2025 revealed that it was documented on the agenda to address residents not receiving their medications. The minutes reflected that the administrator documented that multiple medications were unavailable, it was an ongoing issue, and they were to develop a PIP. During an interview on 6/2/2025 at 1:08 pm, the Director of Nursing (DON) revealed that she started working at the facility in February 2025, and she confirmed that since then, there were instances when the residents were out of medications, including pain medications. She confirmed and acknowledged that there were gaps in the MAR for the residents, and if the residents did not refuse or say they did not want it at a specific time, it was likely that the medications were not ordered in a timely manner, and the facility was waiting on the pharmacy to deliver the medications to the facility. She confirmed that this had happened on a few occasions when the residents did not receive their medications because the medications were not ordered timely manner. She stated that the nurses on the units were responsible for ordering and reordering the medications in time for the resident to receive them and not allow them to run out. The DON stated that medications for the residents were reordered by faxing the order to the pharmacy or by calling the pharmacy. She stated that there was a fax machine in the medication rooms on each unit, but they were not operational yet. She stated that the main fax machine was at the front desk on the first floor, and the staff were required to fax the paper script to the pharmacy for reordering the medications from that fax machine. She stated there is a pyxis on the second floor and it is available 24 hours with additional medications for the facility. The DON further stated there was no set schedule for the medications to get to the facility, and it was dependent on different variables, such as if the medications were ordered early enough. During an interview on 6/5/2025 at 1:08 pm, the Administrator revealed that he was aware there were residents in the facility who were not receiving their medications in a timely manner. He stated that when he started on 4/22/2025, he was made aware of this issue. He stated the issue was discussed in QAPI

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nurse Care of Buckhead	2920 Pharr Court South NW Atlanta, GA 30305

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, records review and review of the facility's policies titled Infection Prevention and Control Program, Standard Precautions, Water Management Program, Wound Care, Hand Hygiene, Pressure Ulcer Treatment, and Housekeeping and Laundry Services, the facility failed to maintain infection control processes and procedures related to (1) failing to maintain a sanitary living environment for four of ten resident rooms (224, 225, 227 and 305); (2) failed to comply with proper hand hygiene practices; (3) failed to comply with appropriate infection control practices regarding laundry services; (4) failed to maintain an effective Infection Prevention and Control Program (ICPC), and Antibiotic Stewardship program and a Water Management Program; and (5) failed to maintain a clean field and practice proper enhanced barrier precautions during wound care for two residents (R) R206 and R146. This failure had the potential to put all residents, staff, visitors, and volunteers at an increased risk of infection. The facility census was 212. Findings included: A review of the undated facility policy titled Infection Prevention and Control Program (IPCP) revealed that the elements of the Infection Prevention and Control Program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, employee health and safety, identifying recording and correcting (ICP) incidents, investigating and reporting communicable diseases and conducting an annual review of the ICP program; that the infection prevention and control committee is responsible for reviewing and providing feedback on the overall program; and that surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include whether physician management of infection is optimal, whether antibiotic usage patterns need to be changed because of the development of resistant strains, whether information about culture results or antibiotic resistance is transmitted accurately and in a timely fashion, and whether there is appropriate follow-up of acute infections. The committee meets monthly and consists of team members from across disciplines, including the medical director. Surveillance will be ongoing, systemic collection, analysis, interpretation, and dissemination of data to: monitor trends of infection and pathogen, detect outbreaks, monitor staff adherence to IPC practices, identify performance improvement opportunities, track progress towards priorities, and identification on annual IPC risk assessment. Antibiotic usage is evaluated, and practitioners are provided feedback on reviews. Data gathered during surveillance is used to oversee infections and spot trends. Important facets of infection prevention include: identifying possible infections or potential complications of existing infections, instituting measures to avoid complications or dissemination, educating staff and ensuring that they adhere to proper techniques and procedures, enhancing screening for possible significant pathogens, immunizing residents and staff to try to prevent illness, implementing appropriate isolation precautions when necessary and following established general and disease specific guidelines such as those of the Center for Disease Control (CDC). Our antibiotic stewardship program promotes appropriate use of antibiotics, includes a system of monitoring to improve outcomes and reduce antibiotic resistance (ensuring antibiotics are prescribed for the correct indication, dose, and duration to appropriately treat residents), and includes the development of protocols and a system to monitor antibiotic use. A review of the facility policy titled Standard Precautions dated April 2022 revealed that standard precautions will be used in the care of all residents regardless of their diagnosis or presumed infection status. Standard precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, or mucous membranes. The policy interpretation and implementation revealed, wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments. Wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body sites. Remove gloves promptly after use, before touching non-contaminated items in environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganisms to other residents or environments. Where a gown is used to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, excretions, or cause soiling of clothing. Ensure that environmental surfaces, bed rails, bedside equipment, and other frequently touched surfaces are promptly cleaned. Handle, transport and process used linen soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, staff interviews, record review, and review of the facility policy titled Infection Prevention and Control Program, the facility failed to establish an Infection Prevention and Control Program (IPCP) and an Antibiotic Stewardship program. The facility failed to develop and implement protocols to optimize and monitor the treatment of infections and reduce the risk of adverse events from unnecessary or inappropriate use of antibiotics. This failure had the potential to place all residents, staff, visitors, contracted staff, and volunteers at risk for infection and the development of antibiotic-resistant organisms. The facility census was 212. Findings included: A review of the undated facility policy titled Infection Prevention and Control Program revealed that The elements of the Infection Prevention and Control Program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, employee health and safety, identifying, reporting and correcting ICP incidents, investigating and reporting communicable diseases and conducting an annual review of the IPC program. The facility will record infections based on policies and procedures for system of surveillance and data to be collected by SBAR criteria and antibiotic stewardship program for infection site, pathogen, signs and symptoms, resident location and summary analysis of number of residents who developed infection; Staff observations; identification of unusual outcomes, trends and patterns; and how the data will be communicated/shared. This will be presented to the infection prevention and control committee monthly. Our antibiotic stewardship program promotes appropriate use of antibiotics, includes a system of monitoring to improve outcomes and reduce antibiotic resistance (ensuring antibiotics are prescribed for correct indications, dose, and duration to appropriately treat residents) and includes the development of protocols and a system to monitor antibiotic use. Antibiotic stewardship protocols include: reports related to monitoring antibiotic usage and resistance data, monitoring of antibiotic use, frequency and mode or mechanism of feedback to prescribing practitioners regarding antibiotic resistant data, their antibiotic use and their compliance with facility antibiotic use protocols, standardized tools and criteria for assessing for infections, and modes and frequency of education on facilities antibiotic stewardship program and protocols. IPCP and its standards, policies, and procedures will be reviewed annually to ensure effectiveness and that they are in accordance with current standards of practice. Periodic facility assessment may identify components of IPCP that need updating related to changes in population or facility characteristics. A review on 5/28/2025 at 4:00 pm of the infection prevention (IP) records revealed that there is no line listing or infection tracing being monitored according to the regulations of the infection control and prevention program. Infection plotting graph observed with no use of an infection surveillance checklist, being used percentage rate calculation of current infections documented. The staff and resident immunization records were not available, along with data for the last Coronavirus disease (COVID-19) outbreak and monitoring. Antibiotic stewardship program policy and protocols, along with the signed committee program, were also not available for evaluation. During an interview on 5/29/2025 at 11:11 am, the Infection Control Preventionist Nurse (ICPN) revealed that she was hired by the facility on 4/16/2025, initially as part-time, and that she recently accepted the full-time position. She stated that this was her first Infection Preventionist job, but has been certified as an ICPN since 11/6/2022. She admits to not having an infectious disease tracking system or percentage rate, but stated she recently got the forms and has not implemented them yet. IP stated that she was aware of the Mc. Greer's criteria, but admits to not having the Antibiotic Stewardship Program or a committee at this time, and therefore has not been using it. She stated the facility has not had an Infection Control Program since July 2024 and that she is working on forming an Infection Control Committee. She further stated that all the immunization records from the past years could not be found and stated that everything disappeared when the previous (ICPN) left, so she had to start from scratch with creating and developing the program. She stated that she is currently keeping a running log of residents currently on antibiotics, but admits to it not being updated this past month (May 2025). During an interview on 6/2/2025 at 9:32 am, the Director of Nursing (DON) revealed that she was aware of the Infection Control Program issues and missing documentation. She stated that she was made aware that an interim corporate personnel member had been visiting the facility and assisting with the Infection Control Program, but that the individual had been terminated. The DON stated, It is possible she either took or destroyed all the documentation. The DON confirmed that she was not certified as an ICPN and stated that it was her expectation for the ICPN to start from the bottom and work on everything related to infection control. The DON stated that she did not have

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on observations, staff interviews, records review and review of the facility policy titled Infection Prevention and Control Program (IPCP), the facility failed to minimize the risk of influenza and pneumococcal disease by ensuring that four of four newly admitted residents (R) (R48, R54, R96 and R217) residents (R) and staff were educated on the risks and benefits of immunizations; were provided opportunities to receive immunizations; and failed to maintain documentation of the information/education provided, the administration of, or the refusal of vaccinations. This failure placed the entire facility at risk for increased complications or even death related to an outbreak of the influenza or pneumococcal virus. Findings included: A review of the undated facility policy titled Infection Prevention and Control Program revealed the following: Immunization is a form of primary prevention. Widespread use of the influenza vaccine in the nursing facility is strongly encouraged. Policies and procedures for immunization include the following: Process for administering the vaccines, who should be vaccinated, contraindications to vaccination, potential facility liability and release from liability, obtaining direct and proxy consent, and how often, monitoring for side effects of vaccination, and availability of the vaccine, and who pays for it. During a review of the electronic medical record (EMR) for residents admitted to the facility within the last 30 days, it was revealed that the immunization records for R48, R54, R96 and R217 contained no documentation of vaccines being received, offered, declined, or contraindicated and there was no documentation in the EMR indicating that education was provided to residents or their representatives. During a review of the information provided by the facility related to the facility's Infection Control Program, there was no documentation presented related resident immunization records or information related to vaccines being offered to staff or residents; there was no documentation related to vaccine monitoring or vaccine education; and there was no documentation related to tracking or trending i.e. line listing of monitoring. During an interview on 5/29/2025 at 11:11 am, the Staff Development Nurse/Infection Control Preventionist Nurse (ICPN) revealed that she was hired on 4/16/2025 as part-time and only recently accepted the full-time ICPN position. She stated that she has been certified as an Infection Preventionist since 11/6/2022, but had no formal training in the field and was awaiting a friend to come and help her. She stated that the friend was scheduled to come earlier that week, but was canceled due to the state survey team arriving. She admitted to not having any documentation of offering the vaccines, resident refusals, or contraindications for staff or residents for this influenza season. The ICPN stated that she did not have an infection tracking system and was not aware if there were any outbreaks in the facility. She stated the facility has not had an Infection Control Program since July 2024 and that she is working on forming an Infection Control Committee. She further stated that all the immunization records from the past years could not be found and stated that everything disappeared when the previous (ICPN) left, so she had to start from scratch with creating and developing the program. A review of the EMR revealed that R54 presented with a Brief Interview of Mental Status (BIMS) score of 15, indicating that R54 is cognitively intact. During an interview on 6/1/2025 at 5:00 am, R54 stated that he was never offered any vaccines on admission. He stated that if it had been offered, he may have opted to receive the vaccinations, but confirmed he was not provided with that information. During an interview on 6/2/2025 at 9:32 am, the Director of Nursing (DON) revealed that she has been working at the facility since 2/17/2025. She confirmed that she was aware of the Infection Control Program concerns regarding missing information. She stated that there was an individual in the ICPN role when she started, but that the individual was terminated. The DON stated that it was a possibility that the terminated employee either took the information with her when she left or destroyed all the documentation.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, staff interviews, records review, and a review of the facility's policy titled Infection Prevention and Control Program, the facility failed to develop and implement policies and procedures to ensure the availability of Coronavirus disease (COVID-19) vaccine to all staff and residents, offer COVID-19 vaccine, educate staff and residents/resident representatives regarding the risk, benefits and potential side effects of the COVID-19 vaccine and keep proper documentation surrounding vaccination, refusal or contraindications for four of four sampled residents (R) (R48, R54, R96 and R217). Findings included: A review of the undated facility policy titled Infection Prevention and Control (IPC) Program revealed that, The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, employee health and safety, identifying, recording and correcting IPC incidents, investigating and reporting communicable diseases and conducting an annual review of the IPC program. Outbreak management is a process that consists of: determining the presence of an outbreak, managing the affected residents, preventing the spread to other residents, documenting information about the outbreak, reporting the information to appropriate state and local authorities. when required, educating the staff and the public, monitoring for reoccurrences, reviewing the care after the outbreak has subsided, and recommending new or revised policies to handle similar events in the future. During a review of the records provided by the Infection Control Preventionist Nurse (ICPN) on 5/28/2025 at 4:00 pm, it was determined that there were no current residents in the facility with a positive diagnosis of COVID-19. The documentation revealed that there was no record indicating the last COVID-19 outbreak nor its monitoring. During an interview with the ICPN, at this time she stated that she was unaware of any policies or procedures related to COVID-19 handling, and COVID-19 education was not readily available nor was there documentation on information for management present for review. She provided the Infection Control Book and confirmed that the book contained no education material for the COVID-19 vaccine; no immunization record related to residents and/or staff being offered, receiving, or declining the vaccine; and no guidelines on management, monitoring, or preventing a COVID-19 outbreak. A review of all new admissions within the last 30 days revealed four out of four residents (R48, R54, R96 and R217) had no documentation in their Electronic Medical Records (EMR) indication that the COVID-19 immunization was offered, received, or declined and no documentation that the education was provided to residents or their representatives regarding the risk and benefits of the vaccine. During an interview on 5/29/2025 at 11:11 am, the ICPN revealed that she was hired by the facility on 4/16/2025, initially as part-time, and that she recently accepted the full-time position. She stated that this was her first Infection Preventionist job, but has been certified as an ICPN since 11/6/2022. She confirmed that she had not developed or implemented an Infection Control Program; that she did not know about the last COVID-19 outbreak in the facility; and that she was not aware of the policies and procedures surrounding COVID-19. She stated that she was aware that there should be monitoring, but had not initiated any at this time. She stated that there was much work to be done to get up to standard and that it will take some time. She stated that the facility has not had an ICPN since July 2024 and that no one had knowledge of the records or monitoring because the Infection Control books disappeared when the previous IPCN left, which is why she is unable to locate the appropriate data required. She stated that she will be receiving some assistance from a friend in the coming days, who will educate her on how to properly do the job. During an interview on 6/2/2025 at 9:32 am, the Director of Nursing (DON) revealed that she was aware of the Infection Control Program issues and missing documentation. She stated that she was made aware that an interim corporate personnel member had been visiting the facility and assisting with the Infection Control Program, but that the individual had been terminated. The DON stated, It is possible she either took or destroyed all the documentation. The DON confirmed that she was not certified as an ICPN and stated that it was her expectation for the ICPN to start from the bottom and work on everything related to infection control. The DON stated that she did not have contact information for the previous ICPN.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and review of facility policies titled Safe Environment and Maintenance service, the facility failed to maintain a safe, functional, and sanitary environment in 14 of 108 resident rooms (214, 217, 218, 224, 225, 226, 322, 325, 326, 405, 417, 421, 505, and 526) related to resident rooms containing debris in packaged terminal air conditioner (PTAC) units, dirty air vents in common areas, and holes/cracks in drywall and doors. Findings included: A review of the facility policy titled Safe Environment revealed the following: Policy Statement: The facility will provide (9)(a) housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A review of the facility policy titled Maintenance service dated 3/6/2018, under Policy Statement revealed: Maintenance Service shall be provided to all areas of the building, grounds, and equipment. Under Policy Interpretation 2. (d) Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. 2. (i) Providing routinely scheduled maintenance service to all areas. During observations on 5/29/2025 between 9:00 am and 10:00 am, the facility's PTAC air filters in the resident rooms 214, 217, 218, 224, 225, 226, 405, 417, 421, 505, and 526 were observed to have soiled air filters with a thick accumulation of dust, dirt, and debris. Originally white, the air filters appeared dark due to contaminants. When lifted for inspection, they released visible dust clouds and were clogged with a dense layer of grime. During an interview and observation on 5/29/2025 at 12:25 pm, the Maintenance Director confirmed the buildup on PTAC filters in rooms 214, 217, 218, 224, 225, 226, 405, 417, 421, 505, and 526. It was also confirmed that the PTAC unit was not working in room [ROOM NUMBER]; there were multiple stained and missing ceiling tiles in rooms [ROOM NUMBER], and throughout the facility; and there were torn window screens and chipped paint throughout the facility. Continued observation also revealed a broken door to room [ROOM NUMBER], a hole in the wall in room [ROOM NUMBER], and the toilet not working in room [ROOM NUMBER]. During the interview at this time, the Maintenance Director revealed that it was the responsibility of the maintenance department to change and clean the PTAC filters and make sure they were working properly. He stated that the maintenance department was also responsible for changing stained ceiling tiles, replacing missing ceiling tiles, and repairing all broken items in the facility. During an observation and interview on 6/2/2025 at 1:45 pm, a family member of the resident in room [ROOM NUMBER]A revealed that the resident has been at the facility since 2020 and stated that the room is never cleaned. She stated that there were times when she cleaned the room herself. She went on to say that there were cobwebs in the corners, sticky substances on the wall and floor. A review of the facility's grievances log revealed that there have been multiple reports/grievances regarding the uncleanliness of the room and odors throughout the facility. An observation on 6/8/2025 at 11:35 am revealed stained ceiling tiles in the residents' room on the third floor. An observation on 6/8/2025 at 11:43 am revealed stained ceiling tiles in the hallway by the shower room on the fourth floor. An observation on 6/8/2025 at 11:44 am revealed an air vent on the fourth floor to the left of the elevator with gray and black debris and dust on it. An observation on 6/8/2025 at 11:50 am revealed an air vent on the fifth floor to the left of the elevator with gray and black debris and dust on it. During an interview on 6/9/2025 at 1:10 pm, the Administrator revealed he expects the maintenance department or the housekeeping department to report any environmental issues in TELS and address the concern right away.