STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115273	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglasville Nursing and Rehabilitation Center	4028 Hwy 5 Douglasville, GA 30135

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35817 Based on observations, record reviews, and interviews, the facility failed to provide services with reasonable accommodation of needs for one of 28 sampled residents (R) (R6) related to scheduled appointments. Findings included: 1. A review of R6's undated Admission Record revealed R6 was admitted to the facility with diagnoses including but not limited to chronic obstructive pulmonary disease (COPD). A review of R6's quarterly Minimum Data Set (MDS) dated [DATE] revealed R6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS further revealed R6 was dependent on staff for toileting and chair/bed-to-chair transfers. An observation and interview on 10/7/2024 at 12:40 pm with R6 in her room revealed the resident was in bed and a large personal wheelchair was inside the room. R6 stated that she missed her appointment last week with her pulmonologist (lung doctor) because her wheelchair did not fit inside the transportation van. R6 further stated that there was a facility wheelchair that fit inside the transportation van, but the facility scheduler was unable to find it for the resident to use. An interview on 10/9/2024 at 10:41 am with Transportation Staff (TS) EE revealed she was newly assigned to her position, and that R6 told her the day before the missed appointment that R6's wheelchair would not fit in the transportation van. TS EE called the Staff Transportation Company (STC) and received confirmation that a wheelchair would fit inside the transportation van. TF EE further stated that it was her mistake to assume that R6's personal wheelchair was the same wheelchair that the STC confirmed. TS EE stated she should have communicated with the previous facility scheduler who had knowledge of the facility's wheelchair previously used by the resident, which she later discovered was stored inside the facility's bus for whoever needed to use it. An interview on 10/10/2024 at 10:15 am with the Director of Nursing Services (DNS) revealed that there was no facility policy for scheduling or arranging transportation for residents outside appointments with other providers such as pulmonologists. The DNS stated, This had nothing to do with professional standards of service. An interview on 10/10/2024 at 10:30 am with TS EE revealed that she did not have any documentation to validate her communications with R6, with the STC, or with the previous facility scheduler.

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35817 Based on observations, interviews, and record reviews, the facility failed to provide toileting assistance and assessment and treatment of a bleeding right leg to one of three sampled residents (R) (R7). Findings included: A review of the undated facility's policy and procedure titled, Subject: Abuse Prevention, indicated: Policy: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Definitions: . f) Neglect: A failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, mental anguish, emotional distress, or pain . IDENTIFICATION: . 2. The Executive Director and Director of Nursing Services must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Executive Director and Director of Nursing Services must be called at home or must be paged and informed of such incidents. PROTECTION: 1. Any allegation of abuse, neglect, misappropriation or exploitation against any employee must result in his/her immediate suspension to protect the resident . REPORTING: The facility will report any knowledge of actions by a court of law against any employee, that would indicate any unfitness for service as a nurse aide or other staff member to the state nurse's aide registry or licensing authorities. Alleged violations involving abuse, neglect, exploitation, or mistreatment ., are reported immediately but not later than 2 hours after the allegation is made . to the administrator of the facility and to other officials (including State Survey Agency, APS, and local law enforcement as required). A review of the facility's job description titled Job Title: Certified Nursing Assistant (CNA), dated 8/1/2012, revealed General Description: Performs resident care activities and related non-professional nursing services under the direction of the Supervisor to provide quality care of residents. Essential Duties: 1. Provides individualized attention and nursing care in accordance with the resident Care Plan which includes communicating, assistance with grooming, bathing, oral hygiene, turning, incontinent care, toileting, colostomy care, prosthetic appliances, transferring, ambulation, and range of motion, as appropriate. A review of R7's Electronic Medical Record (EMR) revealed that R7 was initially admitted to the facility on [DATE] and readmitted on [DATE] for diagnoses including end-stage renal disease, dependence on renal dialysis, diabetes mellitus, and infection of amputated left lower limb. A review of R7's Annual Minimum Data Set (MDS) assessment dated [DATE], revealed R7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS further revealed that R7 required substantial/maximal assistance from one person for toileting. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/8/2024, at 12:25 pm, with Licensed Practical Nurse (LPN) DD revealed that R7's bedside commode was observed with dried bowel movements inside it and on the toilet seat. LPN DD confirmed that the bedside commode was not cleaned and should have been cleaned by the assigned CNA per shift. An observation and interview on 10/9/2024, at 12:29 pm, with R7 in his room, the resident was observed sitting on his bed with his left lower extremity amputated stump and his right lower leg wrapped loosely with gauze. R7 stated that he was not being assisted to the bedside commode and staff were not cleaning his bedside commode. R7 further stated he called 911 the previous night for chest discomfort because the staff was not attending to his call light. R7 showed a cell phone video he recorded from the previous week with his bleeding right leg while he was screaming for staff to help. A review of R7's recorded video revealed night shift LPN EE came inside his room and stated, What do you want, you have to wait for the wound care nurse tomorrow, I don't have the key, I don't have anything, I'll come back. R7 was observed teary-eyed and stated, This was how I'm being treated here; they would not answer my call lights, and I had to scream and beg for help. R7 further stated he was very frustrated that CNAs didn't assist him with toileting, did not clean his bedside commode, and that LPN EE never came back to assess, wrap his bleeding right leg, or notify the physician about his bleeding right leg. R7 further revealed that he told his Family Member (FM) and the Advance Registered Nurse Practitioner (APRN) about the alleged abuse. A concurrent observation on 10/9/2024, at 12:29 pm, with LPN AA, revealed R7's bedside commode appeared to be in the same location as observed the day before with dried bowel movement inside it and on the toilet seat. LPN AA stated that the bedside commode should be cleaned by the CNAs assigned to R7 after every use. An interview on 10/9/2024, at 10:30 pm, with LPN EE, revealed that she was responsible for giving PRN (as needed) medications to R7, and the CNA HH was assigned to clean the bedside commode. LPN EE was asked how R7 transferred to his bedside commode, LPN EE stated that she did not know how R7 transferred to the bedside commode and that CNA HH should be the one to provide transfers and assistance with toileting R7. LPN EE further stated all nurses including her and CNA EE were supposed to attend to R7's call light. LPN EE further revealed and denied allegations of abuse for not helping R7 with his bleeding right leg. An interview on 10/9/2024, at 10:45 pm, with CNA HH, revealed that she had been employed by the facility for [AGE] years. CNA HH was asked how she provided assistance with toileting to R7, CNA HH stated that R7 was alert and oriented and she would only attend and provide assistance to R7 to use the bedside commode. CNA HH further stated that she discarded the used clear plastic bag liner from R7's bedside commode and replaced it with a new clear plastic bag liner when he was finished but she did not clean the bedside commode. CNA HH stated she should be assisting with R7's toileting and cleaning the bedside commode because it was soiled after resident's use. An interview on 10/10/2024, at 9:45 am, with the APRN, revealed that R7 notified her of the cell phone video recorded when R7 had an incident with his bleeding right leg, and he was screaming for staff to help. The APRN stated that she was going to wait to tell the DON and Executive Director until after the survey was over. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/10/2024, at 10:00 am, with the DNS, revealed that the CNAs were expected to clean the resident's bedside commode. The DNS stated that there was no facility policy for nursing standards of care. The DNS stated, CNAs should be checking R7's bedside commode every 12-hour shift. The DNS further stated that there was no documentation by CNAs that R7 was being assisted with toileting (bedside commode) per his comprehensive care plan. DNS agreed there was no way to validate the toileting assistance for R7 without documentation. An interview on 10/10/2024, at 12:42 pm, with the Executive Director, revealed that he was informed about the allegation of abuse in the morning after the Surveyor's interview with APRN was conducted. The Executive Director stated that he will be suspending LPN EE pending his investigations. An interview on 10/10/2024, at 12:43 pm, with the [NAME] President of Operations (VP Operations), revealed that he spoke to the APRN and the facility will be reporting the abuse allegation to the State.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35817 Based on observations, resident and staff interviews, record review, and review of the facility policy titled Abuse Prevention, the facility failed to ensure that an allegation of sexual abuse was thoroughly investigated to rule out abuse for two of 28 sampled residents (R) (R11 and R12). Findings included: A review of the facility policy titled Abuse Prevention dated October 2022 included definitions of different types of abuse. The policy defined, Sexual Abuse: This included, but is not limited to sexual harassment, sexual coercion or sexual assault, or non-consensual sexual contact of any type with a resident. The policy also indicated the facility would initiate an investigation at the time of any finding of potential abuse or neglect allegation to determine cause and effect and provide protection to any alleged victims to prevent harm during the investigation. A review of R11's electronic medical record (EMR) revealed they were admitted to the facility with multiple diagnoses, one of which included dementia. The most recent annual Minimum Data Set (MDS) assessment dated [DATE] showed the Brief Interview for Mental Status (BIMS) score could not be completed for R11 and a score of 99 was documented, indicating that the resident was unable to answer questions. The assessment showed R11 was dependent on staff to complete all their Activities of Daily Living (ADLs). During an observation on 10/8/2024 at 2:22 pm, R11 was observed dressed lying on the top of his/her bed asleep, and did not respond to verbal cues when greeted. During an observation on 10/9/2024 at 11:05 am, R11 was lying in bed sleeping, partially covered with blankets, and again did not respond to verbal queueing. A review of R12's EMR revealed they were admitted to the facility with multiple diagnoses including but not limited to bipolar disorder and insomnia. The most recent MDS assessment completed for R12 dated 7/30/2024 and revealed the resident was independent with ADLs and scored a 15 out of 15 on the BIMS test, which indicated they had no cognitive impairment. During an interview on 10/7/2024 at 11:00 am, R12 was greeted in their room, and when asked general questions about the facility, including care and services provided, the resident expressed satisfaction with the facility's services. On 10/7/2024 at 9:10 am, the Director of Nursing (DON) provided copies of the facility investigations for R12 and R11. However, there was no evidence of any other staff statements regarding the residents' interactions. In addition, there was no evidence other residents (who could respond) were interviewed to see if they experienced, observed, or heard of any similar incidents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a letter dated 8/6/2024 documented R12 had ambulated towards R11 via their wheelchair and kissed him/her on what appeared to be the lips the DON reported witnessing. When asked what they were doing, R12 responded they were kissing that resident but only on the cheek. The letter further revealed R11 was interviewed but [he/she] was not aware of the incident happening. Further review went on to describe R11 as has severe dementia and has a BIMS of 99. The letter also indicated, that when asked, R12 admitted he/she was kissing him/her but only kissed him/her on the cheek and stated that he/she reminded them of a family member. Further reading revealed a Social Worker (SW) counseled R12 and noted: that it was illegal to kiss an individual without their permission. [R12] stated that [he/she] didn't mean any harm and that [he/she] was sorry. A review of the letter addressed to the Georgia Department of Community Health (DCH) dated 8/6/2024 revealed the facility concluded: . suspected sexual abuse allegation unable to be substantiated at this time due to unclear motivation. A review of a two-page document titled Facility Incident Report Form dated 7/30/2024, documented at 3:45 pm under Type of incident with an asterisk found next to it revealed Resident to Resident. Under Details of Incident it also read R12 was seen by staff kissing R11. The next section of the form had yes and no written next to questions that included, Was there an injury? Treatment required? Physician notified? Responsible party notified? Police notified? Other agencies involved? However, there was no indication the yes or no answers to the questions had been provided by the reporter, the Administrator. In addition, the document did not identify the location of the incident. A review of the only other information provided was a witness statement dated 7/30/2024, signed by the DON, but did not identify what the DON observed as stated in the letter and the statement read [named resident] noted what happened to be leaning over to kiss [named resident] on the cheek. During an interview on 10/8/2024 at 2:30 pm, the Social Worker (SW) denied any other incidents involving either R12 or R11 had occurred in the past. They then explained R11 had severe dementia and did not have the cognitive ability to consent to any sexual contact. The SW further stated they talked to R12, who reported he/she had kissed the other resident because he/she reminded him of a family member. During an interview on 10/9/2024 at 2:26 pm with Licensed Practical Nurse (LPN) MM, who was working near the 300-hallway, when asked if they were aware of any residents who might be aggressive with others, they stated no. During an interview on 10/9/2024 at 2:30 pm with LPN II, assigned to a medication cart on the 300-hallway revealed when asked if they were aware of any residents who were aggressive with others, LPN II stated no. Follow-up interview on 10/9/2024 at 2:35 pm with the DON, when asked where the incident occurred, he/she stated it happened in the hallway outside the administrative offices. The DON denied any other witnesses were in the area, no staff or residents. When asked if nursing staff were aware of the incident, the DON said, Yes. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/2024 at 9:45 am with the Administrator and DON, when asked if they had interviewed other residents to determine if they had observed or experienced any problems while residing in the facility, they responded No. When asked if they had spoken to any staff about the residents' interactions with others, the DON stated they did ask staff about the two resident's interactions but did not have any written statements. When asked if the Care Plans had been updated the Administrator stated, don't need to update the Care Plan and said he/she could not understand if it was intentional.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35817 Based on record review, and resident and staff interviews, the facility failed to ensure that the resident environment remained free of accident hazards for one of four residents (R) (R16) related to receiving adequate supervision and assistance devices to prevent accidents. Findings included: A review of the facility's undated policy titled INVACARE TOTAL LIFT noted the Invacare Total Lift is to be used for total lifts and/or to obtain a resident's weight from bed to chair, chair to bed, or from the floor. Maintain contact with the resident in order to guide or steady the resident during lift, as necessary. A review of the Electronic Medical Record (EMR) revealed that R16 was admitted on [DATE] and readmitted on [DATE] with diagnoses including bipolar disorder, current episode mixed, mild, unspecified psychosis not due to a substance or known physiological condition, type two (2) diabetes mellitus with hyperglycemia, other specified disorders of the skin and subcutaneous tissue, and unspecified open wound, and left lower leg subsequent encounter. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that R16 was cognitively intact with a Brief Interview for Mental Status Score of 15 out 15; had functional limitations in the range of motion to both upper and lower extremities; and was totally dependent on staff for most activities of daily living including transfer between surfaces. A review of R16's care plan revealed no explicit plan that addressed how the resident should be transferred between surfaces other than simply identifying that R16 required assistance with activities of daily living (ADL) care related to impaired mobility secondary to Cardiovascular Accident. An additional review of R16's Physical Therapy evaluation dated 10/8/2024 revealed that R16 required a Hoyer lift, however, the evaluation report did not address the number of staff needed to safely operate the lift. A review of R16's nursing progress note dated 12/27/2023 at 10:30 am documented that while Certified Nursing Assistant (CNA) JJ was transferring R16 from bed to [NAME] chair with nurse Licensed Practical Nurse (LPN) PP [author of the note] on standby, the sling from the mechanical lift swung forward and R16's lower extremity contacted the bar on the mechanical lift. According to the progress note, R16 was assessed, and a lemon-sized swelling was noted on the resident's left lower extremity that was painful to touch. Further review of R16's medical record revealed the facility notified R16's attending Nurse Practitioner (NP) who ordered a stat (immediate) x-ray to rule out any fracture to R16's left lower limb which came back negative for any fractures. A review of the facility incident report dated 12/27/2023 at 10:30 am identified CNA JJ as the only witness to the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/8/2024 at 3:14 pm, R16 stated they sustained the reported injury to their left lower extremity when a CNA JJ attempted to transfer R16 from the bed to [NAME] chair using a mechanical lift and, in the process, R16's left shin hit the frame of R16's bed. R16 stated the task of transferring them with the mechanical lift was completed by two staff members, however, on the day of the incident CNA JJ was in R16's room without help and CNA JJ completed the task alone. During a telephone interview with LPN RR on 10/10/2024 at 9:29 am, LPN RR stated they were passing medication in a room adjacent to R16's room when CNA JJ went to transfer the resident. LPN RR clarified that when they documented being on standby, they meant they were available and could assist CNA JJ should CNA JJ need help with transferring R16. LPN RR stated they were not in the room with CNA JJ when CNA JJ completed the transfer and did not observe how the accident with R16 happened. LPN RR stated they did not recall their care and management of R16 after obtaining and executing the x-ray order which was negative for fracture. During an interview on 10/10/2024 at 10:40 am, CNA JJ (the CNA implicated for transferring R16 alone with the mechanical lift) stated they had informed LPN RR of their intention to transfer R16 with the mechanical lift and had gotten clear from LPN RR to be on standby should CNA JJ require additional support during the transfer. CNA JJ verified they transferred R16 alone using the mechanical lift. CNA JJ reiterated that during the cause of the transfer, the sling swung back and forth, and R16 hit their leg in the process. Per CNA JJ, they were not able to operate the lift and stabilize R16 simultaneously. CNA JJ stated they were educated after the incident to always have another staff member present when they needed to transfer any resident with a mechanical lift. During an interview on 10/10/2024 at 9:40 am, the Director of Rehab (DOR) stated the use of mechanical lifts required two staff to be hands-on with the mechanical lift during transfer. The DOR clarified that the requirement to have two staff present during the use of a mechanical lift was to ensure safety. The DOR went on to say that a mechanical lift could not be safely maneuvered with just one staff. The DOR emphasized that while one staff member operated the lift, it was important to have another staff present to stabilize the slings attached to the lift during the operation to prevent the sling from unsafe swinging which the DOR stated could result in an accident. In speaking specifically to the situation with R16, the DOR stated while they did not observe the incident firsthand, being on standby does not equate to the recommendation to have two staff hands-on during the operation of a mechanical lift. The DOR termed the practice of having staff on standby during the operation of a mechanical lift as a reactive strategy that does not necessarily prevent an accident as opposed to the preventive measure of having two staff get hands-on during a resident transfer with mechanical devices. During an interview on 10/10/2024 at 12:13 pm, the Director of Nursing stated the facility's practice with the use of mechanical lift was that one staff member was able to use the lift while another staff member was on standby. The Director of Nursing elaborated the meaning of standby to mean that a second staff member only needed to be in close proximity to where another staff member was using the mechanical lift with a resident. Per the Director of Nursing, the use of a mechanical lift does not require two staff members to be hands-on with the lift device and the resident during transfer.