

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Harborview Satilla		STREET ADDRESS, CITY, STATE, ZIP CODE  1600 Riverside Ave Waycross, GA 31501	

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)
<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff interviews, and review of the facility policy titled Comprehensive Care Plan the facility failed to ensure the care plan was followed for two person assistance toileting for one Resident ((R) R1) of three residents which resulted in R1 having a fall. On 4/12/2025, actual harm was identified when Certified Nursing Assistant (CNA) BB was providing care alone resulting in R1 falling out of bed and sustaining a left femoral neck fracture and left frontal scalp hematoma.</p> <p>Findings include</p> <p>Review of the Comprehensive Care Plans dated 3/1/2022, revealed Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Review of the admission Record revealed resident was admitted to the facility on [DATE] with the following diagnoses that include but are not limited to hemiplegia and hemiparesis following cerebral infarction, atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, restless legs syndrome, hypertension, adult failure to thrive, and neuralgia and neuritis.</p> <p>Review of the medical record revealed R1 admitted to the facility with the facility with the diagnoses that included but are not limited to hemiplegia and hemiparesis following cerebral infarction, atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, restless legs syndrome, hypertension, adult failure to thrive, and neuralgia and neuritis.</p> <p>Review of the Minimum Data Set (MDS) admission dated 1/15/2025 revealed R1 was dependent for eating, shower, bathing, roll left or right, personal hygiene, upper and lower body dressing, self-care and toilet hygiene.</p> <p>Review of the care plan dated 1/22/2025 revealed resident needs assistance with grooming, bathing and personal hygiene related to inability to care for themselves, mobility impairment, range of motion limitations, self-care impairment, contracture left hand, hemiplegia and hemiparesis affecting the left nondominant side, muscle weakness. He has an assist rail to left side of bed. Interventions included toileting assist of two; transfers assist of two people; bathing assist of two; bed mobility assistance of two; and dressing assistance of two.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0656  Level of Harm - Actual harm  Residents Affected - Few	An interview with Registered Nurse (RN) MDS Coordinator on 4/22/2025 at 2:56 pm revealed the [NAME] should be pulled from the electronic health record (EHR). It was reported that R1 was very contracted and could not give help with his care. RN MDS Coordinator reported that CNA BB should have had another CNA to assist her. It was further reported that CNA BB could have gotten another CNA from another hall or the nurse to assist her with caring for R1. It was reported that the care plan should have been followed for the safety of the resident. RN MDS Coordinator confirmed again that two people were needed, one for each side of the bed, when caring for R1.  Cross reference F689		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on medical record review, staff interviews and review of the facility policy Accidents and supervision, the facility failed to ensure that one resident (R1) of three residents was provided with enough staff to complete perineal care of residents while in bed. On 4/12/2025, actual harm was identified when Certified Nursing Assistant (CNA) BB was providing care alone resulting in R1 falling out of bed and sustaining a left femoral neck fracture and left frontal scalp hematoma.</p> <p>Findings include:</p> <p>Review of the facility policy, Accidents and Supervision dated 3/1/2022, revealed Policy: the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazards (s) and risk (s). 2. Evaluating and analyzing hazard (s) and risk (s). 3. Implementing interventions to reduce hazard(s) and risk (s). 4. Monitoring for effectiveness and modifying interventions when necessary.</p> <p>5. Supervision - Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency. b. Based on the individual resident's assessed needs and identified hazards in the resident environment.</p> <p>Review of the closed medical record revealed R1 was admitted to the facility with the following diagnoses that include but are not limited to hemiplegia and hemiparesis following cerebral infarction, atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina pectoris, restless legs syndrome, hypertension, adult failure to thrive, and neuralgia and neuritis.</p> <p>Review of NSG: Fall Risk Evaluation dated 4/12/2025 revealed a score of five indicating low risk.</p> <p>Review of Progress Notes dated 4/12/2025 revealed resident had a five-centimeter (5 cm) laceration to the top of the scalp and was sent to the ER (emergency room) for evaluation.</p> <p>Review of the facility 5-day follow-up dated 4/12/2025 revealed an interview that resident was turned to the right side to clean his bottom and then positioned on his backside where he was in the middle of the bed. CNA proceeded to the other side of the bed to clean that side of his bottom. The resident then shifted leg to the right side causing his bottom half to roll off the bed.</p> <p>Review of the hospital emergency room medical records dated 4/12/2025 revealed multiple computed tomography (CT) scans of cervical spine revealed no fracture or subluxation for R1. No paravertebral soft tissue swelling; CT Brain revealed left frontal scalp hematoma. There are no mass effects for midline shift; CT Chest revealed the patient has scoliosis as well as kyphosis. No sternal fracture or rib fracture is relatively identified. CT Abdomen and Pelvis revealed left femoral neck fracture, no evidence of acute injury within the chest, abdomen and pelvis. It was also noted that R1 had a Do Not Resuscitate (DNR) status with comfort care.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview on 4/22/2025 at 11:53 am with Certified Nursing Assistant (CNA) BB revealed she was doing her last round on 4/12/2025 and went to change R1. She stated that she rolled the resident to the right side and then adjusted the bed so she could roll him. She reported that she had her supplies, and she then walked to the other side of the bed. While walking to the other side of the bed, she reported that R1 started trying to put his feet off the bed. The bed did not have regular side rails. R1 is reported as getting one foot out of the bed and then rolled off the bed. CNA BB reported that she tried to catch him, but the bedside table was on the side she was walking to which slowed her from getting to R1 before he fell. After he fell, she noticed that his head was bleeding and she left the room to get the nurse. It is reported that LPN CC assessed R1 and he was then taken to the local hospital via Emergency Medical Services (EMS). CNA BB further stated she was trained that R1 was a one person assist for care. Lastly, CNA BB reported that there was only one CNA per hall so R1 was a one person assist because of that.</p> <p>An interview with CNA EE on 4/22/2025 at 1:40 pm revealed she worked with R1 in the past and had the assistance of CNA AA because it was easier to provide care with two people. R1 was reported as being very contracted. CNA EE stated that she was not comfortable changing R1 by herself.</p> <p>An interview with CNA FF on 4/22/2025 at 2:15 pm revealed R1 required two people to assist because he was very contracted, and it was hard to roll him. CNA FF reported that two people were also needed to help maintain his posture. CNA FF further reported that she trained CNA BB that R1 as a two-person assist. It was also reported that R1 required two-person assistance and normally a CNA from another hall would have to help with assisting R1.</p> <p>An interview with LPN GG on 4/22/2025 at 2:22 pm revealed R1 was total care and had severe contractions resulting in his legs being stiff, but he could kick his legs off the bed resulting in his feet dangling off the bed. LPN GG further explained that R1 required two people for his ADLs and the 2nd person was needed to maintain posture, the resident could not help with any aspect of his care.</p> <p>An interview with the Director of Nursing (DON) on 4/22/2025 at 3:17 pm revealed she does not know why CNA BB did not have a second person assisting with R1. DON further reported that the nurse could have assisted the CNA with bed mobility and toileting for R1. The DON reported that CNA BB should have waited for someone to assist her with caring for R1.</p> <p>An interview with the Administrator on 4/22/2025 at 3:23 pm revealed that she is unsure why CNA BB did not have a second person assisting her with R1. The Administrator reported that the CNA had not started the process for perineal care and R1 had a side of his body that he favored. The Administrator further reported that R1 had a tendency to throw his legs and his weight would follow his legs and R1 could not stop himself from falling.</p> <p>LPN CC was unavailable for an interview.</p> <p>Cross reference F656</p>		