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	06/27/2025

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled, Self-Administration Protocol, the facility failed to adequately assess two of 72 sampled Residents (R) (R65, R54) for self-administration of medication. The deficient practice had the potential to allow access to medications otherwise not prescribed by a physician to other residents. Findings include: Review of the facility's policy titled Self-Administration Protocol with a revised date of 8/2016 documented under Policy: Beside medication storage is permitted for residents who are willing and able to self-administer medication upon the written order of the prescriber, when it is deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team, and in accordance with start law. Under the section Procedure: 1. If the resident wishes to participate, the interdisciplinary team (IDT) will complete Medication Self-Administration Assessment. 2. A written order for the bedside storage of medication is placed in the resident's medical record. 5. The resident is instructed in the proper use of bedside medication is for, how it is to be used, how often It may be used, proper cleaning of inhaler, where appliable, proper storage if the medication, and the necessity of reporting g each dose used to the nursing staff. The completion of this instruction is documented in the resident's medical record. Periodic review of these instructions with the residents is undertaken by the nursing staff as deemed necessary. 1. R65 was admitted to the facility with a diagnoses of but not limited to hypovolemia (decreasing volume of blood plasma), other seizures, and vascular dementia. Review of R65's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Further review in Section O (Special Therapy and Treatment) revealed R65 had intravenous (IV) therapy. Review of the care plan revealed R65 no documentation for self-administration of medication. Review of Physician's Orders for R65 revealed no orders were found for 5 percent dextrose and 0.45 percent sodium chloride injection, united states pharmacopeia (USP) (parenteral fluid, nutrient and electrolyte replenisher). Review of Physician's Orders for R65 revealed no orders were found for heparin lock flush solution 50 usp units/5 milliliters (ml) (10 USP units/ml) sterile solution. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R65's electronic medical record (EMR) revealed no assessment for self-administration of medication. During an observation on 6/23/2025 at 2:34 pm revealed 5 percent dextrose and 0.45 percent sodium chloride injection, usp and heparin lock flush solution 50 usp units/5 milliliters (mL) (10 USP units/mL) sterile solution were found at R65's nightstand. During an observation and interview on 6/23/2025 at 2:56 pm with License Practical Nurse (LPN) LL stated R65 was not on IV therapy, and she was not assessed for self-administration of medication. She continued to state R65 once had an IV, but she pulled it out and did not recall the last time she had it. LPN LL further confirmed the IV bag was not supposed to be there. 2. R54 was admitted to the facility with diagnoses of but not limited to chronic pulmonary edema, acute and chronic respiratory failure with hypoxia, and unspecified osteoarthritis. Review of R54's quarterly MDS assessment dated [DATE] revealed a BIMS score of 13, indicating little to no cognitive impairment. Further review in Section O (Special Therapy and Treatment) revealed R65 received oxygen therapy. Review of the care plan revealed R54 no documentation for self-administration of medication. Review of Physician's Orders for R54 revealed albuterol sulfate HFA inhalation aerosol solution 108 (90 based) medication in micrograms (MCG)/per actuation (ACT). Review of Physician's Orders for R54 revealed fluticasone propionate nasal suspension 50 MCG/ACT. Review of Physician's Orders for R54 revealed no orders were found for diclofenac sodium topical gel, 1 percent (arthritis pain reliver). Review of R54's clinical record revealed there was no assessment for self-administration of medication. During an observation and interview on 6/23/2025 at 3:35 pm, R54 stated she recently went to the hospital and that was the medication given to her. She continued to state she self-administered the medication herself, and the nurses would assist her with it. An interview with LPN MM confirmed R54 was not assessed for self-administration of medication, and she did leave the medication on her bedside table. LPN MM continued to state she helped with the medication but R54 did the nasal spray on her own. LPN MM went on to reveal she did not know the facilities procedure for self-administration of medication. An interview on 6/25/2025 at 4:46 pm with the Director of Nursing (DON) revealed no one in the facility was assessed to administer medication and the nurses should know a resident should have an assessment done before assisting a resident with medication.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to maintain a clean, comfortable, homelike environment as evidenced by broken wall molding trim in three of 31 resident rooms (room [ROOM NUMBER], 320, and 324) on Unit 30. In addition, two wall tiles were broken in room [ROOM NUMBER]. Findings include: Observation of resident rooms beginning on 6/23/2025 at 10:00 am revealed broken wooden wall molding trim in three rooms (room [ROOM NUMBER], 320, and 324) on Unit 30. Additionally, two broken ceiling tiles were observed in room [ROOM NUMBER], one of the tiles was observed with a piece of paper towel inserted in the tile hole. Interview on 6/26/2025 at 2:45 pm with the Maintenance Director (MD) revealed that currently only the MD and one assistant were working in the Maintenance Department. The MD revealed they don't do environmental rounds; they recceived orders from the TELS system (system for maintenance requests/orders). The MD revealed that all nurses have access to this system to report maintenance issues. Interview and observations of resident rooms on Unit 30 on 6/27/2025 at 11:40 am with the MD revealed that wall molding trim in rooms [ROOM NUMBER] were broken and needed repair. The MD stated that the resident in room [ROOM NUMBER] was refusing to leave the room in order for maintenance to repair wall trim behind his bed.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on record review, staff interviews, and review of the facility's policy titled, Abuse Prevention, the facility failed to ensure that the hiring of staff was proceeded by a completed background check to ensure that individuals who have been hired have not been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment in a court of law. Specifically, the Dietary Manager (DM) was allowed to continue working at the facility after two unsatisfactory criminal background checks. Findings include: Review of the facility's policy titled Abuse Prevention with a revised date January 2025 documented under 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 individuals. Under the section A, Steps to Prevent, Detect and Report: Screening . 3. The facility will pre-screen all potential new employees, volunteers, and residents for a history of abusive behavior. Review of the Georgia Background Checks (G-CHECKS) dated 11/21/2022 and 2/11/2025 documented as unsatisfactory for the Dietary Manager (DM). During an interview on 6/25/2025 at 1:25 pm with the Human Resource Director (HRD) stated the DM criminal background check was done prior to this onboarding in July of 2022 and stated the background results came back as unsatisfactory on 11/21/2022. During an interview on 6/27/2025 at 9:41 am with the HRD and Administrator revealed the first unsatisfactory background results on 11/21/2022 were brought to the attention of the previous Administrator and they were given the approval for the DM to continue to work. The HRD continued to state she was aware of the unsatisfactory status while working in the facility and once the DM was promoted, she asked him to submit an appeal from his initial unsatisfactory results. She further stated, when the appeal came back on 2/11/2025, the DM was still found unsatisfactory and informed the current Administrator and reached out to the Regional Human Recourses for further instructions and was given the approval for the DM to continue to work in the facility. Cross Reference -F835

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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 policy titled, Abuse Prevention, the facility failed to report injuries of unknown origin to the State Survey Agency (SSA) within the required timeframe for one resident (R) (R512) reviewed for abuse and neglect. The deficient practice had the potential for future unreported injuries of unknown origin, with the potential to affect residents' quality of life. Findings include: Review of the facility policy titled Abuse Prevention revised January 2025 revealed under 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. Alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including State Survey Agency, APS, and local law enforcement as required). Report the results of all investigations to the administrator or designated representative and other officials in accordance with state law including State Survey Agency withing 5 working days of the incident. Review of the electronic medical record (EMR) for R512 revealed he was admitted to the facility with diagnoses including but not limited to Alzheimer's disease, dementia, cerebral ischemia, dysphagia, speech and language deficits, sequelae of cerebral infarction. Review of Facility Incident Report Form (FRI) dated 2/21/2025 documented the type of injury as injury of unknown source. The details of the incident revealed that R512 was noted to be in discomfort favoring left shoulder. Resident did not complain of pain, but the eyesight appeared slightly abnormal, MD notified, and x-ray ordered. Findings stated that the osseus structures are unremarkable. There is no fracture of periosteal reaction (new bone formation). Anterior dislocation is suspected. Review of the Five-Day follow-up dated 2/28/2025 summarized the details of the incident: Staff were interviewed, Restorative Aide reported noticing that R512 wasn't extending his left arm. She stated that she walked around R512 bed onto his left side and noticed what seemed like a knot a little below his shoulder. She stated that she asked R512 if it hurts, but she did not get a response from him. She states that she gently touched the area and it felt like a bone, she states that the area was barely visible but it became noticeable due to him favoring his left side, other staff whom were in direct care of R512 within last 72 hour did not recall noticing anything out of the ordinary with R512 pertaining to his left shoulder. R512, who has a history of falls, hasn't had any recent falls. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conclusion of the Fine-Day follow up report stated that the origin of injury is unable to be identified at this time. Resident's ortho appointment was scheduled. R512 attended an orthro appointment, Physician diagnosed R512 with dislocated left shoulder, resident was sent to local Emergency Department (ED) for reduction under sedation per physician orders. Review of Restorative Aide written statement revealed that she reported her findings to the Unit Manager on 2/18/2025, immediately after leaving R512's room. Review of nurses note from 2/18/2025 revealed late entry, dated 2/21/2025: Resident has been observed for the swelling found on his left shoulder with a sign of contusion at 12.40 pm. NP (Nurse Practitioner) notified. Received an order for X ray left shoulder. RP (responsible party) notified. Interview with Administrator on 6/26/2025 at 3:10 pm revealed that he submitted a Facility Incident Report (FRI) to the State as soon as the unknown injury was reported to him. The Administrator confirmed that staff received regular in-services related to Abuse and Abuse reporting. The Administrator stated that he would make sure that staff would receive new in-service on Abuse reporting time frames. The Administrator continued stating that during the investigation process he was not able to determine how R512's shoulder got dislocated. R512 was receiving Physical Therapy (PT) at that time, he was very thin and fragile. No incidents related to personal care for R512 were reported.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and a review of the facility policy titled, PASRR (Preadmission Screening and Resident Review) Screening for Mental Disorder or Intellectual Disability, the facility failed to submit a PASARR Level II for one of two residents (R) (R153) reviewed for a mental illness diagnosis. This deficient practice had the potential to affect the appropriate level of care and services provided for R153. Findings include: A review of the facility policy titled PASRR Screening for Mental Disorder or Intellectual Disability dated July 2024, revealed the Policy stated, It I the policy of the Facility for each resident to be screened for Mental Disorder (MD) as defined or Intellectual Disability (ID) prior to admission and the individuals identified with MD or ID are evaluated by the State Mental Health Authority and receive care with services appropriate to their need. Referring all Level II with new MD, ID, or related conditions a review upon a significant change in status assessment. A review of the electronic medical record (EMR) revealed that R153 was admitted to the facility with diagnoses including, but not limited to, schizophrenia, bipolar disorder, and major depressive disorder. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed in section A (Identification Information) the resident was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, section I (Active Diagnoses) documented schizophrenia, and section O (Special Treatments and Programs) documented R153 did not receive psychological services. Review of R153's paper medical records on 6/27/2026 at 8:40 am revealed no evidence of PASARR level II. Interview with Social Services Director (SSD) on 6/27/2025 at 8:50 am revealed that the Social Service department have behavior meetings on Wednesdays. During these weekly meetings new admissions, diagnoses, and residents' behaviors were discussed. She confirmed that R153 had qualifying diagnoses for PASARR level II, but documents were not submitted for him.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, staff interviews, record review, and review of the facility policy titled, Oxygen Therapy, the facility failed to deliver oxygen (O2) per physician order for one of 37 residents (R) (R76) receiving O2 therapy. The deficient practices had the potential to cause respiratory distress. Findings include: Review of the facility policy titled Oxygen Therapy revised 8/14 revealed under Policy: Oxygen (O2) is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress. Under Procedure: Oxygen therapy is to be provided under the direction of a written physician's order. A Physician's Order for O2 therapy is to contain liter flow per minute via mask or cannula/timeframe. Review of the electronic medical record (EMR) for R76 revealed she admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD), cough, and pleural effusion Review of the Physician Orders for R76 dated 10/18/2024 revealed an order for continuous humidified Oxygen 2-4 L (liters) via NC (nasal canula) Observation on 6/23/2025 at 2:12 pm of R76 revealed her using O2 via NC at 5 liters per minute (LPM). Observation on 6/24/2025 at 12:45 pm revealed R76 was resting in her bed, using O2 at 5 LPM. Observation on 6/25/2025 at 10:45 am revealed R76 was using O2 via NC at 5 LPM. Interview on 6/25/2025 at 11:15 am with Licensed Practical Nurse (LPN) KK confirmed that R76's O2 concentrator was set to deliver 5 LPM via NC. Review of the physician's orders for R76 by LPN KK confirmed an order dated 10/18/2024 for 2-4 liters of oxygen via nasal cannula continuous. LPN KK stated that she will adjust O2 immediately. Interview with the Director Of Nursing (DON) on 6/25/2025 at 4:40 pm revealed her expectations for nurses to follow Doctor's orders related to O2 administration. If there were any changes, a new order was needed from a doctor, the previous order should be discontinued and family should be notified of changes.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review, staff interviews, and review of the facility's policy titled, Abuse Prevention, the facility administration failed to provide oversight to ensure one employee was free from adverse action on the criminal background check while working in the facility. Findings include: Review of the facility's policy titled Abuse Prevention with a revised date January 2025 documented under 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 individuals. Under Procedure: A. Steps to Prevent, Detect and Report: Screening .3. The facility will pre-screen all potential new employees, volunteers, and residents for a history of abusive behavior. Review of the Georgia Background Checks (G-CHECKS) dated 11/21/2022 and 2/11/2025 documented as unsatisfactory for the Dietary Manager (DM). During an interview on 6/25/2025 at 1:25 pm with the Human Resource Director (HRD) stated the DM stated the background results came back as unsatisfactory on 11/21/2022. During an interview on 6/27/2025 at 9:41 am with the Administrator confirmed he was aware of the DM's unsatisfactory background check. He stated he did not see any issues with it because he was not working in direct care. The Administrator stated the DM's convicted charges of aggravated assault did not fit into the category of a domestic offense. Cross Reference -F606

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, record review, and review of the manufacturer's instructional sheet titled, How to clean and disinfect your Blood Glucose Meter, the facility failed to ensure proper cleaning technique for a glucometer during routine fasting blood sugar checks on one resident (R) (R44). The deficient practice had the potential to put residents at risk for a possible bloodborne pathogen. Findings include: Review of the Manufacturers' recommendation for the Assure Platinum blood glucose monitoring system on page 47 on cleaning and disinfecting guidelines revealed: Critical item-glucometer. Healthcare professionals should wear gloves when cleaning the Assure Platinum meter. Wash hands after taking off gloves. Contact with blood presents a potential infection risk. We suggest cleaning and disinfecting the meter between patient use. Cleaning and disinfecting can be completed by using a commercially available EPA Environmental Protection Agency)-registered disinfectant, detergent or germicide wipe. Many wipes act as both cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used: use one wipe to clean and a second wipe to disinfect. During an observation on 6/23/2025 at 8:10 am it was revealed that fasting blood sugar checks were performed on R44 on C hall. Certified Medication Aide (CMA) AA used alcohol wipes to clean the glucometer without using a disinfectant. CMA AA stated that she used alcohol to clean the glucometer and a germicidal cloth to wipe down her cart at the end of her shift. An interview on 6/24/2025 at 8:04 am with B Hall CMA BB revealed that she used alcohol wipes to clean the glucometer. There were no EPA registered disinfectant wipes in the B hall cart. Interview on 6/25/2025 at 8:13 am with Licensed Practical Nurse (LPN) CC, she revealed she had been educated on cleaning glucometers. She explained cleaning with purple top germicidal wipes in her cart and let dry. She stated normally they had two glucometers, and they cleaned one while the other one dried. Interview on 6/25/2025 at 9:51 am with the Infection Preventionist revealed that there was supposed to be two glucometers per medication cart. They should use one and wipe with germicidal wipes, let dry and use the second glucometer to go to the next patient. She stated that germicidal wipes (purple top) were the only approved wipe in the building for cleaning glucometers. Nurses were educated on glucometer cleaning and storage. Interview 6/24/2025 at 12:54 pm with the Director of Nursing DON on glucose cleaning and monitoring, she stated when they took blood sugar they came out and cleaned the glucometer with purple top disinfectant wipes. They were not allowed to clean the glucometer with just alcohol pads. She stated they have two glucometers on every cart and germicidal wipes at the bottom of the cart.