STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on resident and staff interviews, record reviews, and a review of the facility's policy titled Resident and Family Grievances, the facility failed to ensure that resolutions were provided for concerns discussed in the Resident Council meetings. Findings included: A review of the policy titled Resident and Family Grievances, with an implementation date of 3/1/2022 and a revision date of 3/1/2025, included Prompt efforts to resolve include facility acknowledgment of working toward resolution of that complaint/grievance. A review of the Resident Council Meeting minutes dated January 2024 showed that during the meeting, a resident requested that her showers be scheduled between 7:00 am and 3:00 pm instead of between 3:00 pm and 11:00 pm. There was no resolution documented for the concern. A review of the Resident Council Meeting minutes dated February 2024, a resident voiced that his linens were not getting changed often enough, and he was having an issue with his sink. No resolution was documented for the concerns. A review of the Resident Council Meeting minutes dated March 2024, a resident complained that when clothing was sent to the laundry, it was not returned. No resolution was documented for the concern. A review of the Resident Council Meeting minutes dated April 2024, residents complained that the Certified Nursing Assistants (CNAs) had bad attitudes toward them. No resolution was documented for the concern. No meeting was documented for May 2024. A review of the Resident Council Meeting minutes dated June 2024, a resident complained that it had been two weeks since his bed linen had been changed. Also, the fourth-floor shower room had not been open to residents. Residents also stated that they wanted more care to be given when food was plated during meal times, as the food looked thrown together, and it was bland and not edible. No resolutions were documented for the concerns. A review of the Resident Council Meeting minutes dated July 2024, residents from the fourth floor stated that CNAs need to be quicker with serving their trays because when they received their food, it was cold. No resolution was documented for the concerns. A review of the Resident Council Meeting minutes dated August 2024, the residents stated that the shower room on the fourth floor was still not available. The resident stated that they had issues with housekeeping staff coming into their rooms without knocking or announcing themselves. The resident stated that he had sent clothing to the laundry and was missing eight shirts. No resolutions were documented for the concerns. A review of the Resident Council Meeting minutes dated September 2024, fourth floor residents stated that CNAs needed to be quicker with serving their trays because their food is cold when they receive it. No resolutions were documented during this meeting. A review of the Resident Council Meeting minutes dated October 2024, a resident stated that his room had not been cleaned for two weeks, and his room had never been deep-cleaned. During the meeting, residents also stated that they did not like the food combo choices, and the portion sizes were too small. Residents also stated that they were not getting linens frequently enough and that their clothes were not being returned from the laundry despite being labeled. Residents from the 4th floor stated that they were not able to use the shower. No resolutions were documented for the concerns. A review of the Resident Council Meeting minutes dated November 2024, residents stated that more snacks needed to be brought to the floors. Residents also suggested that snacks be brought to the floor at a specific time that residents are made aware of, so that they can get snacks before the staff gets them. No resolutions were documented for the concerns. A review of the Resident Council Meeting minutes dated December 2024, the resident stated that he had a hard time getting linens. No resolutions were documented for the concerns. A review of the Resident Council Meeting minutes dated January 2025, a resident stated that housekeeping staff didn't mop her room even when the floor was very dirty. Another resident stated that housekeeping staff didn't knock or announce themselves before entering the room. A resident stated that the CNAs will refuse to take her dirty clothing to the laundry when they smell bed. A resident stated that she needed her wheelchair fixed, and her roommate needed a wheelchair. A resident stated that she has an allergy to pecans, that it stated it on her meal ticket, and she was given a dessert with pecans. No resolutions were documented for the concerns. A review of the Resident Council Meeting minutes dated February 2025, several residents stated that they were getting items on their tray that they did not want, like, or could not have. A few residents stated that their overhead light needed to be fixed, and the string to pull the light on needed to be replaced and/or made longer. A resident stated that housekeeping staff were better about announcing themselves, but they would go through his drawers, although he did not want them to. The Resident Council President (RCP) suggested putting out flyers to remind residents of the Resident Council meetings. No resolutions were documented for the concerns. A review of the Resident Council Meeting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of the facility's policy titled Resident Funds Management Policy and Procedure, the facility failed to ensure one of 48 sampled residents (R) (R114) responsible parties (RP) had immediate access to the resident's funds. Findings included: A review of the facility's policy titled Resident Funds Management Policy and Procedure, revised 3/1/2022, revealed that .if a resident requests a check to be cut from their resident funds account, the facility will withdraw funds from the Resident Funds Account to the petty cash account and print the request within 24 hours. A review of the Electronic Medical Record (EMR) for R114 revealed an original admission date of 5/13/2022 with multiple diagnoses of, but not limited to, metabolic encephalopathy, dysphagia following cerebral infarction, acute pulmonary edema, Type II diabetes, hemoptysis, cognitive communication deficiency, and dysphagia. A review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed R114 had a Brief Interview for Mental Status (BIMS) score of eight, indicating R114 had moderately impaired cognition.A review of the R114's Resident Fund Management Service (RFMS) revealed the following: R114's Social Security Administration (SSA) direct deposit was deposited on 11/1/2024; the resident's cash advance was debited on 11/19/2024 R114's SSA direct deposit was deposited on 12/3/2024; the resident's cash advance was debited on 12/24/2024. R114's SSA direct deposit was deposited on 2/3/2025; the resident's cash advance was debited on 2/14/2025. R114's SSA direct deposit was deposited on 3/3/2025; the resident's cash advance was debited on 3/11/2025. R114's SSA direct deposit was deposited on 5/2/2025; the resident's cash advance was debited on 5/29/2025. During an interview on 6/11/2025 at 4:48 pm, R114's RP revealed that the RP does receive the funds from the resident's account; however, it's always one to two months late. R114's RP continued that she received the resident's funds for May on 6/10/2025. The checks are supposed to be mailed on the 10th of each month. During an interview on 6/12/2025 at 8:59 am, the Business Office Manager (BOM) revealed that R114's RP has had access to R114's funds since September 2022. The BOM continued that the residents received verbal communication about wanting the checks by the 15th of each month. The process includes speaking to residents to receive their confirmation that the resident's family can get their funds. There was some lateness due to being busy. But the resident must sign off on the checks before it is sent off to the resident's family or the family member picks it up. R114 hasn't had any cognitive issues to give permission to sign off on the funds to her RP. During an interview on 6/12/2025 at 10:24 am, the BOM stated R114 was the only resident whose RP was to receive access to their monthly cash advance. There might be other residents who occasionally provide permission to send their monthly cash advance to their family members, but R114 is the most consistent since September 2022. During an interview on 6/16/2025 10:15 am, R114 confirmed that her RP has access to her resident funds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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	115270	A. Building B. Wing	06/17/2025

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F 0580 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 staff interviews, record review and review of the facility's policies titled Notification of Changes, and Change of Room or Roommate, the facility failed to notify two of five sampled residents (R) (R381and R6) responsible parties of changes; and failed to notify one resident's (R) (R194) physician of a change in condition and transfer to the hospital. Findings included: During a review of the facility policy titled Change of Room or Roommate, revised 3/1/2025, revealed that .6. The social services designee or Licensed Nurse should inform the resident's sponsor/family in advance of a change in the resident's room or roommate. Review of the facility policy titled Notification of Changes dated 4/1/2024, revealed that the purpose of this policy is to ensure the facility promptly informs the resident and consults the resident's physician when there is a change requiring notification. These notifications include a significant change in the resident's physical, mental, or psychosocial condition and a transfer or discharge of the resident from the facility. 1. A review of the Electronic Medical Record (EMR) for R381 revealed the resident admitted with multiple diagnoses of, but not limited to, encephalopathy, fracture of the shaft of the right fibula, dementia, hypomagnesemia, insomnia, and muscle weakness. A review of the 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed R381 had a Brief Interview for Mental Status (BIMS) score of 11, indicating R381 had moderately impaired cognition. In a review of R381's progress note dated 4/10/2024, it was noted that Resident was COVID-19 tested because his roommate tested positive in the ER. Resident had no (signs/symptoms) s/s of respiratory distress, afebrile, and (vital signs)VS stable. The COVID-19 test was negative, and residents moved to another room, 339. Will continue to monitor and follow up as required. During an interview on 5/21/25 at 10:23 am, R381's Responsible Party (RP) revealed that R381's room was changed without her knowledge. The RP went to the second floor looking for R381 before finding out he was moved to the third floor of the facility due to R381's roommate testing positive for Covid-19. During an interview on 6/3/2025 at 9:06 am, Social Service Coordinator (SSC) QQ revealed that, depending on the situation, Nursing or Social services will notify the family of the residents of the change in the room. When asked if R381's family was notified of his room change, SSC QQ stated she couldn't see anything in her notes where the resident's family was notified. During an interview on 6/3/2025 at 9:18 am, Assistant Director of Nursing (ADON) HH revealed, he was in close communication with R381's RP for the duration of the resident's stay at the facility. The ADON HH continued that he or a nurse would have called the resident about the room change. He doesn't recall the RP coming to the facility looking for R381 and not finding him. When asked why it wasn't documented, ADON HH was unable to answer. 2. A review of a Facility Reported Incident (FRI) dated 9/19/2024 showed that R6 and her roommate's family member got into a physical altercation. Details of the incident revealed that R6 was assaulted by her roommate's family member when the family threw a plate of food in the resident's face. It was stated that there was no injury apparent. The police were called, and the responsible parties were notified. A review of the progress notes for R6, dated 9/19/2024, written by License Practical Nurse (LPN) JJJ revealed that R6 stated, she had hit me in my face with a paper plate full of food. Further review of the note showed that the Director of Nursing (DON)/Administrator was notified via phone of the incident. The Medical Director (MD) was notified. Note: did not document that RP was notified. A review of the admission records for R6 revealed that the resident was admitted to the facility with diagnoses that included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, unspecified, and heart failure. A review of the admission record for R6 showed that the resident's son was not the resident's responsible party. During an interview on 5/19/2025 at 3:47 pm with R6's RP, who stated that when the incident occurred, she received a call from R6 stating that her roommate's family member had asked her why their mother's Vaseline was on her bedside tray. R6 stated that she explained to her roommate's family member that she did not put it there; it had to be left there by staff being as she could not get out of her bed without assistance. RP stated that R6 stated that the roommate's family member started hitting her in her head with a paper food tray. RP stated that she called the nurse's station, and the unit manager (she could not recall her name) answered the phone but stated that the facility was having an emergency and hung up the phone before RP could state what she wanted. RP stated that she did not get a phone call back, nor did anyone from the facility call to let her know about the altercation. During an interview on 6/11/2025 at 11:09 am spoke with LPN JJJ, who stated that she recalled the incident. LPN JJJ stated that the family member of the roommate was separated from R6. LPN JJJ stated that R6 had called her son, and she spoke to R6's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

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Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's policy titled Confidentiality of Personal and Medical Records, the facility failed to safeguard the personal and medical information of residents. In addition, the facility failed to ensure computer screens located on the medication carts were locked when not in use by a nurse who displayed residents' personal and medical information. This affected two out of 48 sampled residents (R26 and R213). Findings included: A review of the facility policy titled Confidentiality of Personal and Medical Records, dated 3/31/2023, revealed that personal and medical records for residents are to be kept confidential, including written documentation, video, audio, and computer-stored information. 1. Observation of the Fourth Floor, on 5/30/2025 at 8:25 am, revealed that a medication cart was unattended in the hall outside of room [ROOM NUMBER]. No nurse was in sight at the time of the observation. The computer located on top of the medication cart was opened, and the medical information was displayed for R26. This information included the resident's name, date of birth , allergies, advance directives, and a list of current physician orders. An interview with Licensed Practical Nurse (LPN) YY, on 5/30/2025 8:28 am, revealed they heard someone coughing down the hall and stepped away from the medication cart without locking the computer screen. They apologized and stated they would ensure it would stay locked in the future. 2. An observation of the Third Floor, on 6/8/2025 at 11:25 am, revealed that a medication cart was unattended beside the nurse station. The computer screen on the cart was open and visible to anyone in the hall. The screen displayed R213's current physician orders. An interview with LPN EE, on 6/8/2025 at 11:30 am, revealed they forgot to lock their computer screen before stepping away. An interview with the Interim Director of Nursing (IDON), on 6/8/2025 am at 12:00 pm, revealed that all medication cart computer screens should be locked when not in use by a nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to provide a safe, clean, and comfortable environment for residents receiving showers in two of the three shower rooms (Third Floor Shower room and Fourth Floor Shower room) in the facility. The shower rooms contained unsecured doors, soiled linens, resident gowns on the floor, unmarked toiletry items, trash, masks, and gloves on the floor, in addition to unclean toilets and equipment. Findings included: 1. Observation on 5/29/2025 at 10:55 am of the Third Floor Shower room revealed, the shower room door was propped open. There were no staff or residents in the shower room at the time of the observation. The shower room contained six wet and visibly soiled wash cloths scattered throughout on the floor, three wet bath towels scattered throughout on the floor, three used and unmarked bars of soap on the floor in the main shower stall, 12 pairs of gloves, inside out, scattered about the floor in multiple areas, multiple visible soiled tissues lying beside the toilet on the floor, and two shower chairs that had brown substance on the seats. The shower room also contained two masks and a fork on the floor. The shower room contained an unlocked and open cabinet with a bottle of unmarked olive oil lotion and a medicine cup full of unmarked green fluid. The room had a strong smell of feces. The toilet was not flushed and had feces and urine in the toilet. Interview on 5/29/2025 at 10:58 am with the Licensed Practical Nurse (LPN) ZZ revealed that the shower room door should never be propped open. LPN ZZ acknowledged that the shower room needed to be cleaned immediately. LPN ZZ apologized for the condition of the shower room. LPN ZZ stated that they did not know what the green fluid was in the medicine cup. 2. Observation on 5/29/2025 at 11:02 am of the Fourth Floor Shower room revealed, the shower room door was propped open. There were no staff or residents in the shower room at the time of the observation. The room contained four wet and visibly soiled wash cloths scattered throughout on the floor, two wet bath towels on the floor, one used and unmarked bar of soap on the floor in the main shower stall, four pairs of gloves, inside out, scattered about the floor in multiple areas, and multiple visibly soiled tissues throughout on the floor. The toilet contained dark brown water that smelled of feces and urine. Interview on 5/29/2025 at 11:04 am with the LPN BBB revealed, the shower room door should not be propped open. The nurse observed the findings in the shower room and stated they would have the room immediately cleaned. The nurse stated the shower room was always a mess after they got done giving showers, but not this bad. Interview on 5/29/2025 at 11:06 am with the Regional Nurse Consultant (RNC) DDD revealed that the shower room door should not be open to the hallway. The RNC revealed they just got done giving showers, but the staff should be straightening up between residents. The RNC stated they would have the room immediately cleaned and secured. 3. Observation on 6/8/2025 at 10:15 am of the Third Floor revealed, the Shower room door was propped open. The shower room had no staff or residents in the room. The shower room contained a used incontinence brief on the floor, the toilet had gloves in it, the floor had multiple visibly soiled and wet gowns, towels, and blankets were lying in multiple places on the floor, and the window seal had used gloves and an unmarked container of body wash. The shower bed had three pairs of gloves, inside out, two bottles of shower gel, opened and unmarked, two wet washcloths, an unmarked medication cup, and a mask. Interview on 6/8/2025 at 10:18 am with Certified Nursing Assistant (CNA) AAA confirmed that the shower room door should always be closed. CNA AAA also confirmed that the staff should have cleaned the room after the last shower and shut the door. Interview on 6/10/2025 at 9:00 am with the Interim Director of Nursing (IDON) confirmed that all shower rooms should be shut and always be locked. The CNAs should be cleaning the shower rooms between residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interviews, record review, and a review of the facility's policy titled Resident and Family Grievances, the facility failed to acknowledge family concerns as grievances via email and failed to investigate grievances for one out of 48 sampled Residents (R) (R384). In addition, the facility failed to provide results for the concerns and grievances reported by residents during the Resident Council Meetings. The facility census was 214 residents. Findings included: A review of the facility's policy titled Resident and Family Grievances dated 3/1/2025 revealed that it is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal. Prompt efforts to resolve, including facility acknowledgement of a complaint/grievance. 1. (Name and Title) has been designated as the Grievance Official and can be reached at (contact information). 2. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility . issuing written grievance decisions to the resident. 10. Under Procedure revealed, b. The staff member receiving the grievance will record the nature of and specifics of the grievance on the designated form or assist the family member to complete the form. c. Forward the grievance form to the Grievance Official as soon as practicable. 11. Evidence demonstrating the results of all grievances will be maintained for a period of no less than 3 years from the issuance of the grievance decision. 1. A review of the grievance log revealed one grievance dated 6/17/2024 filed by R384's family member that stated the resident's legs were hanging off the bed when [they] visited, and the bed was not made. [R384] was wearing socks in bed, which [family member] does not want. [Family member] stated staff made bed during visit, but [family member] wants to understand bedding protocols occurred on 6/16/2024 on the 7:00 am to 3:00 pm shift. The grievance form was completed by the third-floor Social Service Coordinator (SSC) QQ. The grievance was investigated by the Registered Nurse (RN) Assistant Director of Nursing (ADON) HH for the second floor. The grievance official follow-up was: In-service conducted with staff regarding checking on residents regularly & ensuring they are properly positioned in bed with appropriate bedding. During an interview on 6/3/2025 at 2:43 pm with the third-floor SSC QQ, who explained that the grievance process begins when the Social Worker writes a grievance and sends it via email to the department head, who then works on it. The Social Service Director keeps the grievance in a binder. The Grievance officer does the research, and the person who resolves it shares the resolution with the family. SSC QQ was not sure who the grievance officer was. SSC QQ called the Social Service Director (SSD) RR for the resolution of R384. SSD RR kept a binder with all the grievances. During an interview on 6/3/2025 at 2:48 pm, SSD RR confirmed that the grievance coordinator shares the resolution with the family, and they maintain the log and a binder with all the grievances. The Assistant Administrator said R384 was nice, pleasantly confused, and their family member was involved in her care. The third floor SSC QQ said R384's family had a lot of complaints like this grievance, like socks and more specific things-but would not elaborate. The third floor SSC QQ said Registered Nurse (RN) ADON for the second floor kept the in-service for this incomplete grievance. During an interview on 6/4/2025 at 12:05 pm, the RN ADON HH revealed, they remember many complaints from R384's family, and they would listen to try to help and then send the grievances to the third-floor SSC QQ. The RN ADON HH revealed they remembered this complaint from R384's family, who had a lot of complaints; this one about socks meant the family member didn't want specific nonskid socks on R384, but instead wanted socks without skids. The bedding portion of the complaint was addressed by an in-service. RN ADON HH revealed, R384 was unable to communicate except to make gestures, so the family member was their advocate, and the family member visited twice a week, called, and sent emails to SSC QQ, who brought them back to the RN ADON HH. R384's family talked to staff about R384's care, then went home and sent the SSC QQ an email. RN ADON HH revealed that R384 had other grievances and sent emails to the SSC QQ, and that the grievance related to the socks and sheets was signed by the Assistant Administrator, but RN ADON HH provided the in-service. During an interview with SSC QQ, on 6/5/2025 at 1:15 pm, SSC QQ provided 17 additional emailed complaints from R384's family, and SSD RR said the 17 emailed complaints should have been acknowledged and investigated as grievances. During an interview on 6/10/2025 at 11:15 am, the Administrative Assistant, who has been the grievance officer for the last couple of months revealed, the grievance process begins when the grievance is sent to the department head that the grievance is about, and it is completed and sent to the grievance officer within three days, and the goal is to make sure the grievance is investigated completely

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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 interviews, record review, and review of the facility policy titled Abuse, Neglect, and Exploitation, the facility failed to report an allegation of abuse incident for one of 48 sampled residents (R) (R101). Findings included: A review of the facility policy titled, Abuse, Neglect, and Exploitation, with an implementation date of 3/1/2022 and a review date of 7/1/2024, included, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Further review revealed the section titled Reporting/Response stated, 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 review of the admission record for R101 showed that the resident was admitted to the facility on [DATE], and diagnoses included, but were not limited to, type 2 diabetes mellitus without complications, muscle weakness (generalized), difficulty in walking, not elsewhere classified, depression, unspecified. A review of the care plan for R101 revealed that the resident was care planned for displaying behaviors, including false accusations, with a date initiated of May 13, 2025. Interventions included administering medications as ordered and evaluating effectiveness. Monitor for adverse effects and report to the physician. Allow resident to make choices in their own care. Assess the resident's coping skills and support system. Assess the resident's understanding of the situation and allow time for them to express themselves and their feelings about it. Attempt interventions before behaviors begin. Let the physician know if any of the resident's behaviors are interfering with daily living. Ensure the resident is not experiencing pain or discomfort. Observe for behaviors: false accusations. Refer the resident to a psychologist or psychiatrist as needed. When negative behaviors begin, remove the resident from the current activity and return/resume it when the behavior subsides. A review of the progress note, dated 2/7/2025, completed by Licensed Practical Nurse (LPN) BB included, Resident came to the nursing station and stated that another resident hit him on his head. He reported to the evening supervisor, who advised him to keep away from the other resident. R101 was very loud and verbally abusive to staff, yelling that they should call the police, but none of the staff witnessed the altercation, and the alleged perpetrator denied hitting him. During an interview on 6/12/2025 at 12:51 pm, R101 stated that he recalled the incident. The resident stated that another resident came up behind him and hit him in the head. R101 stated that he told the staff, but the staff did nothing about it. R101 stated that he called the police on his own, but the staff never addressed the incident with him. An attempt was made to interview LPN BB on 6/12/2025 at 2:08 pm, but there was no answer, and a voicemail message was left. A second attempt was made to reach staff on 6/16/2025 at 10:58 am. During an interview on 6/16/2025 at 10:48 am, the current Administrator stated that staff failed to inform the previous Administrator of the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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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	115270	A. Building B. Wing	06/17/2025

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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, resident and staff interviews, record review and review of the facility's policy titled, Maintaining Minimum Data Set (MDS) Assessments, and the MDS Resident Assessment Instrument (RAI) User's Manual, the facility failed to ensure MDS assessments was accurately coded for two of 48 residents (R) (R114 and R155). Findings included: In a review of the facility policy titled Maintaining Minimum Data Set (MDS) Assessments, revised 9/1/2024, it was documented that .8. MDS information will be made available to all professional staff members who need to review the information in order to provide care to the resident. Review of the facility provided document titled MDS Resident Assessment Instrument (RAI) User's Manual for coding Active Diagnosis from the CMS RAI Version 3.0 Manual CH 3: MDS Items [I] October 2024 page I-17 revealed, Section I: Active Diagnosis in the last 7 days (cont.) 4. The resident was admitted without a diagnosis of schizophrenia. After Admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician, However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the residents mental, physical, psychosocial, and functional status (483.45 (e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards. Coding: Schizophrenia item (I16000) would not be checked. Rationale: Although the resident has a physical diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenic diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (483.21 (b)(3)(i), of the resident's mental, physical, psychosocial, and functional status (483.45(e)) and persistent behaviors for the time period required. 1. A review of the Electronic Medical Record (EMR) for R114 revealed the resident was admitted with multiple diagnoses of, but not limited to, metabolic encephalopathy, dysphagia following cerebral infarction, acute pulmonary edema, Type II diabetes, hemoptysis, cognitive communication deficiency, and dysphagia. A review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed R114 had a Brief Interview for Mental Status (BIMS) score of eight, indicating R114 had moderately impaired cognition. Additionally, Section B - Hearing, Speech, and Vision, R114 was coded for adequate hearing. In a review of previous MDS assessments for Section B - Hearing, Speech, and Vision revealed the following: Quarterly MDS assessment dated 12/18/ 2023 for Section B - Hearing, Speech, and Vision revealed R114's hearing was coded at 1-minimal difficulty. Quarterly MDS assessment dated [DATE] for Section B - Hearing, Speech, and Vision revealed R114's hearing was coded at 1-minimal difficulty. Quarterly MDS assessment dated [DATE] for Section B - Hearing, Speech, and Vision revealed R114's hearing was coded at 1-minimal difficulty. Quarterly MDS assessment dated [DATE] for Section B - Hearing, Speech, and Vision revealed R114's hearing was coded at 1-minimal difficulty. Quarterly MDS assessment dated [DATE] for Section B - Hearing, Speech, and Vision revealed R114's hearing was coded at 0- Adequate. In a review of R114's admission progress note dated 5/13/2022 at 2:30 pm, it was revealed that R114 was admitted with diagnoses of encephalopathy and dysphagia. The note continued that the resident was verbally responsive with slurred speech, 'Hard of Hearing' (HOH) does not have hearing aids. In a review of R114's EMR, a hearing assessment was performed on 11/2/2023. It was noted that R114 had bilateral Sensorineural hearing loss. A Physician's Hearing aid statement signed on 11/10/2023 revealed that R114 would benefit from hearing aids. During an interview on 5/6/2025 at 10:16 am, R114 was hard of hearing and kept saying huh and what during the screening process. R114 stated she was supposed to get a hearing aid, but hasn't been able to get one yet. During an interview on 5/21/2025 at 10:50 am, R114's responsible Party (RP) stated she signed up R114 with auxiliary care to assess the resident's hearing. During an interview on 5/27/2025 at 12:18 pm, the MDS/Resident Assessment Coordinator (MDS Coordinator) QQQ revealed he thought R114 had adequate hearing based on his assessment. The MDS Coordinator QQQ showed the Physician Hearing aid statement dated 11/10/2023, the hearing assessment results, and the progress notes indicating the resident was hard of hearing. MDS Coordinator QQQ stated it must have been a mis click in the system. 2. A review of the EMR for R155 revealed the resident was admitted on [DATE], discharged on 9/2/2024, and readmitted on [DATE] with a diagnosis including dementia without behavioral disturbance, schizoaffective disorder, and mild cognitive impairment. A record review of the electronic medical record revealed a letter from The Georgia Collaborative ASO (Administrative Services Organization) regarding a Georgia PASRR Level II Summary of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

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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 - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review, the facility failed to develop a care plan to include activities of daily living (ADL) and legal blindness for one out of 48 sampled residents (R) (R387). Findings included: Review of the facility's policy titled Comprehensive Care Plans implementation date of 3/1/2022, read in part, The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of R387's admission Record located in the electronic medical records (EMR) section revealed the resident was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, burn of second degree, legal blindness, and homelessness. Review of R387's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/24/2024, located in the resident's EMR under the MDS tab indicated the facility assessed R387 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R387 was alert and oriented. Review of R387's Care Plan, located in the resident's EMR section titled Care Plans, revealed the resident did not have an activities of daily living (ADL) or legal blindness care plan. The care plan only addressed R387's skin issues, discharge planning, and fall risk. Review of R387's care plan progress note, dated 6/25/2024, revealed initial care plan meeting was completed. An interview on 6/2/2025 at 11:35 am with the MDS Coordinator confirmed R387's comprehensive care plan only addresses his skin concerns, fall risk, and discharge planning. MDS Coordinator stated her expectation is for the R387 to have an ADL care plan and a care plan that addresses the resident's legal blindness. MDS Coordinator stated they were unsure why the comprehensive care plan was not entered because, according to R387's progress notes, there was a care plan done. The MDS Coordinator stated that staff were responsible for completing care plans.

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	115270	A. Building B. Wing	06/17/2025

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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. (continued on next page)

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	115270	A. Building B. Wing	06/17/2025

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F 0657 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 interviews, record review, and review of the facility's policies titled Comprehensive Care Plans and Fall Prevention Program, the facility failed to ensure that care plans were updated for three of 19 sampled residents (R) (R372, R393, and R122). Findings included: Review of the facility's policy titled Comprehensive Care Plans implemented 3/1/2022 and last revised 3/1/2025, documented on page 2: The comprehensive plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Qualified staff responsible for carrying out the interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Review of the facility's fall prevention policy titled, Fall Prevention Program: implemented 3/1/2022 and last revised 8/1/2024, revealed on page 2: Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. The fall policy continued and stated, when any resident experiences a fall, the facility will a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. 1. Review of Electronic Medical Record (EMR) for R372 revealed the resident was admitted to the facility with diagnoses that included, but were not limited to: rhabdomyolysis, orthostatic hypotension, dependence on renal dialysis, and muscle weakness. Review of the progress notes dated 12/13/2023 at 7:30 pm revealed the R372 was walking to the bathroom and had an unwitnessed fall. R372 had reported that he hit the back of his head. The progress notes also indicated the resident was assessed and sent to the emergency department for an evaluation and treatment. The progress notes dated 12/14/2023 at 2:10 am revealed R372 returned to the facility with no new orders. Review of the Care Plan for R372 revealed the care plan dated 11/20/2023 had not been updated to reflect the resident's fall on 12/13/2023. Review of the EMR for R372 revealed that the EMR did not document any updates for fall prevention. 2. Review of the EMR for R393 revealed the resident was admitted to the facility with diagnoses that included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease, hypertension, and diabetes. Review of the Electronic Medical Record (EMR) for R393 revealed the resident was ordered oxygen on 9/22/2024. Further review of the EMR revealed R393's weight was 119 pounds upon admission on [DATE] and 116.2 pounds on 9/22/2024, and a supplement was ordered at that time. Review of the care plan for R393 dated 11/20/2023 revealed the facility failed to care plan for oxygen use, although the resident was diagnosed with hypertension, congestive heart failure, and chronic obstructive pulmonary disease. Further review of the care plan revealed that the facility failed to plan the resident's weight loss with interventions. An interview on 6/4/2025 at 10:10 am with the Interim Director of Nursing (DON) revealed that the clinical managers, nursing staff, DON, and Minimum Set Data (MDS) staff were responsible for updating the residents' care plans. 3. A review of the EMR for R122 revealed an original admission date of 7/26/2022 with multiple diagnosis of, but not limited to, diffuse traumatic brain injury with loss of consciousness (TBI) systemic lupus erythematosus, traumatic subarachnoid hemorrhage without loss of consciousness, Parkinson's disease with dyskinesia, hypotension, type ii diabetes mellitus, restlessness and agitation, dysphagia, and personal history of transient ischemic attack (TIA). During an interview on 6/12/2025 at 3:15 pm, a progress note regarding the fall that occurred on 4/20/2025 was reviewed with the Interim Director of Nursing (I-DON) revealed that R122 was witnessed falling from her wheelchair to her knees during a smoke break, causing a black eye. Review of R122's care plan with a last revision of 5/16/2025, revealed interventions were in place for the falls for the following dates: 4/27/2024, 9/25/2024, 10/27/2024, 11/20/2024, 4/13/2025, 4/20/2025, and 5/1/2025. The incident that occurred on 4/23/2025 was not included in the care plan. During an interview on 6/12/2025 at 3:51 pm, the I-DON revealed that R122's blackeye may not have made it to the care plan if the staff were not sure how it happened. However, this should have been a wound nurse's task. During an interview on 6/16/2025 at 11:09 am, the facility's Wound Care Manager revealed Wound Care Nurse LLL would have handled R122's incident to her black eye.

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	115270	A. Building B. Wing	06/17/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, resident and staff interviews, record review, and review of the facility policy titled Activities of Daily Living (ADLs), the facility failed to ensure Activities of Daily Living (ADL) care was provided for one of four residents (R) (R212) reviewed. Findings included: A review of the facility's policy titled Activities of Daily Living (ADLs), implemented 3/1/2022 and last revised 3/1/2025, documented that the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. A review of the Electronic Medical Record (EMR) for R212 revealed an original admission date of 2/21/2025 with diagnoses including, but not limited to, multiple injuries, contusion of lung, injury at unspecified level of thoracic spinal cord, injury at unspecified level of cervical spinal cord, open wound of scalp, hemothorax, acute respiratory failure with hypoxia, acute respiratory failure with hypercapnia, and kidney failure. A review of the Quarterly Minimum Data Set (MDS) assessment, dated 3/28/2025, revealed R212 had a Brief Interview for Mental Status (BIMS) score of 15, indicating R212 was cognitively intact. Section GG (Functional Ability) revealed that R212 was dependent on two or more helpers when it for toilet transfers. Additionally, R212 requires substantial/maximal assistance for bed mobility. A review of R212's care plan, with a revision date of 4/11/2025, revealed R212 had an ADL self-care performance deficit related to weakness and impaired mobility. During an interview on 5/22/2025 at 4:50 am, R212 revealed that the last time her briefs were changed was last night, 5/21/2025. R212 was asked if she needed to be changed now, and R212 responded yes. R212 turned on her call light at 4:51 am. During an observation on 5/22/2025 at 4:53 am, Licensed Practical Nurse (LPN) JJJ entered R212's room and turned off the call light, and walked out of the room. LPN JJJ was observed walking to the unit's nurses' station. During an interview on 5/22/2025 at 6:18 am, LPN JJJ stated that if the call light was on, any staff member was able to answer it. LPN JJJ continued that if it was something the nurse was able to complete, they would do it, and if a resident needed to be changed, then a CNA was notified. When asked about R212's call light, LPN JJJ confirmed that R212 needed to be changed. When asked if a CNA was notified, LPN JJJ replied that she had notified CNA III that R212 needed her brief changed. LPN JJJ proceeded to ask CNA LL if CNA III had notified her about R212. During an interview on 5/22/2025 at 6:23 am, CNA LL revealed CNA III did not notify her that R212 needed to be changed. CNA LL also revealed the call light wasn't on, so she wasn't aware R212 needed assistance. During an interview on 5/22/2025 at 6:57 am, CNA III revealed that no one had told her that R212 needed to be changed. During an interview on 5/22/2025 at 6:59 am, CNA LL confirmed R212 had a bowel movement. During an interview on 6/10/2025 at 2:48 PM, R212 revealed the facility did not have enough staff, and the CNAs do their best. R212 continued that it makes her feel bad when she sat in her bowel movement or urine for a long period of time. During an interview on 6/16/2025 at 1:10 pm, the Administrator revealed that staff were responsible for answering the call light as quickly as possible, providing assistance within their scope, and notifying the appropriate staff of resident needs.

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	115270	A. Building B. Wing	06/17/2025

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Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on record review and staff interviews, the facility failed to provide podiatry services for one of 48 sampled residents (R) (R 384). The deficient practice had the potential to lead to a lack of nail care and inappropriate foot care.Findings included:A review of the electronic medical record (EMR) revealed that R384 was admitted with diagnoses including but not limited to aphasia following cerebrovascular disease, cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side, major depressive disorder, nontraumatic intracerebral hemorrhage in subcortical hemisphere, cardiac murmur, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified psychosis not due to a substance or known physiological condition, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and vitamin deficiency.The most recent Minimum Data Set (MDS) assessment, dated 6/7/2024, revealed a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment.A review of R384's EMR revealed Social Services progress notes from 7/22/2024 at 1:11 pm that revealed a late entry note that read, [R384] was not seen (by the) podiatrist due to COVID-19 positive residents on the floor. Resident to be rescheduled. On a second late entry social service note dated 4/2/2025 at 3:57 pm read, [R384] was seen by name of company providing podiatry services podiatrist.During an interview on 6/12/2025 at 2:20 pm, the Interim Director of Nursing stated, I would expect the podiatrist to see [R384] if they did not have COVID, but someone else on the floor had COVID. If they were not seen, the podiatrist returns every 62 days to follow up with missed residents. name of company providing podiatry services is the in-house podiatrist. The expectation is that nursing notifies social services to put the resident on the list to see the podiatrist. This was a system failure that the resident was not seen by the podiatrist for eight to nine months. Although requested several times, the facility did not provide a policy for podiatry care.

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	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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. (continued on next page)

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	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to provide adequate supervision to prevent accidents for one of nine sampled residents (R) (R122) reviewed for accident hazards. Harm was identified to have occurred on 4/23/2025 when R122 sustained an injury of unknown origin resulting in ecchymosis and swelling around the right periorbital area.Findings included:A review of the Electronic Medical Record (EMR) for R122 revealed an original admission date of 7/26/2022 with multiple diagnosis of, but not limited to, diffuse traumatic brain injury with loss of consciousness (TBI) systemic lupus erythematosus, traumatic subarachnoid hemorrhage without loss of consciousness, Parkinson's disease with dyskinesia, hypotension, type ii diabetes mellitus, restlessness and agitation, dysphagia, and personal history of transient ischemic attack (TIA).A review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed R122 had a Brief Interview for Mental Status (BIMS) score of three, indicating R122 had severe cognitive impairment.A review of R122's change of condition progress notes dated 4/20/2025 at 9:43 am revealed R122 had witnessed a fall to her knees out of the wheelchair during a smoke break.A review of R122's behavior progress notes dated 4/20/2025 at 11:01 am revealed R122 was observed with eyeglasses that did not belong to her, became aggressive when asked to give them to staff, clutching them tighter. Difficult to redirect, became very agitated, given anxiety med effective.A review of R122's Physician Progress note dated 4/20/2025 at 4:30 pm revealed According to nursing staff, patient took sunglasses that do not belong to light. She became aggressive when asked to give feedback, and she became agitated and difficult to redirect. Patient had to be given a benzodiazepine.A review of R122's late entry post-fall documentation notes dated 4/21/2025 at 8:47 am revealed R122 was not experiencing any pain. The notes also revealed no Skin Issues (Skin Intact, No Bruise/Rash or Other Issues).A review of R122's late entry post-fall documentation notes dated 4/21/2025 at 7:47 pm revealed R122 had no Skin Issues (Skin Intact, No Bruise/Rash or Other Issues).A review of R122's late entry post fall documentation notes dated 4/22/2025 at 8:22 am revealed R122 had no Skin Issues (Skin Intact, No Bruise/Rash or Other Issues.A review of R122's Change of Condition note dated 4/23/2025 at 7:18 am revealed that Nurse observed rt eye swollen, dark purple discoloration increased confusion. The note continued that Executive Director and DON notified. DON assessed the resident. NP advised. In order to transfer to the ER for evaluation. [NAME] Springs police performing an investigation. Left msg for 'R122's responsible party (RP)'A review of R122's hospital record dated 4/30/2025 revealed that R122's reason for the hospital admission was due to sustaining a blackeye from the fall. It was also noted that R122 does not take blood thinners. The hospital record continued that Patient now returns to this facility, found to have ecchymosis and swelling around the right periorbital area. Injury likely occurred between 11:00 pm to 7:00 am. Unknown method of injury. Patient was seen in the emergency room and was noted to be hallucinating, oriented to self only. This does appear to be the patient's baseline. Evaluation in the ER showed intracranial hemorrhage, and she was placed for admission. During an Interview on 5/6/2025 at 9:56 am, Assistant Director of Nursing (ADON) HH revealed that R122 had a few falls. ADON HH continued, he came into work one day and saw R122 had a black eye. They couldn't determine what happened or how to happened. ADON HH continued that R122 is confused today. Since R122's fall, they have been keeping her at the nurse's station for observation. R122 also tends to wander into other residents' rooms.During an interview on 5/21/2025 at 10:41 am, Police Officer YYY revealed that when he arrived at the facility, the resident had a blackeye and it was extremely swollen. No one seems to know what happened to R122, which is very unusual for him. Police Officer YYY continued the ADON HH claimed she fell a few days ago, and it might have happened from that. As Police Officer YYY was exiting the facility, a staff member (unidentified) stated there was another incident with a black eye earlier that week. The Police Officer YYY stated the hospital didn't think the swollen eye was caused by the fall. During an interview on 6/12/2025 at 3:15 pm, the Interim Director of Nursing (I-DON) was provided with the progress notes regarding the fall that occurred on 4/20/2025. The resident was witnessed falling to her knees from her wheelchair during a smoke break; no indication of R122 falling to her head. The I-DON confirmed that, based on the 4/20/2025 progress notes, the blackeye manifesting due to the resident falling to her knees does not make sense.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 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 the interview and record review, the facility failed to assess and provide one of 48 sampled residents (R) (R124) with sufficient fluid intake via gastric tube feeding to maintain proper hydration and health. As a result, R124 was admitted to an acute care hospital on [DATE] and died on [DATE] from septic shock, hypoxic respiratory failure, and non-ST elevation myocardial infarction. On [DATE], 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 was informed of the Immediate Jeopardy (IJ) for F692, F710, and F835 on [DATE] at 3:00 pm. The noncompliance related to the IJ was identified to have existed on [DATE]. 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 [DATE]. Findings included:A review of the Notification of Changes Policy dated [DATE] and revised on [DATE] revealed that the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.A review of the Hydration Policy dated [DATE] and revised on [DATE] revealed that the facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health.A review of the Physician Visits and Physician Delegation Policy dated [DATE] and revised on [DATE] revealed that it is the policy of this facility to ensure the physician takes an active role in supervising the care of residents.1. A review of an admission Record revealed R124 was an [AGE] year-old male admitted to the facility on [DATE] with medical history that included, but was not limited to, dementia, dysphagia, gastric tube, sepsis, urinary tract infection, hypovolemia, hyperosmolality, and hypernatremia, chronic obstructive pulmonary disease, essential hypertension, atrial fibrillation, and seizures. A review of a Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], revealed R124 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was dependent for all activities of daily living (ADL) care, required PEG-tube feedings, was bedfast, and was non-verbal.A review of R124's Care Plan included a focus area initiated on [DATE], which indicated the resident required tube feeding (PEG) related to dysphagia. Interventions directed staff to observe/document/report as needed (PRN) any symptoms of aspiration-fever, shortness of breath, tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration date initiated [DATE].A review of physician orders dated [DATE] revealed R124's facility physician (MM) ordered comprehensive metabolic panel (CMP) labs that revealed R124 had an abnormal blood sodium level of 151 mEq/L. (Normal Sodium 136 - 145 mEq/L)A review of the electronic medical record (EMR) revealed the facility's previous Director of Nursing (DON) reviewed R124's CMP labs on [DATE] at 10:43 am. The previous facility's DON did not notify/follow up with physician MM since interventions were not ordered to correct R124's hypernatremia.A review of the EMR revealed the facility's Nurse Practitioner (NP) reviewed R124's CMP labs on [DATE] at 9:31 pm. No record of notifying the resident's physician or ordering interventions.A review of labs ordered from [DATE] through [DATE] (Eight days) revealed, physician MM did not recheck labs or provide orders for intravenous (IV) fluids as an intervention to correct R124's hypernatremia. Record review of hospital CMP labs on [DATE] revealed R124's sodium level was 161 mEq/L. R124 was admitted to the hospital from [DATE] through [DATE] (24 days).A review of the nurse's progress note dated [DATE] revealed R124 was observed in bed using accessory muscles to breathe, and he was unresponsive. R124's oxygen saturation levels were out of range (no value documented). Oxygen 100% was applied with no improvement. Physician MM was notified, and they gave orders to send R124 to the hospital.A review of hospital CMP labs on [DATE] revealed R124's sodium level was 161 mEq/L. Record review of hospital Medication Administration records revealed R124 was hospitalized for 24 days and administered continuous IV fluids for severe dehydration, weakness, and acute respiratory failure. The resident was discharged from the hospital and returned to the facility on [DATE]. A review of facility readmission CMP labs ordered by physician MM on [DATE] revealed R124's sodium level was 142 mEq/L on [DATE].A review of nursing notes dated [DATE] at 2:46 pm revealed, Note Text: (Nurse) Writer called physician MM concerning resident weight. Physician MM stated that she does not totally agree

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. (continued on next page)

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	115270	A. Building B. Wing	06/17/2025

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F 0710 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 interviews and record review, the physician failed to assess laboratory orders for routine monitoring for two of 48 sampled residents (R) (R124 and R213).On 6/2/2025, 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 was informed of the Immediate Jeopardy (IJ) for F692, F710, and F835 on 6/2/2025 at 3:00 pm. The noncompliance related to the IJ was identified to have existed on 4/2/2025. 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 6/4/2024.Findings included:1. Record review of the Physician Visits and Physician Delegation Policy dated 3/1/2022 and revised on 3/1/2025. Policy: It is the policy of this facility to ensure the physician takes an active role in supervising the care of residents. Record review of an admission Record revealed R124 is an [AGE] year-old male admitted to the facility on [DATE] with medical history that included but was not limited to dementia, dysphagia, gastric tube, sepsis, urinary tract infection, hypovolemia, hyperosmolality, and hypernatremia, chronic obstructive pulmonary disease, essential hypertension, atrial fibrillation, and seizures. Record review of a Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/24/2025, revealed R124 has a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is dependent for all activities of daily living (ADLs) and requires PEG-tube feedings, is bedfast, and non-verbal.Record review of R124's Care Plan included a focus area initiated on 2/17/2025, which indicated the resident requires tube feeding (PEG) related to dysphagia. Interventions directed staff to observe/document/report as needed (PRN) any symptoms of aspiration-fever, shortness of breath, tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration date initiated 2/17/2025. On 2/17/2025, R124's facility physician (MM) ordered comprehensive metabolic panel (CMP) labs that revealed R#124 had an abnormal blood sodium level of 151 mEq/L. (Normal Sodium 136 -145 mEq/L)Record review revealed the facility's previous Director of Nursing (DON) reviewed R124's CMP labs on 2/18/2025 at 10:43 am. No record of notifying the resident's physician.Record review revealed the facility's Nurse Practitioner (NP) reviewed R124's CMP labs on 2/20/2025 at 9:31 pm. No record of notifying the resident's physician or ordering interventions.Record review of physician orders and labs revealed that physician MM provided no orders for IV fluids as an intervention to correct R124's hypernatremia, nor orders to recheck labs. Physician MM failed to monitor R124's condition to prevent serious injury, serious harm, serious impairment, or death.Record review of nurse progress notes dated 2/24/2025, a nurse observed R124 in bed using accessory muscles to breathe, and he was unresponsive. R124's oxygen saturation levels were out of range. 100% oxygen was applied with no improvement. R124's physician, MM, was notified of the resident's change in condition, and physician MM gave orders to send R124 to the hospital.Record review of hospital CMP labs dated 2/24/2025 revealed R124's abnormal blood sodium level had progressed to 161 mEq/L. R124 was hospitalized for 24 days on continuous IV fluids for severe dehydration, weakness, and acute respiratory failure.Record review of facility readmission CMP labs ordered by MM on 3/19/2025 revealed R124's sodium level was 142 mEq/L on 3/21/2025.Record review of nursing notes dated 3/25/2025 at 2:46 pm revealed, Note Text: (Nurse) Writer called physician MM concerning resident weight. Physician MM stated that she does not totally agree with fluctuating weight. Physician MM recommends that the resident (R124) be re-weighed tomorrow and that RD follow up with weights and tube feeding. Physician MM was made aware of the lab results of 3/21/2025 of hemoglobin of 8.2 compared to 9.5 on 2/17/2025. Physician MM stated no new orders at this time based on the normal value of MCV, Albumin of 2.3, and per physician MM the RD can review and recommend supplements. The Responsible Party (RP) was made aware.Record review of R124's labs revealed that physician MM did not order any new labs related to R124's change in condition noted by the RD on 3/26/2025, nor after the resident was re-weighed on 3/26/2025. Weight Results: 3/26/2025 at 10:00 am 145.4 lbs. via mechanical lift.Record review of nurse progress notes revealed on 4/1/2025, a nurse observed R124 in bed using accessory muscles to breathe, and he was unresponsive. R124's oxygen saturation levels were out of range. (No value documented) 100% oxygen was applied with no improvement. R124's physician (MM) was notified, and they gave orders to send

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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	115270	A. Building B. Wing	06/17/2025

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F 0725 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 observation, interview, record review, and review of the facility policy titled Nursing Services and Sufficient Staff, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services. The facility census was 214. Findings included: 1. An observation of the third floor, on 6/8/2025 at 10:15 am, revealed that the medication cart beside the nurse station was unlocked. No nurses were on the floor at the time of the observation. Resident (R) (R422) was sitting by the unlocked medication cart. The medication cart was unlocked from 10:15 am until 10:35 am, when a Certified Medication Aide (CMA) CCC locked the cart.An interview with CMA CCC, on 6/8/2025 at 10:35 am, revealed they believed the nurse was on break. The CMA attempted to contact the nurse by phone but was unsuccessful. The CMA locked the cart at 10:35 am and stated they would have the Licensed Practical Nurse (LPN) come and speak with me when she was back on the floor.An interview with LPN EE on 6/8/2025 at 11:00 am revealed that they left the faciity on 6/8/2025 at 10:00 am to take a Certified Nursing Assistant (CNA) to get feminine hygiene products at a local retail store. The LPN stated they were gone for a minimum of 30 minutes, maybe longer because of traffic. The LPN stated they did not let any other nurses know they were leaving the facility. The LPN stated they did not leave her keys for anyone. The LPN stated they left in a hurry and forgot to lock their medication cart before leaving the facility.Observation on the third floor, on 6/8/2025 at 11:20 am, revealed that a medication cart beside the nurse station was unlocked. No nurses were in sight at the time of the observation. The medication cart was unlocked from 11:20 am to 11:25 am.An interview with LPN EE, on 6/8/2025 at 11:25 am, revealed that the nurse forgot to lock the medication cart again. The LPN stated she was too frazzled to remember anything.An interview with the Interim Director of Nursing (DON), on 6/8/2025 at 11:55 am, revealed LPN EE was terminated for leaving the medication cart unlocked multiple times and leaving the facility and not letting anyone know. The Interim DON stated that any staff member who must leave the facility during their shift is to let another nurse know, give a report, leave their keys, and clock out. The Interim DON stated the LPN was clearly incompetent and should not be caring for residents.A review of the Punch Detail Form (employee timecard) for LPN EE, on 6/9/2025 at 1:00 pm, revealed the LPN did not clock out when they left the faciity on 6/8/2025 to go to the retail store at 10:00 am.2. Interview with LPN FF, on 6/8/2025 at 11:15 am, revealed they were the on-call nurse for 6/8/2025. LPN FF stated they were called by the Weekend Floor Supervisor, LPN BB, on 6/8/2025 at 8:00 am, to come to the facility to be the nurse on the fourth Floor. LPN FF stated there were no nurses on the fourth floor when they arrived at 9:18 am. The LPN stated they counted the narcotics by themself and had no report on the residents.Interview with the Interim DON, on 6/8/2025 at 12:10 pm, revealed that no nurse should leave the facility until they have a replacement, give a report, count narcotics, and transfer the responsibility of the medication carts and residents to the oncoming nurse.A review of the Punch Detail Forms, for the night shift ending on 6/8/2025 at 7:00 am, revealed the Fourth Floor LPN DD clocked out at 7:50 am on 6/8/2025.A review of the Punch Detail Forms, for the night shift ending on 6/8/2025 at 7:00 am, revealed the Fourth Floor LPN CC clocked out at 7:43 am on 6/8/2025.A review of the Punch Detail Forms, for the night shift ending on 6/8/202025 at 7:00 am, revealed the Weekend House Supervisor LPN BB out at 8:02 am on 6/8/202025.A review of the Punch Detail Forms, for the day shift starting at 7:00 am on 6/8/2025, revealed the LPN FF clocked in on 6/8/2025 at 9:18 am.An interview with the Interim DON, on 6/10/2025 at 9:00 am, revealed that the Interim DON verified the Fourth Floor had no nurses from 8:02 am until 9:18 am on 6/8/2025.An interview with the Weekend Floor Supervisor LPN BB, on 6/13/2025 at 4:35 pm, revealed they were the floor supervisor on the night shift ending at 7:00 am on 6/8/2025. The LPN stated that at around 8:00 am, the Fourth Floor had no day shift nurses. The LPN stated they then called the on-call nurse, LPN FF, to come in and work. Once they made the call, they clocked out and left the facility. The LPN verified they left the Fourth Floor with no nurse coverage. The LPN stated they should not have left the facility until all floors had nursing coverage.A review of the facility policy titled Nursing Services and Sufficient Staff, dated 3/1/2024, revealed it is the policy of this facility to provide sufficient staff with the appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.3. April staffing hours for Friday, 4/4/2025, were 571.5 hours for the facility. Saturday, 4/5/2025 staffing hours for the facility were 562.5. Sunday, 4/6/2025, staffing hours were 482.0 for the facility. Monday, 4/7/2025, staffing hours were 518.0 for the facility. Friday

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observations, interviews, and resident council minutes reviews, and staffing record reviews, the facility failed to provide a registered nurse (RN) to provide care for eight hours a day during the weekends. This failure to provide an RN eight hours a day during the weekends could result in reduced quality of care and one-star staffing levels. Findings included:During a record review of the Resident Council Minutes, not dated, revealed Multiple residents say that the call light response sometimes takes up to three hours and that the RCA's (Resident Care Assistants) will come and turn off without resolving their issue. [Resident Council President] says that he has witnessed nurses coming in and leaving medications on tray tables without making sure that the resident has taken them.During an interview with the Scheduler Coordinator SS, on 5/27/2025 at 10:38 am, said, Capacity for the facility is 240 residents. There is a bad staffing shortage for nurses. Nurses have a full template, meaning they work three days a week and every other weekend. The second floor has two nurses. The third floor has three nurses, and the fourth floor has one nurse, and a unit manager assists.On 6/7/2025 from 12:46 am to 3:00 am, there were LPN (Licensed Practical Nurse) AA, LPN BB, LPN CC, and LPN DD. There was no RN listed on staff for Saturday, 6/7/2025. During an interview on 6/12/2025 at 2:58 pm, the Interim Director of Nurses (DON) said they meet 8 hours of RN coverage-Monday through Friday, and on the weekends, if we don't have an RN scheduled, the ADONs (Assistant Director of Nurses) are expected to come in for an 8-hour shift. There is an LPN ADON on the 2nd floor and an RN ADON on the fourth floor who may come in. The Interim DON said, I don't have enough staff to take care of all the residents.Record reviews of the March 2025 staffing hours revealed there was no RN coverage hours for March 1, 2, 3, 4, 5, 6, 8, 10, 11, 13, 14, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31. No RN coverage for 27 out of 31 days in March 2025.Record reviews of the April 2025 staffing hours revealed there was no RN coverage hours for April 1, 3, 4, 7, 8, 9, 10,12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 30. There was no RN Coverage for 25 out of 30 days in April 2025.Record reviews of the May 2025 staffing hours revealed there were no RN coverage hours for May 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 24, 25, (there was no staffing sheet provided for 5/26/2025), and 5/28/2025. There was no RN coverage for 23 out of 29 days in May 2025.During an interview with the Administrator regarding the RN coverage hours, on 6/16/2025 at 3:21 pm, revealed that these days show no RN coverage for eight hours a day, which is covered by the two ADONs that are RNs (only 1 ADON is an RN). Interim DON is an RN. The majority of MDS (Minimum Data Set assessment) staff (4) are RN's, but they don't provide direct care to the staff. These are the numbers that are sent on the PBJ (payroll-based journal); they are not included, sometimes they work the cart.

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	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observations and staff interviews, the facility failed to post the nurse staffing data daily at the beginning of each shift. The facility did not ensure the nurse staffing data was posted daily in a prominent place readily accessible to residents, staff, and visitors. This practice had the potential to affect all residents in the facility. The facility census was 205. Findings included:1. During observation of the facility lobby on 6/8/2025 at 10:05 am revealed that nurse staffing data was posted by the front door, dated 6/6/2025.An interview with the Interim Director of Nursing (IDON) on 6/8/2025 at 12:15 pm revealed that the staff schedule from 6/6/2025 should not be posted. The IDON stated that a new staffing sheet should be posted daily. The IDON stated she would look into where the staff posting for 6/8/2025 was and why it was not posted. An interview with the IDON on 6/12/2025 at 3:00 pm revealed that the front desk receptionist who was at the facility on Fridays was usually given the weekend staffing to leave for the weekend receptionists to post. This receptionist had an emergency on 6/6/2025 and had to leave early. Since the receptionist had to leave early, no staff posting sheets were left for the weekend receptionists to post in the lobby on 6/7/2025 and 6/8/2025.2. An interview on 5/21/2025 at 2:12 pm with R183, the Resident Council President, revealed that there was no staffing posted in the building or on any of the 3 halls.An observation on 5/21/2025 at 2:16 pm of the front desk, front hallway, and elevator areas, or anywhere on the first floor, revealed no staffing hours posted.An observation on 5/27/2025 at 10:19 am revealed there were no staff hours posted on the fourth floor.An interview on 5/27/2025 at 10:35 am with the Staff Development Coordinator revealed that they did not do the staffing hours.An interview on 5/27/2025 at 10:38 am with Scheduler Coordinator SS revealed that they did the staff hours posted at the front door with numbers and totals for the whole day.An observation on 5/27/2025 at 11:07 am revealed there were no staff hours posted on the third floor near either elevator.An observation on 5/27/2025 at 11:21 am revealed staff hours were observed above wheelchair height and above eye level of a person standing only at the front elevator, not the resident elevator, and only on the first floor.During a tour on 5/27/2025 at 12:23 pm with the Administrator revealed there were no staffing hours posted on the second floor.During an interview on 6/10/2025 at 12:35 pm with the Administrator, they said the only place staffing hours were posted was at the front door next to the elevator at the height of the Administrator's eyes. The Administrator squatted down and said, I think the residents could see the staffing if they had good eyesight, but we can lower it so that residents can see it.

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	115270	A. Building B. Wing	06/17/2025

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Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policy titled Medication Storage, the facility failed to ensure medication carts were locked and secured when unattended by authorized staff. This failure had the potential to allow unauthorized access to medications and biologicals by staff, residents, and visitors. The facility's census was 214 residents. Findings included:A review of the facility's policy titled, Medication Storage, implemented 3/1/2022 and last revised 3/1/2025, included . 1: 1a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. 1b. Only authorized personnel will have access to the keys to locked compartments. 1c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 1. During an observation on 5/22/2025 at 5:07 am, medication administration with Licensed Practical Nurse (LPN) JJJ revealed that the LPN JJJ left the medication cart unlocked and entered the resident's room to administer medication.During an interview on 5/22/2025 at 5:10 am, LPN JJJ revealed she had forgotten to lock the medication cart before entering the resident's room.During an interview on 5/30/2025 at 12:11 pm, the Interim Director of Nursing (DON) revealed that all medication carts were to be locked when unattended. The Interim DON stated that the nurse or medication aid should never leave the medication cart unlocked if unattended.During an observation on 6/2/2025 at 10:21 am of the medication cart on the third floor revealed the cart was unlocked and unattended. The medication cart had two bags of gastrostomy supplements and one bottle of gastrostomy supplements sitting on top of the cart.During an interview on 6/2/2025 at 10:23 am, LPN RRR revealed she had no knowledge of whose medication cart it was. LPN RRR removed the gastrostomy supplements from the top of the cart and placed them in the medication room.During an interview on 6/2/2025 at 10:30 am, LPN YY revealed that the cart that was unlocked belonged to her. LPN YY stated she did not normally leave the cart with gastrostomy supplements exposed or the medication cart unlocked and/or unattended. 2. Observation of the 4th Floor, on 5/30/2025 at 8:25 am, revealed a medication cart was unattended and unlocked in the hall outside of room [ROOM NUMBER]. There was no nurse in sight at the time of the observation. The medication cart was unlocked and unattended from 8:25 am to 8:28 am. During an interview with LPN YY on 5/30/2025 8:28 am, they stated that they heard someone coughing down the hall and stepped away from the medication cart.An observation of the third floor on 6/8/2025 at 10:15 am revealed that the medication cart beside the nurse station was unlocked. There were no nurses on the floor at the time of the observation. Resident (R) 422 was sitting by the unlocked medication cart. The medication cart was unlocked from 10:15 am until 10:35 am, when a Certified Medication Aide (CMA) CCC locked the cart.An interview with CMA CCC on 6/8/2025 at 10:35 am revealed they believed the nurse was on break. An interview with LPN EE on 6/8/2025 at 11:00 am revealed they left the faciity on 6/8/2025 at 10:00 am and they were gone for a minimum of 30 minutes, maybe longer because of traffic. The LPN stated they left in a hurry and forgot to lock their medication cart before leaving the facility. Observation on the third floor, on 6/8/2025 at 11:20 am, revealed that a medication cart beside the nurse station was unlocked. There were no nurses in sight at the time of the observation. The medication cart was unlocked from 11:20 am to 11:25 am. An interview with LPN EE, on 6/8/2025 at 11:25 am, revealed that the nurse forgot to lock the medication cart again. The LPN stated she was too frazzled to remember anything. An interview with the Interim Director of Nursing (IDON), on 6/8/2025 at 11:55 am, revealed LPN EE was terminated for leaving the medication cart unlocked multiple times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and review of facility policy titled Standardized Menus, the facility failed to serve food that was palatable, attractive, and hot for four of seven sampled residents (R) (R62, R114, R472, and R473) reviewed for food palatability. This failure had the potential to affect 203 of 214 residents who consumed food prepared from the facility's kitchen.Findings included:A review of the facility's policy titled, Standardized Menus revised 3/30/2025, revealed that the facility shall provide nourishing, palatable meals to meet the nutritional needs of the residents based on the Recommended Daily Allowances (RDA) of the food and Nutritional Research Council, of the National Academy of Sciences, standardized cycle menus are planned in advance and utilized. The policy continued that the facility will make reasonable efforts to provide food that is appetizing and culturally appropriate for residents. A review of the Resident Council Meeting Minutes dated 2/2/2024 at 10:10 am revealed that resident complained that they sometimes receive their food cold, and it would be better if it were passed out in a better timely manner. A review of Resident Council Meeting Minutes dated 7/3/2024 at 10:07 am revealed that fourth floor residents said that the CNAs need to be quicker in serving their trays because when they receive the food, the food is cold. A record review of Resident Council Meeting Minutes dated 9/3/2024 at 10:07 am revealed that fourth floor residents say that the CNAs need to be quicker in serving their trays because when they receive them, the food is cold.A record review of Resident Council Meeting Minutes dated 3/3/2025 at 10:10 am revealed that the food served over the weekend was too tough and that the food was not served hot. A record review of Resident Council Meeting Minutes, undated, revealed that the food on the weekends was not good, and the vegetables were mushy.1. A review of the Electronic Medical Record (EMR) for R114 revealed an original admission date of 5/13/2022 with multiple diagnoses of, but not limited to, metabolic encephalopathy, dysphagia following cerebral infarction, acute pulmonary edema, Type II diabetes, hemoptysis, cognitive communication deficiency, and dysphagia. A review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed R114 had a Brief Interview for Mental Status (BIMS) score of eight, indicating R114 had moderately impaired cognition.During an interview on 5/21/25 at 1:06 pm, R114 asked if something could be done about the food because it's just so horrible. 2. A review of the EMR for R472 revealed an original admission date of 4/17/2025 with multiple diagnoses of but not limited to, FRACTURE OF UPPER end of right humerus, type II diabetes mellitus with diabetic nephropathy, metabolic encephalopathy, orthostatic hypotension, chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease, and acute kidney failure. A review of the admission MDS assessment dated [DATE] revealed R472 had a BIMS score of 14, indicating R472 is cognitively intact.During an interview on 5/7/2025 at 9:47 AM, R472 stated that the food was cold 98% of the time. R472 continued that she gets served on Styrofoam plates sometimes. She had the same thing over and over, green beans and rice four days in a row.3. A review of the EMR for R473 revealed an original admission date of 5/6/2025 with multiple diagnoses of, but not limited to, displaced fracture of an anterior wall of left acetabulum, fracture of unspecified lumbar vertebra, fracture of sacrum, dislocation of left shoulder joint, dislocation of right shoulder joint, sacroiliitis, and unsteadiness on feet. A review of the admission MDS assessment dated [DATE] revealed R473 had a Brief Interview for Mental Status (BIMS) score of 15, indicating R473 is cognitively intact.During an interview on 5/28/2025 at 9:55 am, R473 revealed there were no plates on the weekend and the hot dogs for lunch on Sunday. Additionally, the dinner meal had questionable meat, so she ended up ordering out. R473 stated that there are a lot of residents who order online food delivery services.On 5/28/2025 at 12:03 pm, a test tray was requested. The regular meal was Caribbean Shrimp, baked potatoes, and coleslaw. The test tray was received on 5/28/2025 at 1:33 pm. The facility staff was asked to taste the test tray with the surveyor. During an interview on 5/28/2025 at 1:33 pm, Resident Care Assistant (RCA) NNN refused to taste the food with the surveyor. During an interview on 5/28/2025 at 1:34 pm, Certified Nursing Assistant (CNA) PPP also refused to taste the food with the surveyor when asked to taste the test tray. On 5/28/2025 at 1:35 pm, RCA OOO offered to taste the food with the surveyor. During an interview on 5/28/2025 at 1:35 pm, RCA OOO revealed that the potatoes were bland. When tasting the Caribbean shrimp, she spat out the shrimp. RCA apologized but had to spit out the food because it was the nastiest thing she had ever tasted. RCA OOO continued, she wouldn't want to eat that food, nor would she want any of her family members to eat that either. RCA OOO walked away in tears. During an interview on 5/28/2025 at 4:42 pm, R473 revealed she did not eat the lunch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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 the interview and record review, the facility's previous Director of Nursing (DON) failed to administer the facility in a manner that enabled the use of resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one of 48 sampled residents (R) (R124). The facility's systemic failure to notify R124's physician of abnormal laboratory results, assess, and provide R124 with sufficient intravenous (IV) fluids, interventions/fluid intake to maintain proper hydration and health, placed the resident at risk. On [DATE], 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 was informed of the Immediate Jeopardy (IJ) for F692, F710, and F835 on [DATE] at 3:00 pm. The noncompliance related to the IJ was identified to have existed on [DATE]. 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 [DATE]. Findings included:Record review of the Notification of Changes Policy dated [DATE] and revised on [DATE]. Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Record review of an admission Record revealed R124 is an [AGE] year-old male admitted to the facility on [DATE] with medical history that included but was not limited to dementia, dysphagia, gastric tube, sepsis, urinary tract infection, hypovolemia, hyperosmolality, and hypernatremia, chronic obstructive pulmonary disease, essential hypertension, atrial fibrillation, and seizures. Record review of a Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], revealed R124 has a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was dependent for all activities of daily living (ADL) care, required PEG-tube feedings, was bedfast, and was non-verbal.Record review of R124's Care Plan included a focus area initiated on [DATE], which indicated the resident requires tube feeding (PEG) related to dysphagia. Interventions directed staff to observe/document/report as needed (PRN) any symptoms of aspiration-fever, shortness of breath, tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration date initiated [DATE]. Record review of physician orders dated [DATE] revealed R124's facility physician (MM) ordered comprehensive metabolic panel (CMP) labs that revealed R124 had an abnormal blood sodium level of 151 mEq/L (hypernatremia - high blood sodium level). (Normal Sodium 136 - 145 mEq/L)Record review revealed the facility's previous DON reviewed/audited R124's CMP labs on [DATE] at 10:43 am. The DON failed to take immediate action after reviewing R124's abnormal CMP labs on [DATE] at 10:43 am; they did not notify/follow up with physician MM to request interventions to prevent serious injury, serious harm, serious impairment, or death.Record review of nurse progress notes dated [DATE], a nurse observed R124 in bed using accessory muscles to breathe, and he was unresponsive. R124's oxygen saturation levels were out of range. 100% oxygen was applied with no improvement. R124's physician, MM was notified of the resident's change in condition, and physician MM gave orders to send R124 to the hospital.Record review of hospital CMP labs dated [DATE] revealed R124's abnormal blood sodium level had progressed to 161 mEq/L. R124 was hospitalized for 24 days on continuous IV fluids for severe dehydration, weakness, and acute respiratory failure. This failure resulted in a preventable hospitalization on [DATE].During an interview on [DATE] at 1:09 pm, the interim DON stated that it is her responsibility to hold nursing staff and the physicians accountable for completing their job duties. The interim DON also stated that audits will be conducted by checking the admissions, pulling out records, and completing the audit check to make sure that nothing is missed. Interim DON further stated that audits for labs will be performed on a weekly or daily basis, depending on what might be going on at that time in the facility.The facility implemented the following actions to remove the IJ: 1. R124 was discharged from the facility on [DATE]. 2. On [DATE], the DON and Assistant DON began reviewing resident labs for the past two weeks to ensure that any abnormal labs from the last two weeks had physician notification and were addressed to provide adequate hydration as needed. 3. The Chief Clinical Officer (CCO) on [DATE] in-serviced the DON and Assistant DON on the Notification of Changes policy and Hydration policy to ensure that review of labs, notification to providers are done timely and correctly to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record reviews of the facility assessment and staff interview, the facility failed to complete the facility assessment. This deficient practice has the potential to affect all residents. The facility census was 214 residents.Findings included:The Facility Assessment for Perimeter Rehabilitation Suites, dated 10/25/2024 by the Executive Director [Administrator] and reviewed by QAA (Quality Assessment and Assurance) Committee on 10/25/2024, section titled Information about our staffing patterns indicates Five Star Staffing Level is a 1 star. Administration- Staffing as described above is adequate as evidenced by: The resident's administrative needs are met. Information about our Staffing Patterns: Individual staff assignments are determined in order to promote continuity of care for residents within and across the assignments in the following ways: Maintaining the same staff on every floor as much as possible. Maintaining the staff based on the budgeted PPD and census. Staffing goals based on the information described above: The goal is to have actual PPD to be the same as (end of statement) . Specialized Rehabilitation Services: Staffing as described above is adequate as evidenced by: The actual PPD is on average above or at the budgeted PPD, and the department functions and provides the services needed. Behavioral Health Services: Staffing is adequate for caring for residents with dementia, mental health conditions, or a history of trauma, as evidenced by: The residents' behavioral health services are being met by the social services staff and the contracted psych services. Other: Staffing for all other departments and support staff is adequate as evidenced by: The residents' needs are being met. On 6/4/25 at 3:05 pm, the Administrator said the facility assessment was complete, even with incomplete sentences and blanks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0880 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's policies titled Infection Surveillance and Laundry, 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. The facility failed to ensure an ongoing system of surveillance for infections and failed to ensure the laundry room and equipment were kept clean, ensure washers were functioning properly, and ensure clean and dirty linens were stored appropriately. The deficient practices had the potential to affect all residents in the facility. The facility census was 212. Findings included: A review of the facility policy titled Infection Surveillance dated 6/1/2024 revealed that under Policy, A system of infection surveillance serves as a core activity of the facility's infection prevention and control programs. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices to reduce infections and prevent the spread of infections. Under Policy Explanation and Compliance Guidelines: .7. Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends. A review of the facility policy titled Laundry dated 1/1/2023 revealed under Policy Explanation and Compliance Guidelines: .3. Soiled laundry shall be kept separate from clean laundry at all times.5. Laundry equipment will be used and maintained according to the manufacturer's instructions. 1. A review of the Monthly Infection Control Logs (Line Lists) for February 2025, March 2025, and April 2025 revealed that the April 2025 Monthly Infection Control Log did not include information on cultures, date culture obtained, type of organism, and antibiotic resistant status, completed for 35 of 37 infections in April 2025. An interview on 5/29/2025 at 8:45 am with the facility's Infection Control Preventionist (ICP) revealed that the Monthly Infection Control Log was not completed entirely in April 2025. The ICP stated, I must have been busier than normal that month. The ICP stated that all sections of the Monthly Infection Control Log should be completed with up-to-date and accurate information, including cultures. 2. Observation of the facility's Clean Laundry Room on 5/29/2025 at 9:00 am revealed a covered linen cart with clean towels on top of the cart. Housekeeper FFF took the linens from the top of the cart and placed them inside the covered cart. There were also two wet, unfolded hand towels on a designated clean storage rack in front of the washers. Another designated clean storage shelf was visibly soiled and dusty, and had four unfolded employee gowns on top of clean towels. The floor of the room was visibly soiled, had several tissues and paper towels on the floor, and was sticky to walk on. The washer was in use and was actively leaking a white fluid from the door of the washer down to the floor. The door of the washer had a buildup of rust and a hard green substance. The base of the wall across from the dryers was cracked and missing large sections. During an observation of the facility's Dirty Laundry Room on 5/29/2025 at 9:10 am revealed that the sink was visibly soiled with red and brown residue. There was a pipe above the sink that was leaking a stream of constant water that was running down the wall onto the floor. The base of the wall across from the dryers was broken and missing in large sections. The wall above the sink in the Dirty Laundry Room has two holes beside a leaking pipe. During an interview with Housekeeper FFF on 5/29/2025 at 9:12 am revealed that clean linens should not be on the top of the clean linen cart, but inside it. The Housekeeper stated the washer had been leaking for several months. The Housekeeper stated she had told her supervisor about the leaking washer multiple times. The Housekeeper stated that the wet towels placed on the clean linen shelf in front of the washer were used to wipe up water from the leaking washer. The Housekeeper verified that the washers needed cleaning. The Housekeeper stated that the pipe above the sink in the Dirty Laundry Room constantly dripped water down the wall and onto the floor. The Housekeeper stated they have reported the pipe leaking water to their supervisor. The Housekeeper stated they would clean the sink in the Dirty Laundry Room. The Housekeeper stated they were unsure why the employee gowns were on the clean shelf in the Clean Laundry Room. During an interview with the Housekeeper Supervisor (HS) on 5/29/2025 at 9:15 am revealed that they were aware of the holes in the walls, the leaking washer, and the leaking pipe. The HS verified that both the Clean and Dirty Laundry Rooms needed to be cleaned, including the floors. The HS stated they would have the staff clean the washers, floors, shelves, and sink immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to have handrails that were firmly secured and affixed to the corridor walls on three of the three resident floors of the facility (Second Floor, Third Floor, and Fourth Floor). Specifically, handrails were loose and crooked throughout each floor. The deficient practice had the potential to affect the residents who can use handrails on all floors. Findings included:The Director of Maintenance job description, revised in October 2020, revealed that the facility will conduct ongoing inspections to identify areas and equipment requiring improvement/repairs. Examine equipment, systems, and physical plant (i.e., buildings) to determine needed installations, services, or repairs.During an observation of the Third Floor on 6/8/2025 at 10:20 am, the handrails across from the Third Floor nurse station were loose and hanging crooked on the wall. The handrails across from room [ROOM NUMBER] were loose and hanging crooked on the wall. The handrails across from room [ROOM NUMBER] were loose and hanging crooked on the wall. During an interview with the facility's Maintenance Director (MD) on 6/9/2025 at 9:20 am revealed that the handrails were loose on all floors, and they were in the process of repairing them. During an observation on 6/10/2025 at 11:09 am, the handrails across from rooms [ROOM NUMBER] were loose and hanging crooked on the wall.During an observation on 6/10/2025 at 11:24 am, the handrails across from room [ROOM NUMBER] were loose and hanging crooked on the wall by the hallway window.During an interview with the facility's MD on 6/11/2025 at 11:00 am, they stated all staff were responsible for checking handrails, and the nurses should create a ticket in the TELS system (maintenance tracking and ordering system). The MD indicated that Maintenance was responsible for the repairs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review, interview, and review of the facility policy titled Nurse Aide Training Program, the facility failed to ensure each Certified Nursing Assistant (CNA) employed by the facility had a minimum of twelve hours of nurse aide training per year, for one of five CNAs reviewed for the required training. Findings included:A review of the facility policy titled Nurse Aide Training Program dated 3/1/2025, revealed that each nurse aide shall be provided 12 hours of in-service training annually. A review of the required yearly Training Transcript for CNA HHH revealed that from April 2024 to April 2025, the CNA only had 10.7 training hours. During an interview with the Interim Director of Nursing (IDON) on 6/5/2025 at 8:35 am, it was confirmed that CNA HHH did not meet the required twelve hours of CNA training from April 2024 to April 2025.