STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115271	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Early Memorial Nursing Facility	11740 Columbia Street Blakely, GA 39823

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on staff and resident interviews, record review, and review of the facility's policy titled, Abuse, Neglect and Exploitation, the facility failed to ensure residents were free from resident-to-resident abuse for two of 22 sampled Residents (R) (R6 and R7). Specifically, R7 was observed to hit R6 on the buttocks. Findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation, implemented on 10/25/2024 revealed, Policy: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subject to abuse by anyone including, but limited to facility staff, other residents. 1. Review of R7's undated admission Record located in the resident's electronic medical record (EMR) under the Profile tab revealed R7 was admitted with diagnoses of peripheral vascular disease, mental disorder due to physiological condition, and irritability and anger.Review of R7's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/1/2024 revealed a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15 which indicated a cognitively intact mental status. 2. Review of R6's undated admission Record located in the EMR under the Profile tab revealed R6 was admitted with diagnoses dysphagia, epilepsy, and dementia.Review of R6's quarterly MDS with an ARD of 7/17/2024 revealed the facility assessed the resident to have a BIMS score of 0 out of 15 which indicated the resident was severely cognitively impaired.Review of the facility investigation provided by the facility revealed on 8/14/2024 at 10:45 am, this morning during prayer meeting service [R7] hit [R6] on the butt. [R6] was walking around the room when she stopped at the table by the window rearranging items on the table. At this time [R7] became upset telling [R6] to leave stuff alone and proceeded to hit [R6].During an interview on 7/16/2025 at 9:33 am, Activities Assistant (AA) recalled R6 would wander around the room during activities and R7 had some items that R6 was moving around the table. AA recalled R7 stated to R6 to move away and R7 hit R6 before anyone could reach them.During an interview on 7/16/2025 at 9:56 am, R6 was lying in the bed watching TV. R6 was asked about the incident. R6 did not respond and just watched the TV.During an interview on 7/16/2025 at 2:30 pm, R7 was seated in the dining room and scratching off cards. R7 was asked about the incident and stated that there had not been any problems with anybody in the facility.During an interview on 7/16/2025 at 3:35 pm, the Director of Nursing (DON) recalled the AA reported that R7 had popped R6 on the butt. The DON stated R7 was immediately placed on one-to-one supervision and sent to the hospital.During an interview on 7/16/2025 at 3:51 pm, the Administrator recalled the incident and stated the incident was substantiated due to contact being made by R7 to R6.

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

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

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F 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. Based on staff interviews, record review, and review of the facility's policy titled, Abuse, Neglect, and Exploitation, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime and reporting of all alleged sexual abuse violations to the State Agency (SA) for one of three Residents (R) (R3) reviewed for abuse out of a total sample of 22 residents. The deficient practice had the potential for continued episodes of unreported abuse, which posed potential for physical harm and/or mental anguish for the victimized resident.Findings include:Review of the facility's policy titled, Abuse, Neglect, and Exploitation revised 10/25/2024, revealed Alleged violation is a situation or occurrence that is . reported by staff, resident, relative, visitor, or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to. abuse. All allegations of abuse must be reported immediately to the designated Abuse Coordinator. Anyone in the facility can report suspected abuse. When abuse . is suspected, staff should . notify the Abuse Coordinator and/or Director of Nursing. Abuse Coordinator should ensure that all alleged violations involving abuse. are reported to the State Survey Agency per State and Federal guidelines. If the allegation rises to the level of a crime, suspicion of a crime, or results in serious bodily injury ensure this is reported within 2 hours.Review of R3's Profile Screen located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted with diagnoses of Alzheimer's disease, psychosis, mood disorder, anxiety disorder, dementia, depression, delusional disorder, and adjustment disorder.Review of R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/6/2024 located under the MDS tab of the EMR, revealed the resident had a Brief Interview of Mental Status (BIMS) score of nine out of 15, which indicated the resident had moderate cognitive impairment.Review of R3's Care Plan located under the Care Plan tab of the EMR, revealed the resident had a care plan for auditory and visual hallucinations dated 6/4/2024.Review of the intake form received from the SA revealed the SA received the report of the allegation of sexual abuse on 10/31/2024.Review of the facility provided investigative documentation dated 11/7/2024, revealed the facility was notified by family member (F) 3 on 10/13/2024 that R3 expressed that something sexually happened to her earlier in the month.Review of R3's Progress notes under the Prog notes tab of the EMR dated 10/13/2024, revealed F3 visited R3. There was no documentation of the allegation.Review of a written statement by Licensed Practical Nurse (LPN) 1, dated 10/31/2024, revealed, On 10/13/2024, I, [LPN3], was informed by [F3] that [R3] said or expressed that something sexually had happened to her. This nurse went to patient's room, CNA was present.Review of a written statement by Certified Nursing Aide (CNA) 3, dated 11/1/2024, revealed, On 10/13/2024, I witnessed [R3], when being asked if anyone had been inappropriate with her in any way. she answered no .During an interview on 7/16/2025 at 10:33 am, LPN3 confirmed she had been notified by F3 that R3 had expressed a sexual assault allegation and stated, It was not reported because [R3] denied that anything had happened to her and [F3] said that maybe [R3] was just dreaming and maybe it would be ok.During an interview on 7/15/2025 at 5:05 pm, the Administrator stated, Family reported the sexual abuse allegation to a staff member on 10/13/2024 but did not report to me. I became aware on 10/31/2024 through a grievance and reported to the [SA].

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interviews, record review, and review of the facility's policy titled, Verbal Orders, the facility failed to ensure medications were received from the pharmacy and available for administration for one of six Residents (R) (R1) reviewed for medications out of a total sample of 22 residents. The deficient practice resulted in a resident not receiving prescribed anti-psychotic medication for 32 days.Findings include:Review of the facility's undated policy titled, Verbal Orders, indicated Follow through with orders by making appropriate contact or notification (e.g., lab or pharmacy). Review of R1's Profile Screen located under the Profile tab of the electronic medical record (EMR) revealed the resident was admitted with diagnoses of bipolar disorder, psychotic disorder with delusions, anxiety disorder, and major depressive disorder. Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date(ARD) of 5/14/2025 located under the MDS tab of the EMR, revealed the resident had a Brief Interview of Mental Status (BIMS) score of 12 out of 15, which indicated the resident had moderate cognitive impairment. Review of R1's Care Plan located under the Care Plan tab of the EMR, revealed the resident had a care plan for psychotic disorder with hallucinations dated 9/10/2024 and used psychotropic medications related to psychosis with an intervention that psychotropic medications were to be administered as ordered and observed for effectiveness of medications. Review of R1's Physician's orders located under the Orders tab of the EMR, revealed a physician's order dated 9/4/2024, for quetiapine fumarate [an antipsychotic medication] tablet 200 milligrams [mg] give one tablet by mouth at bedtime for psychosis. A copy of the quetiapine pill card showed the medication was not filled by the pharmacy until 10/7/2024. R1 did not receive the quetiapine medication from 9/4/2024 until filled on 10/7/2024. During an interview on 7/14/2025 at 4:05 pm, the Administrator stated, The quetiapine [Seroquel] did not come from the pharmacy until 10/7/2024. During an interview on 7/15/2025 at 12:20 pm, the Director of Nursing stated, I can't recall exactly how the discrepancy was found. I believe one of the nurses was reviewing medications with the family. The resident's medications were filled by a community pharmacy per their request. The family had called the pharmacy to inquire about the medication. [UM1] spoke with the pharmacy. The process is that we send the order to the pharmacy and the pharmacy delivers the medication to our facility. We don't have a policy/procedure on ordering new medications. During an interview on 7/15/2025 at 12:32 pm, the Unit Manager (UM) 1 stated, A day shift nurse had reviewed medications with the family and discovered that the resident had not been receiving the medication [quetiapine]. Initially, I faxed the order to the community pharmacy on 9/4/2024 when the resident returned from the hospital. I resent the order to the community pharmacy on 10/7/2024 when it was discovered that the order had not been filled. Normally, I come to work at 6 am to communicate with night shift staff. No one communicated that the medication was not available.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interviews, and review of the facility's policy titled, Medication Storage Policy, the facility failed to ensure medications were stored securely for one of five medication carts (Wing 2-North). This had the potential for residents, visitors, or unlicensed staff to have access to the medications.Findings include:Review of the facility's policy titled, Medication Storage Policy, dated 6/20/2018 revealed, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.During an observation on 7/15/2025 at 9:02 am of the medication cart located in the hallway near room [ROOM NUMBER], an intravenous (IV) bag of vancomycin (an antibiotic) and a bottle of vitamin D3 were found sitting on top of the medication cart. A housekeeper was in the area near the medication cart. At 9:07 am, Licensed Practical Nurse (LPN) 1 came walking down the hallway from around the corner. The cart was not in sight of the nurse at this time. LPN1 then proceeded to unlock the medication cart and place the medications in the cart after the observation was made by the surveyor.During an interview on 7/15/2025 at 9:21 am, LPN1 stated, I left the medications on top of the cart by mistake. They should not be left on top of the cart.During an interview on 7/15/2025 at 12:20 pm, the Director of Nursing (DON) stated, The expectation is that medications should not be left sitting on top of the medication cart. Medications should be kept locked in the medication cart. We have a lot of dementia residents.