STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115262	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appling Nursing and Rehabilitation Pavilion	163 East Tollison Street Baxley, GA 31513

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 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** 43637 Based on interviews, record review and review of the facility policy, titled Abuse, Neglect, and Exploitation Prevention and Reporting, the facility staff failed to timely report an allegation of staff to resident abuse for one of two residents reviewed (Resident (R) #50). Findings include: Review of the facility titled Abuse, Neglect and Exploitation Prevention and Reporting, last reviewed 1/9/2020, revealed VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or b. Not later than 24 hours if the events the allegation do not involve abuse and do not result in serious bodily . During an interview on 3/5/25 at 9:39 a.m., R#50 revealed he had an incident with a male aide (referring to Certified Nursing Assistant (CNA) EE) and that he revealed to staff the male aide was very rough with him and also man handled him while transferring him from his bed. R#50 revealed he reported his concerns to a female nurse and revealed he told facility staff, I don't want him coming into my room anymore. R#50 revealed after he reported the incident to nursing staff and told them what happened he was okay. R#50 revealed CNA EE raised his voice and yelled at him repeatedly. R#50 could not recall the exact day or time this incident occurred; however, he did reveal it occurred a few weeks back (Record review determined the incident occurred on 2/21/25). Review of R#50's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses including but not limited to, heart disease (admitting diagnosis), anxiety disorder, and dementia. Review of R#50's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/7/25 revealed the resident had a Brief Interview for Mental Status score of 11, which indicated the resident had moderate cognition. Further review of the MDS revealed the resident had not exhibited any physical or verbal behaviors towards staff, rejection of care and required moderate/partial assistance of staff with activities of daily living (to include transfers from bed to wheelchair, personal hygiene, eating, toileting, etc.). (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's reported incident dated 3/4/25 revealed on 2/22/25 R#50 reported to Registered Nurse (RN) VV of an incident that took place on 2/21/25. R#50 initially complained of pain during incontinent care then revealed the day prior (2/21/25) CNA EE was rough with him and man handled him while transferring him from his bed to wheelchair. R#50 further revealed to RN VV that he was experiencing pain, and that CNA EE yelled at him. Further review of the investigation concluded that the Administrator did not report the incident to the state and local authorities until 2/24/25. Interview on 3/6/25 at 10:31 a.m., with CNA EE who returned phone call and revealed he was assigned to R#50 as a CNA on 2/21/25. CNA EE revealed R#50 had a scheduled haircut appointment at the facility and was told to get the resident up and dressed. CNA EE revealed he entered R#50's room and provided assistance with a gait belt to transfer the resident to his wheelchair. CNA EE revealed he had worked with R#50 and that he was noncompliant with getting out of his bed. CNA EE revealed he assisted the resident into his wheelchair and back to his room. CNA EE revealed he was suspended pending the facility's investigation, was asked by staff to write a witness statement on the events that occurred, and did not return to the facility until 3/3/25. Review of CNA EE's timecard revealed the CNA was out of the building from 2/23/25 - 3/3/25. During an interview with the Administrator on 3/6/25 at 10:42 a.m., the Administrator revealed she was the facility's Abuse Coordinator. The Administrator confirmed the alleged abuse occurred on 2/21/25, was reported to RN VV on 2/22/25, and reported to state and local officials on 2/24/25. The Administrator confirmed all allegations of abuse were to be investigated immediately and should be reported to the state agency within 24 hours. During an interview on 3/6/25 at 12:01 p.m., revealed on 2/22/25 the Director of Nurses (DON) was notified by RN VV of an incident that occurred on 2/21/25. The DON revealed RN VV reported that R#50 revealed during care he was yelled at, man handled and bearhugged by CNA EE. The DON revealed she contacted several nursing staff to provide witness statements regarding the incident. The DON revealed that all alleged reports of abuse and neglect should be reported to the appropriate agencies within 24 hours of receiving a complaint. During an interview on 3/6/2025 at 2:20 p.m., RN VV returned the phone call and revealed she worked on 2/22/25 and R#50 reported to her that a male CNA (CNA EE) was rough with him on 2/21/25. RN VV revealed R#50 complained of pain and revealed CNA EE yelled at him, man handled him, and bearhugged him while transferring him to his wheelchair for a haircut. RN VV revealed she reported the incident immediately to the DON and was told to complete a witness statement with the details provided by R#50.

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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 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** 43637 Based on interviews, record review and review of the facility policy, the facility staff failed to implement care plan interventions for two residents ((R) #33 and R#34) of 30 residents reviewed. Specifically, the care plan was not followed for R#34 resulting in elopement from the facility on two occasions. Additionally, on 12/30/24 R#33 sustained fractures of the distal left femur with mild comminution when staff transferred her without using appropriate number of staff and equipment. On March 11, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy on March 11, 2025, at 9:55 am. The noncompliance related to the Immediate Jeopardy was identified to have existed on February 2, 2025. At the time of exit on March 13, 2025, the Immediate Jeopardy remained ongoing. Findings include: 1. Record review indicated R#34 was admitted [DATE] and had diagnoses of Alzheimer's disease, generalized anxiety disorder, other depressive episodes, and generalized weakness. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/5/24, revealed R#34 had a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had a severe cognitive impairment. Review of records indicated R #34 had two facility reportable incidents for elopement that occurred on 5/20/24 and 2/2/25. Review of R #34's care plan documented a risk for elopement and wandering that was initiated 7/9/21. Care plan interventions initiated on 7/9/21 included, Staff to supervise resident as she moves on and off the unit. Following the 2/2/25 elopement, care plan interventions were updated as follows: 2/3/25 Resident in view of staff at all times within the facility for 3 days as ordered, Date Initiated 2/3/25 .Daily check on locked doors, Date Initiated 2/4/25, Staff education/Inservice as needed, Date Initiated 2/4/25. During an interview, on 3/6/25 at 12:17 p.m., the Director of Nursing (DON) reported that the resident had not had an elopement risk assessment since admission. The DON further stated that she did not know why the resident had not been escorted from the activity department to their unit per the care plan intervention of 2021. The DON stated they initiated door lock checks, but this was not placed on the care plan after the first elopement. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on 3/11/25 at 1:23 p.m., the DON stated that facility-wide changes were implemented to include census checks performed at 8:00 p.m. for all units and that the glass doors were locked after the first elopement. The DON further stated that care plan decisions are made during Interdisciplinary Team (IDT) meetings held daily at 9:00 a.m . 2. Review of the facility policy titled, IDT [Interdisciplinary Team]/Care Plan Activities, last revised 5/1/19 revealed Purpose: To evaluate, implement and maintain a thorough plan of care for each resident ensuring that he/she maintains the highest quality of life possible. Review of R#33's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, Alzheimer's Disease (admitting diagnosis), encounter for other orthopedic aftercare, fracture of lower end of left femur (12/31/24). Review of R#33's significant change in status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was severely cognitively impaired and rarely/never understood. Further review of the MDS revealed the resident was dependent of staff and required two persons' physical assistance with transfers. Review of R#33's comprehensive care plan, initiated on 12/18/23, revealed Resident has a self-care deficit r/t [related to] impaired mobility and cognition. Care plan approaches included resident is dependent on staff for chair/bed transfers and resident is dependent on staff for transfers and a mechanical lift [Hoyer] is used by 2 [two] staff (initiated 2/28/25). Review of R#33's Monthly Nursing Summary, dated 12/4/24, revealed Resident required assistance of 2 [two] or more staff and Hoyer lift used for transfers .care needed for positioning required assistance of 1 [one] staff . Review of R#33's Progress Note dated 12/31/24 at 1:32 a.m. revealed At 2200 [10:00 p.m.] CNA [Certified Nursing Assistant] called nurse into room to see resident's leg. When CNA attempted to reposition resident, her left thigh was deformed and touching the leg it made a crunching sound and moved. Put the leg on the pillow to support it and notify the nurse manager. Sent resident to ER [emergency room] to be evaluated and treated. Notified family of situation . Review of the R#33's Hospital Discharge Summary revealed an x-ray that concluded R#33 had sustained fractures of the distal left femur with mild comminution and a few degrees of posterior angulation (a broken femur). Review of the facility's Investigation Report dated 1/7/25 revealed R#33 sustained a broken femur. Further review of the report revealed the facility was unable to substantiate the exact cause of the injury, however, it likely occurred during transfer to or from the shower chair due to age, immobility, contractures, and malnutrition. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with R#33's Responsible Party (RP) on 3/5/25 at 10:10 a.m. via telephone, the RP revealed she was notified via telephone on 12/31/24 by facility staff that R#33 was transferred to the hospital and had sustained a broken femur. The RP revealed she was confused due to R#33 being incapable of moving without assistance from nurses. The RP revealed she had asked facility staff how it happened, and facility staff revealed they were unsure of how it occurred. The RP revealed she had spoken with the Administrator and Director of Nursing a couple of days later (was unsure of the exact date) and revealed the injury may have occurred during transferring the resident to the shower room. An interview with Certified Medication Aide (CMA)/CNA AA on 3/5/25 at 12:49 p.m. revealed on 12/30/24 she was passing medications during the day shift. CMA/CNA AA stated another CNA requested assistance with transferring R#33 from the bed to the shower chair. CMA/CNA AA revealed she was in the middle of passing medications to another resident and had to put away several items on the medication cart prior to assisting CNA DD with transferring R#33 to the shower chair. CMA/CNA AA revealed that when she entered R#33's room, R#33 was positioned on the edge of the bed with her legs crossed at the ankles. CMA/CNA AA revealed CNA DD was behind R#33 and held her up with both arms under the resident's arm for support. CMA/CNA AA revealed R#33 was unable to hold themselves up without assistance from staff. CMA/CNA AA revealed she assisted CNA DD with transferring R#33 from the bed to the shower chair. CMA/CNA AA revealed they did not use any equipment (gait belt or mechanical lift) to transfer the resident to the shower chair. CMA/CNA AA revealed she did not witness CNA DD assisting the resident to the edge of the bed. However, due to prior occasions, R#33 required more than one person to be transferred due to her physical and medical conditions. During an interview with CNA BB on 3/5/25 at 1:01 p.m., it was revealed that on 12/30/24, CNA DD assisted R#33 to the shower room. CNA BB revealed she showered the resident and during this time, CNA BB revealed she observed an open area on R#33's bottom (referring to the resident's buttocks). CNA BB revealed she reported the open area to the Nurse Manager. CNA BB revealed that after she showered R#33, she assisted the resident back to their room and put her in bed. CNA BB revealed that even though she was aware the resident required two staff with transfers, she did not request assistance from another staff member prior to transferring the resident back to bed. During an interview with CNA CC on 3/5/25 at 1:59 p.m., it was revealed she was working the day shift on 12/30/24. CNA CC revealed she was to the shower room to assess R#33 because another staff member revealed the resident's toes were bleeding. CNA CC revealed when she went to assess R#33, her toes were dry and she did not observe any blood. CNA CC revealed he/she left the shower room and did not provide any care to R#33 for the rest of the shift. An interview with CNA DD via telephone on 3/5/25 at 2:06 p.m. revealed on 12/30/24 she was assigned to provide care for R#33. CNA DD revealed she went to R#33's room to get the resident up for a shower. CNA DD revealed she requested assistance from another CNA to transfer the resident. CNA DD revealed she did not move the resident until CMA/CNA AA entered the room. CNA DD revealed they did not use any equipment to transfer the resident from the bed to the shower chair. CNA DD revealed R#33 was showered by another staff member, and when she went back to R#33's room, the resident was in bed resting. CNA DD revealed R#33 required two staff members for transfers due to the resident's immobility (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Director of Nurses (DON) on 3/6/25 at 11:56 a.m., the DON revealed the facility concluded that R#33 was transferred improperly. The DON revealed she expected staff to use a lift or gait belt when transferring residents. The DON also revealed she expected staff to follow care plan approaches with transfers and that R#33 should have been transferred by two staff members due to resident's condition. (Cross refer F689)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46565 Based on interview and record review, the facility failed to follow physician's orders to ensure that residents receive treatment and care in accordance with professional standards of practice for one resident (R) #290 of one resident reviewed for quality of care. Findings include: A review of the facility's policy titled, Physician Orders, with a reviewed date of 2/20/23, stated the facility policy was established to ensure physician orders were implemented. R#290 was a [AGE] year-old resident who was admitted to the facility on [DATE], with diagnoses including diabetes, history of heart attack, and high blood pressure. The resident had a Brief Interview for Mental Status (BIMS) score of 13 on the quarterly Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 10/16/24, which indicated the resident was cognitively intact. Record review of the physician orders revealed that the resident had an order for administration of sliding scale insulin of Humalog that specified if the blood sugar (BS) was over 400 mg/dL (milligrams per deciliter) two hours after insulin administration, send the resident to the ER (emergency room) and the MD (Medical Doctor) must be notified. In addition, there was another order which stated, Accu-Check twice a day if results were less than 40 mg/dL or greater than 400 mg/dL; repeat finger stick in other hand. If confirmed same, get STAT lab confirmation of Serum BS. Do not give insulin until lab confirmation results are received. MD must be notified if BS was greater than 400 mg/dL. This was ordered four times daily and as needed. On 10/7/24 at 3:14 p.m., the resident had a BS of 465 mg/dL, then at 5:46 p.m. the BS was 453 mg/dL, and at 6:15 p.m. the BS was 453 mg/dL according to the blood glucose section of the vitals in the medical record. A progress note at 10/7/24 at 6:15 p.m. said the nurse tried to reach the medical doctor (MD), non-emergency communication was given, and nine units of Humalog was administered. On 10/8/24 at 4:48 p.m., the resident had a BS of 464 mg/dL, then at 5:58 p.m., it was 505 mg/dL, and finally at 6:00 p.m. it was 505 mg/dL, and no further readings were documented according to the blood glucose section of the vitals in the medical record. The progress note 10/8/24 at 6:15 p.m. stated that nine units of insulin was given, staff attempted to reach the MD, and faxed MD. Increased agitation was documented that night and an as needed sedative was administered. There were no negative outcomes documented for R#290 as a result of not being sent out to the ER when her BS was greater 400 mg/dL. In an interview, on 3/11/25 at 1:23 p.m., the Director of Nursing (DON) stated it was expected that staff follow the orders of the physician and if there was a question, the physician should be contacted for verification.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 44785 Based on interviews, record review, and review of the facility policy titled Elopement and Wandering Residents and Safe Transfers - Hoyer Lift, the facility failed to ensure one resident (Resident #34) of two residents reviewed for elopement, did not leave the facility without the nursing staff being aware. This failure led to Resident (R) #34 eloping on 2/2/25 for a second time, which could have caused harm or death. The facility also failed to provide one of two residents reviewed the appropriate interventions when transferring (Resident (R) #33). Additionally, on 12/20/24, actual harm was experienced when R#33 sustained fractures of the distal left femur with mild comminution and was transferred to the hospital for further medical treatment. The failure to use appropriate facility equipment and follow care plan approaches resulted in the resident sustaining an avoidable injury. On March 11, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy on March 11, 2025, at 9:55 am. The noncompliance related to the Immediate Jeopardy was identified to have existed on February 2, 2025. At the time of exit on March 13, 2025, the Immediate Jeopardy remained ongoing. Findings include: 1. Review of the facility's policy titled, Elopement and Wandering Residents, dated 2/27/19, specified, . ensure residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents .PROCEDURE: .c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. PROCEDURE POST ELOPMENT: . g. Documentation in the medical record will include findings from social and nursing service assessments, physician/family notification, care plan discussions, and consultant notes as applicable. A record review indicated R #34 was admitted to the facility on [DATE] and had diagnoses of Alzheimer's disease, generalized anxiety disorder, other depressive episodes, and generalized weakness. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/5/24, revealed R #34 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The resident utilized a wheelchair independently for locomotion. Review of a nursing progress note, dated 5/20/24 at 2:34 a.m., documented that R #34 was found outside, had sustained a small skin tear to the top of the left foot, and was unable to answer questions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R#34's In-service for Elopement and Reportable Incidents, held 5/20/24 through 5/27/24, documented that an elopement occurred on 5/20/24 at 1:30 a.m. The in-service documented, CONCLUSION: R #34 exited the facility without staff knowledge through a door that had not been reset to alarm. Review of R #34's care plan documented a risk for elopement and wandering, initiated on 7/9/21, with an intervention for Staff to supervise resident as she moves on and off the unit. Further record review documented that R #34 had a second elopement, which occurred on 2/2/25. A review of a facility incident report, dated 2/2/25, indicated R#34 was observed outside the building by a staff member at approximately 3:10 p.m. rolling down the sidewalk in her wheelchair. The report documented, INTERVENTIONS: Exit doors checked for locked/secured. The final report documented a review of inside and outside cameras determined the resident exited the dining area door at approximately 3:05 p.m. The surveyor requested to view the inside and outside cameras but was denied access. Review of R#34's care plan following the second elopement, documented the following approaches: 2/3/25 Resident in view of staff at all times within the facility for 3 days as ordered, Date initiated 2/3/25 .Daily check on locked doors, Date initiated 2/4/25, Staff education/inservice as needed, Date initiated 2/4/25. A review of the Emergency Door Log Checks for A, B, and C halls initiated on 2/4/25 following the 2/2/25 elopement revealed the log had been signed daily from 2/1/25 through 2/28/25 for Units A and B, and signed from 3/1/25 through 3/27/25 for Unit C. The facility was not able to provide logs prior to February 2025. During an interview, on 3/6/25 at 12:17 p.m., the Director of Nursing (DON) reported that the resident had not had an elopement risk assessment completed since admission. The DON further stated that she did not know why the resident had not been escorted from the activity department to their unit per the care plan intervention of 2021. The DON stated they initiated door lock checks, but this was not placed on the care plan after the first elopement. On 3/7/25, at approximately 12:15 p.m., the DON provided documentation to indicate staff had participated in training and discussion of elopement. The DON provided a Daily Stand-up Meeting Sign-in Sheet, dated 1/4/25. Handwritten in the left margin revealed, QAPI committee met and discussed elopement event on 2/2/25 RE: R #34. During an interview, on 3/11/25 at 1:24 p.m., the DON stated she did not know why the resident's care plan was not updated following the May 2024 incident, but that facility-wide changes were implemented to include census checks performed at 8:00 p.m. for all units and that the glass doors were locked. The DON further stated that care plan decisions are made during Interdisciplinary Team (IDT) meetings held daily at 9:00 a.m. 43637 2. Review of the facility policy titled, Safe Transfers - Hoyer Lift, last revised on 8/29/22, revealed All residents require handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R#33's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses including but not limited to, Alzheimer's Disease (admitting diagnosis), encounter for other orthopedic aftercare, fracture of lower end of left femur (12/31/24). Review of R#33's significant change in status the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was severely cognitively impaired and rarely/never understood. Further review of the MDS revealed the resident was dependent of staff and required two persons for physical assistance with transfers. Review of R#33's comprehensive care plan, initiated on 12/18/23, revealed Resident has a self-care deficit r/t [related to] impaired mobility and cognition. Care plan approaches included resident is dependent on staff for chair/bed transfers and resident is dependent on staff for transfers and a mechanical lift [Hoyer] is used by 2 staff (initiated 2/28/25). Review of R#33's Monthly Nursing Summary, dated 12/4/24, revealed Resident required assistance of 2 [two] or more staff and Hoyer lift used for transfers .care needed for positioning required assistance of 1 [one] staff . Review of R#33's Progress Note dated 12/31/24 at 1:32 a.m. revealed At 2200 [10:00 p.m.] CNA (Certified Nursing Assistant) called nurse into room to see resident's leg. When CNA attempted to reposition the resident, her left thigh was deformed, and when touching the leg, it made a crunching sound and moved. Put the leg on the pillow to support it and notify the nurse manager. Sent resident to ER [emergency room] to be evaluated and treated. Notified family of the situation . Review of the R#33's Hospital Discharge Summary revealed an x-ray that concluded R#33 had sustained fractures of the distal left femur with mild comminution and a few degrees of posterior angulation [a broken femur]. Review of the facility's Investigation Report dated 1/7/25 revealed that R#33 sustained a broken femur. Further review of the report revealed that the facility was unable to substantiate the exact cause of the injury; however, it likely occurred during transfer to or from the shower chair due to age, immobility, contractures, and malnutrition. During an interview with R#33's responsible party (RP) on 3/5/25 at 10:10 a.m. via telephone, the RP revealed he was notified via telephone on 12/31/24 by facility staff that R#33 was transferred to the hospital and had sustained a broken femur. The RP revealed he was confused due to Resident #33 being incapable of moving without assistance from the nurses. The RP revealed he/she asked facility staff how it happened, and the facility staff revealed they were unsure of how it occurred. The RP revealed he/she spoke with the Administrator and Director of Nursing a couple of days later (was unsure of the exact date) and revealed the injury may have occurred during transferring the resident to the shower room. (continued on next page)

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	115262	A. Building B. Wing	03/13/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Certified Medication Aide (CMA)/CNA AA on 3/5/25 at 12:49 p.m., revealed on 12/30/24 she was passing medications during the day shift. CMA/CNA AA stated another CNA requested assistance with transferring R#33 from the bed to the shower chair. CMA/CNA AA revealed she was in the middle of passing medications to another resident and had to put away several items on the medication cart prior to assisting CNA DD with transferring R#33 to the shower chair. CNA AA revealed when she entered R#33's room, R#33 was positioned on the edge of the bed with her legs crossed at the ankles. CNA AA revealed CNA DD was behind R#33 and holding her up with both arms under the resident's arms for support. CNA AA revealed R#33 was unable to hold themselves up without assistance from staff. CNA AA revealed she assisted CNA DD with transferring R#33 from the bed to the shower chair. CNA AA revealed they did not use any equipment (gait belt or mechanical lift) to transfer the resident to the shower chair. CNA AA revealed she did not witness CNA DD assisting the resident to the edge of the bed. However, based on prior occasions, R#33 required more than one person to be transferred due to her physical and medical conditions. An interview with CNA BB on 3/5/25 at 1:01 p.m., revealed on 12/30/24, CNA DD assisted R#33 to the shower room. CNA BB revealed she showered the resident and during this time, CNA BB revealed she observed an open area on R#33's bottom (referring to the resident's buttocks). CNA BB revealed he/she reported the open area to the nurse manager. CNA BB revealed after she showered R#33 she assisted the resident back to their room and put her in bed. CNA BB revealed that even though she was aware the resident required two (2) staff with transfers, he/she did not request assistance from another staff member prior to transferring the resident back to bed. During an interview with CNA CC on 3/5/25 at 1:59 p.m. it was revealed she was working the day shift on 12/30/24. CNA CC revealed she went to the shower room to assess R#33 because another staff member revealed the resident's toes were bleeding. CNA CC revealed when she went to assess R#33, R#33's toes were dry, and she did not observe any blood. CNA CC revealed she left the shower room and did not provide any care to R#33 for the rest of the shift. During an interview with CNA DD via telephone on 3/5/25 at 2:06 p.m. it was revealed on 12/30/24 she was assigned to provide care for R#33. CNA DD revealed she went to R#33's room to get the resident up for a shower. CNA DD revealed she requested assistance from another CNA with transferring the resident. CNA DD stated she did not move the resident until CNA AA entered the room. CNA DD revealed they did not use any equipment to transfer the resident from the bed to the shower chair. CNA DD revealed R#33 was showered by another staff member and when she went back to R#33's room, the resident was in bed resting. CNA DD revealed R#33 required two staff members for transfers due to the resident's immobility. During an interview with the Director of Nursing (DON) on 3/6/25 at 11:56 a.m., the DON revealed the facility concluded that R#33 was transferred improperly. The DON revealed she expected staff to use a lift or gait belt when transferring residents. The DON also revealed she expected staff to follow care plan approaches with transfers and that R#33 should have been transferred by two staff members due to resident's condition. (Cross refer F656) 39786

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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. 43637 Based on interviews and record reviews, the facility's Administration failed to ensure it administered in a manner that enabled it to use its resources effectively and efficiently to prevent residents from elopement. This resulted in a lack of supervision and processes, which placed residents at risk for multiple elopements and at risk for serious adverse outcomes. This failure resulted in resident (R)#34 eloping from the facility twice. The census was 81. On March 11, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy on March 11, 2025, at 9:55 am. The noncompliance related to the Immediate Jeopardy was identified to have existed on February 2, 2025. At the time of exit on March 13, 2025, the Immediate Jeopardy remained ongoing. Findings include: Review of a nursing progress note, dated 5/20/24 at 2:34 a.m., documented that R #34 was found outside, had sustained a small skin tear to the top of the left foot, and was unable to answer questions. A review of R#34's In-service for Elopement and Reportable Incidents, held 5/20/24 through 5/27/24, documented an elopement occurred on 5/20/24 at 1:30 a.m. The in-service documented, CONCLUSION: R #34 exited the facility without staff knowledge through a door that had not been reset to alarm. Review of a facility reported incident revealed a resident eloped from the facility on 2/2/25. The investigation concluded that the exit door, which the resident went out of, did not alarm and staff were not notified that the resident left the building unattended, without staff knowledge. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Administrator on 3/13/25 at 11:49 a.m., the Administrator revealed she was aware of the resident's elopement on 2/2/25. The Administrator revealed after the resident's elopement; the Interdisciplinary Team (IDT) met the next day to discuss additional interventions for the resident who eloped. The Administrator revealed the IDT did not discuss any other residents who had the potential to elope. The Administrator revealed at the time, all of the residents were at risk for elopement and the facility should have conducted risk assessments on the residents who were at high risk for elopement. The Administrator revealed door checks were also implemented, however; they were not implemented on all shifts and were implemented just on the day shift. The Administrator revealed a resident could have eloped at any time of the day and that the facility failed to implement door checks on every shift to hold staff accountable and residents safe. The Administrator revealed there were several key areas of concern the facility staff had addressed, however, they failed to implement those interventions until the situation resulted in an IJ. The Administrator revealed moving forward she expected IDT members to discuss any areas of concern in QAPI (Quality Assurance Performance Improvement) meetings to identify care areas of concern and initiate appropriate interventions immediately. 39786

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46565 Based on observation, interview, record review, and review of the facility policy titled, Infection Prevention and Control Program, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections, which affected all 81 residents in the facility. Findings include: Record review of the facility's policy titled, Infection Prevention and Control Program, last revised 4/30/2020, directed that the Infection Preventionist would consult on infectious diseases, resident room placement, implementation of isolation precautions, and other related tasks. The policy further indicated that a system of surveillance was created for preventing, identifying, reporting, and investigating communicable diseases for all residents, staff, volunteers, visitors, and other individuals. In an interview on 3/4/25 at 9:37 a.m., during the entrance conference, the Director of Nursing (DON) stated that she also acted as the Infection Preventionist for the facility. The DON revealed that the facility currently had an outbreak of Influenza A with nine residents on the 100 hall (A Hall) that were positive, and six residents on the 300 hall (C Hall) that were positive. When asked to provide a line list of Influenza A positive for residents and staff, the DON stated that they would have to go and re-read text messages from staff to create a line list. Record review of the line list of positive residents dated 3/5/25 revealed that eight residents were listed from A Hall, and seven residents were positive from C Hall. A review of the facility's Resident Matrix (Form 802), provided on 3/4/25, identified three residents that were Influenza A positive but were not on the line list of positive residents provided on 3/5/25, including Resident (R) #36, (R) #2 and (R) #29. In an interview, on 3/5/25 at 10:21 a.m., with the DON, she stated that for staff, they only had the date they called out or a doctor's note, and that half of the staff were out last week for the flu. She further stated that she would need to type up a line list for flu positive residents as well. The DON stated that isolation for influenza was 10 days, with the start date being the diagnosed date and going until the day after the 10th day. The DON stated that someone accidentally typed in seven days of isolation for a resident, but that must be a mistake because the DON was typing in standing orders for influenza and put 10 days as what the isolation period should be. The DON stated that the facility had not reported the influenza A outbreak to any health authority or health department. In an interview on 3/5/25 at 1:23 p.m., with a Southeast Health District employee, with jurisdiction for the facility, the employee stated that Influenza A was reportable on the list of reportable diseases classified as an outbreak/cluster of infectious diseases, and the facility should have reported the Influenza A outbreak according to the Georgia Department of Health. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview, on 3/5/25 at 2:10 p.m., with the DON and Infection Preventionist, she stated that no one reports outbreaks to the health department, and they did not know that it was required. The DON stated she had to work three days on the floor last week due to call outs of staff who had the flu. When asked about proper isolation for influenza, the DON stated that Airborne Isolation and Droplet Isolation were pretty much the same thing according to the CDC [Centers for Disease Control and Prevention] and that residents should be on airborne isolation and contact isolation for influenza. An observation on 3/6/25 at 10:19 a.m., outside of room [ROOM NUMBER], revealed three isolation signs for (R) #49, who was listed as positive for Influenza A. The signs indicated the following requirement for R #49: Contact Precautions, Airborne Precautions, and Droplet Precautions. Record review of the Georgia Department of Health Notifiable Disease Condition Reporting list revealed, all outbreaks/clusters (including infectious and non-infectious causes, toxic substance and drug-related, and any other outbreak) should be reported.