STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115279	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
High Shoals Health and Rehabilitation	3450 New High Shoals Rd Bishop, GA 30621

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50940 Based on observations, staff interviews, record reviews, and review of the facility's policy titled Pharmacy Services - Medication Administration: General, the facility failed to follow professional standards of nursing practice for two of 39 sampled Residents (R) (R386 and R17). Specifically, the facility failed to document an explanation for a missed dose of enoxaparin (a blood thinner used to prevent and treat blood clots) for R386 and failed to follow prescribed blood pressure parameters outlined in a physician's order and to ensure that an antihypertensive medication was transcribed accurately for R17 observed during medication administration. Findings include: Review of the undated facility policy Pharmacy Services - Medication Administration: General under the Intent section revealed, To facilitate that medications are administered as prescribed, in accordance with good nursing principles. Under the section titled Guidelines revealed, . The joint responsibility of the center and the pharmacy is to facilitate accurate medication administration . Medications are . administered with a valid prescribed order . If a dose of regularly scheduled medication is withheld, refused, or given at an alternate time . the nurse or CMA should document an explanation of each instance in the permanent medical record. 1. Review of medical records revealed, R386 was admitted with diagnoses that included but not limited to right femoral fracture, status post right hip open reduction internal fixation (ORIF), fall, and compression fracture of the lumbar vertebra. Review of R386's physician orders dated 1/29/2025 revealed, an order for enoxaparin 40 mg (milligram)/0.4 ml (milliliter) subcutaneously, to be administered daily. Review of R386's Electronic Medication Administration Record (eMAR) revealed that the medication was documented as administered daily, except on 2/16/2025. It was signed by Licensed Practical Nurse (LPN) AA with the comment See nurse note; however, no corresponding nurse's note was documented. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/27/2025 at 2:45 pm with the Director of Nursing (DON) revealed, she contacted LPN AA, who stated she was unable to locate the enoxaparin at the time and had forgotten to document the reason it was not administered. LPN AA also reported that she had informed the incoming nurse on the next shift that the medication had not been given. The following day, the medication was located, and the resident received the next dose prior to discharge. As a result, one dose was missed during the resident's stay. The DON further stated that she expects staff to document a reason whenever a medication was not administered. In an interview with Pharmacist EE from [Name] Pharmacy on 3/26/2025 at 3:20 pm she stated that, upon reviewing the records, enoxaparin was dispensed three times during the resident's stay, each as a one-week supply-on 1/29/2025, 2/7/2025, and 2/14/2025. She confirmed that the facility could not have been out of stock of that medication. Pharmacist EE also provided the surveyor with a faxed confirmation showing that the medication was sent and delivered to the facility. The surveyor reviewed the delivery sheet, which confirmed that the medication was last delivered on 2/14/2025. In an interview with Pharmacist EE from Eldercare Pharmacy on 3/27/2025 at 4:05 pm, the surveyor asked her about the possible consequences if a resident missed a dose of enoxaparin. Pharmacist EE explained that enoxaparin was typically prescribed to prevent blood clots, and while it was difficult to say with certainty whether a single missed dose would directly result in a clot, the risk cannot be ruled out. She emphasized that the medication must be administered daily to maintain its effectiveness, as inconsistent dosing could compromise the resident's protection against thromboembolic events. 52213 2. Review of the medical records for R17 revealed diagnoses that included, but not limited to, prostate cancer with metastasis, heart failure, Gastro-Esophageal Reflux Disease (GERD) hyperlipidemia, Benign Prostatic Hypertrophy (BPH), vitamin D deficiency and cognitive communication deficit. Review of R17's Physicians Orders revealed an order dated 2/18/2025 for lisinopril (an Angiotensin Converting Enzyme (ACE) inhibitor medication used to treat high blood pressure), one tablet by mouth one time a day. Hold if systolic blood pressure less than (<) 110, diastolic blood pressure greater than (>) 65. Review of the R17's eMAR revealed, on 3/4/2025 Blood Pressure(B/P) was 107/46, on 3/8/2025 B/P was 95/42, on 3/10/2025 B/P was 115/48, and on 3/18/2025 B/P was 90/48 however, lisinopril was documented as administered on these dates. During observation of medication administration on 3/25/2025 at 8:36 am with Certified Medication Assistant (CMA) BB revealed, R17's lisinopril was held by CMA BB because his blood pressure was outside of parameters, as the diastolic blood pressure was greater than 65. R17's blood pressure reading was 137/76. CMA BB was questioned about her decision and if the parameter was appropriate. The CMA BB then administered the medication, stating the appropriate use of the drug and admitting that the parameter was incorrect. She brought it to the attention of her supervisor the Resident Care Coordinator (RCC). The RCC also agreed that the order for the parameters had been entered incorrectly. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/25/2025 at 9:00 am, the RCC stated all nurses were able to transcribe physician orders. She verified that R17's orders related to the parameters for lisinopril was not transcribed accurately and should specify, hold for a diastolic blood pressure less than (<) 65.

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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. 50803 Based on observations, staff interviews, and record review, the facility failed to cover clean laundry when transporting to prevent the spread of infection on one of five halls. These failures had the potential to increase the risk of infection transmission. Findings include: Observation on 3/25/2025 at 9:51 am revealed an unattended, uncovered clean clothes rack in the hallway. Further observation revealed two staff members transporting the hanging clothes from the cart to the resident rooms. An interview on 3/25/2025 at 9:52 am with the Environmental Supervisor (ES) revealed, that they have never covered the hanging clean laundry in the hallways, and that they use a sheet to cover the hanging clothes when transporting outside from the laundry room to the main building, as the laundry room was in a separate building from the main building. The ES further stated that their standard practice was not to cover the clean hanging laundry when in the hallways. An interview on 3/26/2025 at 1:20 pm with Laundry Aide (LA) DD revealed she has worked at the facility for four years. LA DD stated they cover the clothes with a sheet on top when transporting the clean hanging laundry from the laundry building to the facility and then remove the sheet when going from room to room. An interview on 3/27/2025 at 11:57 am with the Administrator revealed that the ES oversees the laundry operations. The Administrator stated that she expects clean laundry carts to be covered when transporting from building to building and in the hallways. The Administrator further stated that they have a clean hanging laundry rack which should also be covered when transported from building to building and in the hallways. The Administrator further confirmed that covering clean linen during transportation was the facility's standard of practice.