STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 46691 Based on staff interviews, record review, and a review of the facility policy titled, Resident Trust Fund Accounting Policies and Procedures, the facility failed to maintain a Surety Bond in an adequate amount to cover the resident trust fund account balance for three of six months reviewed. This deficient practice had the potential to adversely affect the finances of 62 of 62 residents with trust fund accounts managed by the facility. Findings include: A review of the undated facility policy titled Resident Trust Fund Accounting Policies and Procedures revealed, .Policy: The facility must purchase a Surety Bond to assure the security of all personal funds of residents deposited with the facility. A review of the facility's Surety Bond revealed that the [NAME] Term Effective was April 1, 2022, to April 1, 2025, in the amount of $80,000.00. A review of the last six months of bank statements for the Resident Trust Account for Chulio Hills revealed that three of the six months' statements documented an ending balance in excess of $80,000.00. The ending balance for February 2024 was $92,715.87, the ending balance for May 2024 was $93,849.05, and the ending balance for July 2024 was $95,520.15. A review of the facility-provided list of residents with resident trust fund accounts, dated 8/4/2024, revealed that 62 of 77 residents had an active resident trust fund account. In an interview on 8/3/2024 at 2:00 pm, the Administrator verified the facility's Surety Bond was for the amount of $80,000.00. She further verified the resident trust fund end-of-the-month bank statement for February 2024 was $92,715.87, May 2024 was $93,849.05, and July 2024 was $95,520.15. She stated she was unsure why the Surety Bond amount was not more than the highest resident trust fund monthly balance. She further stated the facility's Corporate Human Resources stated the bond company had recommended the amount of $80,000.00 based on the resident trust fund end-of-the-month balance of August 2021 to January 2022.

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
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 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** 47146 Based on observations, staff interviews, record review, and review of the facility policy titled, Resident Assessment - Coordination with PASARR Program, the facility failed to refer one of 35 sampled residents (R) (R33) for a preadmission screening and resident review (PASARR) level two. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: Review of the facility policy titled Resident Assessment - Coordination with PASARR Program copyright date 2021, revealed the Policy was The facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to insure that individual with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The sub-section titled Policy Explanation and Compliance Guidelines revealed under number nine any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Subsection nine (b) revealed a resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. Review of the electronic medical record (EMR) revealed Resident (R)33 was admitted to the facility with pertinent diagnoses including but not limited to general anxiety disorder and major depressive disorder diagnosed on [DATE]. Review of R33's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/14/2024 revealed a Brief Interview for Mental Status (BIMS) of 15, which indicates R33 was cognitively intact. Section D (Mood) revealed that R33 had a total severity score of 2 which indicated no depression. Section E (Behaviors) revealed no potential indicators for psychosis. Review of R33's care plan with focus on use of anti-anxiety medications related to mood disorder, anxiety, and depression (initiated 4/20/2018) and use of antidepressant medication related to mood disorder and insomnia (initiated 4/20/2018). Her goals included but not limited to R33 will be free from discomfort or adverse reactions related to anti-anxiety therapy or medications (initiated 4/20/2018). Interventions included but not limited to administer anti-anxiety and antidepressant medications as ordered by the physician (initiated 4/20/2018), monitor/record occurrence of target behaviors, monitor for worsening signs of depression, monitor for adverse reactions to anti-anxiety therapy (initiated 4/20/2018). Review of the EMR revealed physician's orders for R33 included but were not limited to: buspirone 10 milligrams (mg) by mouth, twice a day (BID); Seroquel 25 mg by mouth at bedtime; and trazodone 75 mg at bedtime. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations made on 8/2/2024 at 11:39 am of R33 revealed she was sitting up in bed, noted to be clean and well groomed, and there were no objectionable odors noted in the room. She was conversational and no behaviors were noted. Observations made on 8/3/2024 at 8:44 am of R33 revealed she was sitting up in bed eating breakfast, she was conversational, and no behaviors were observed. An interview with the Social Service Director on 8/3/2024 at 11:10 am revealed that R33 was not currently receiving psychiatric services because the facility was changing mental health service providers. She stated she would soon be under the care of the new service provider. She stated she did not resubmit a PASARR for R33 to obtain a level two PASARR because she did not think R33 needed a level two because her primary diagnosis was not a mental health diagnosis. An interview with the Administrator on 8/3/2024 at 1:35 pm revealed that her expectation related to the submission of PASARR for level two PASARR was that each resident's diagnosis be reviewed and if the resident had a major mental health diagnosis, then it was expected that the Social Service Director resubmit the PASARR and obtain a level two PASARR. She stated not obtaining a level two PASARR for residents with a major mental health diagnosis places the resident at risk for improper placement and not receiving the correct mental health care needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35180 Based on record review, staff interviews, and review of the facility policy titled, Medication Orders, the facility failed to ensure a stop date was implemented, not to exceed 14 days for psychotropic medications for four of nine residents (R) (R31, R56, R59, and R40) reviewed for unnecessary medications. Findings include: A review of the facility policy titled Medication Orders effective date November 28, 2017, revealed under Procedures: .E. PRN [as needed] orders for psychotropic drugs are limited to 14 days. If the attending prescribing practitioner believes it was appropriate for a PRN order to be extended beyond 14 days, he or she should document the rationale in the resident's medical record and indicate the duration of the PRN order. 1. A review of the Medical Doctor's (MD) orders for R31 dated 6/22/2024 revealed an order for 1 mg (milligram) of lorazepam by mouth every four hours as needed for anxiety. The order had an indefinite end date. A review of the Medication Administration Record (MAR) revealed that R31 was administered 1 mg of lorazepam by mouth on 6/30/2024 at 7:33 am, 7/19/2024 at 2:33 pm, 7/23/2024 at 10:19 am, 7/25/2024 at 8:42 pm, 7/29/2024 at 9:07 am and 9:06 pm, and 7/30/2024 at 7:19 pm. During an interview on 8/3/2024 at 4:40 pm with the Director of Nursing (DON), she stated that Licensed Practical Nurse (LPN) Unit Manager (UM) CC reviewed all new medications to ensure all stop dates were entered if required. The DON explained she went behind the UM to verify stop dates were entered. The DON acknowledged staff did not enter a stop for R11's lorazepam and said the medication should have had one as it was a psychotropic medication. 46691 2. A review of R56's Physician's Orders revealed an order dated 6/19/2024 for lorazepam 1mg oral tablet, one by mouth every 4 hours as needed for agitation. The order had an indefinite end date. A review of R56's MARs revealed he was administered lorazepam 1 mg by mouth on 6/22/2024 at 7:46 am, 6/23/2024 at 11:38 am, 6/25/2024 at 12:11 am, 7/3/2024 at 1:58 am, 7/6/2024 at 8:50 pm, 7/7/2024 at 2:44 am and 12:52 pm, 7/17/2024 at 2:14 am, and 7/20/2024 at 8:16 pm. In an interview on 8/3/2024 at 10:55 am, LPN/UM CC and LPN/UM DD stated they reviewed new physician orders daily. They stated the physician normally indicates a stop date for psychotropic medications, and they were unsure how the order for PRN lorazepam 1 mg was missed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/3/2024 at 1:20 pm with the Administrator and DON, the DON stated that the nurses transcribe the physician orders, and PRN medication orders should not be transcribed without a stop date. The Administrator stated her expectation was that if a physician's order for antipsychotic medications was received without a stop date, the nurse should put a 14-day stop date on the order and call the physician for clarification of the stop date. In an interview on 8/3/2024 at 5:00 pm, the DON verified R56's physician's order dated 6/19/2024 for lorazepam oral tablet 1 mg, give 1 mg by mouth every 4 hours as needed for agitation did not have a stop date. She stated there should be a stop date and the resident should be assessed before re-ordering the medication to determine if the medication order was still indicated based on the resident's needs. 47146 3. Review of the electronic medical record (EMR) revealed medication orders for R59 included but was not limited to Ativan solution 2 milligrams (mg)/milliliters (ml), inject 1 ml intramuscularly every four hours as needed for anxiety/agitation related to seizures. Interview on 8/3/2024 at 10:55 am with LPN Unit Manager CC and LPN Unit Manager DD, they verified and confirmed R59 had an physician order for Ativan, as needed with no stop date documented in the EMR. They revealed that they reviewed all new orders on each resident each day. Interview with the DON and the Administrator on 8/3/2024 at 1:20 pm, the DON revealed that PRN orders are entered into the system by the nurse who transcribes the order from a written physician order. She stated she was not sure how or why a PRN Ativan order was entered without a stop date. She stated that she and the Assistant Director of Nursing (ADON) review new orders daily to catch these type errors. She stated she was not sure of what adverse effect this type error could have on a resident. The Administrator stated her expectation was that orders be entered into the EMR correctly and if the physician order for an antipsychotic medication was received without a stop date, the nurse should automatically put a 14 day stop date on the order and call the physician to clarify the stop date. 33548 4. Review of R40's EMR revealed they were admitted to the facility with a diagnosis of, but not limited to epilepsy. Review of the physician orders revealed R40 was ordered to receive lorazepam injection solution 2 ml, inject 1 ml every four hours as needed for seizures. The lorazepam was ordered 4/3/2024 with no stop date indicated. Review of the care plan revealed a focus area indicating R40 uses anti-anxiety medication (Xanax and lorazepam, as needed) due to adjustment disorder with anxiety and seizures. Interview on 8/3/2024 at 5:00 pm, the DON confirmed that R40 had an order for as needed lorazepam. The DON revealed that R40 has seizure activity about every other day and was given the lorazepam at those times. The DON revealed that the as needed lorazepam should have had a 14 day stop date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 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** 46691 Based on observations, staff interviews, and review of the facility policy titled, Medication Storage In The Facility, the facility failed to ensure one of three medication carts was locked and secured when left unattended by the nurse. This deficient practice created the potential for residents, unauthorized staff, and visitors to have access to medications and biologicals stored on the medication cart. The facility census was 77 residents. Findings include: A review of the facility policy titled Medication Storage In The Facility, dated 4/1/2016, revealed the Policy stated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The Procedures section included, . B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. An observation on 8/2/2024 at 7:37 am, during the initial tour of the facility, revealed one unlocked and unattended medication cart positioned with the drawers facing the hallway, located on the 300 Hall between rooms [ROOM NUMBERS]. At 7:38 am, Registered Nurse (RN) EE walked by the cart without looking at the cart. At 7:39 am, a resident self-propelled himself from room [ROOM NUMBER] and by the cart. At 7:40 am, RN EE walked by the cart without looking at the cart. In an interview at 7:41 am, RN EE stated he was responsible for the medication cart and verified the cart was unlocked. unattended, and located in an area easily accessible to residents. He locked the medication cart and walked away, declining further interview. In an interview on 8/2/2024 at 8:30 am, the Administrator stated the medication carts should be locked and secured when left unattended by the nurse. She stated the nurses knew to lock the carts when walking away from them, and she had no explanation for the cart being left unlocked and unattended. In an interview on 8/4/2024 at 8:05 am, the Director of Nursing (DON) stated she expected the medication carts to be locked and secured when left unattended by the nurse to prevent residents, unauthorized staff, or visitors from obtaining medications from the cart. She stated a pharmacy consultant conducted random audits of the medication carts and provided monthly education to licensed nursing staff. She further stated she was unsure whether the night shift nurses received the education provided by the pharmacy consultant since the education was provided during the day shift. She stated leaving the medication carts unlocked and unattended increased the chance for a resident or unauthorized staff to have access to medications that could cause harm to the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 33548 Based on staff interviews and review of the facility policy titled, Management/Dietary Services Manager, the facility failed to ensure that the staff designated as Dietary Manager (DM) was certified in dietary or food service management or had a similar food service management certification or degree. The facility census was 77 with 71 residents receiving an oral diet. Findings include: Review of the facility policy titled Management/Dietary Services Manager dated March 2024 revealed under Procedure: The Dietary Service Manager is responsible for obtaining and maintaining current Serve Safe Food Handler certification and CEU's (continuing education unit) required for the Certified Dietary Managers (CDM) certification once obtained. The Dietary Services Manager will follow the CMS (Centers for Medicare/Medicaid Services) guidelines for obtaining CDM certification per the CMS regulations. Review of the DM's employee file revealed she was hired as a dietary cook on 9/28/2012 and promoted to Dietary Manager on 7/13/2023. Interview on 8/2/2024 at 9:25 am with the DM revealed that she did not have any dietary certifications. The DM revealed that she was in the process of becoming certified and only needed to complete the test. Interview on 8/3/2024 at 2:15 pm with the Administrator revealed that when the DM was promoted to current position there was an expectation that the DM would at least obtain the Serve Safe Food Manager certification and then eventually become a Certified Dietary Manager. The Administrator revealed that she was Serve Safe certified and provides dietary oversite when needed. The Administrator revealed the facility was not utilizing a DM from any sister facilities to assist with dietary oversite. Continued interview revealed that the Registered Dietitian visits the facility once a month and provides dietary guidance when needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33548 Based on observations, staff interviews, and review of facility policies titled, Food Brought by Visitors and Food Storage Guidelines, the facility failed to ensure dietary staff labeled and dated open food items in the dry storage area; failed to prevent/remove ice build-up on top of opened food to prevent contamination in the walk-in freezer; failed to label and date resident foods items the resident nourishment room and; failed to demonstrate the proper procedure to sanitize dishware in the three compartment sink to prevent food borne illness. The facility census was 77 with 71 residents receiving an oral diet. Findings include: Review of the facility policy titled Food Brought by Visitors revealed: Food items are covered, dated with the date the food was brought to the facility and a discard date if applicable, and labeled with the resident's name. Review of the facility policy titled Food Storage Guidelines revealed: non-perishable food will have the following dates available: Delivery date and once opened, will have the open date. 1. Observation on 8/2/2024 at 8:55 am of the dry storage area revealed an opened five-pound bag of grits in a clear, resealable plastic bag. There was no open date. Interview on 8/2/2024 at 8:55 am, the Dietary Manager (DM) confirmed that the bag of grits did not have an open date. The DM revealed that dietary staff should have placed an open date on the open bag before placing inside the resealable plastic bag and putting in dry storage area. 2. Observation on 8/2/2024 at 9:00 am and 8/4/2024 at 9:45 am of the walk-in freezer revealed an open case of frozen strawberries on the food storage shelf located under the air condenser with ice build-up on top. The ice build-up covered half of the top of the case and was over the open seam. Interview on 8/2/2024 at 9:00 am, the DM confirmed that there was ice build-up on the top of the open case of frozen strawberries. The DM revealed that the air condenser in the walk-freezer had been producing some ice due to high temperature outside and mechanics for the freezer were located on the roof of the building. The DM revealed that dietary staff had been removing the ice build-up as needed. 3. Observation on 8/3/2024 at 8:40 am of the resident nourishment room revealed the bottom shelf had a large white Styrofoam container with no resident name or date. On the top shelf was a small white Styrofoam container with no resident name. The top shelf also had a plastic restaurant bag with several containers of food inside, this bag did not have a resident name or date. Further observation revealed the top freezer had three individual sized frozen pizzas with no resident name or date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 8/3/2024 at 8:40 am, the DM revealed that dietary was only responsible for stocking food items in the nourishment room. The DM revealed that nursing staff were responsible for label and dating resident foods when placed in resident refrigerator and freezer. The DM confirmed that both white Styrofoam containers had no resident name or date, the DM confirmed that the plastic restaurant bag had no resident name or date and confirmed that the pizzas in the resident freezer had no name or date. The DM stated that when she was stocking food items in the resident nourishment room and noticed resident's foods with no name or date, she will let the nursing staff know so they can label and date. Interview on 8/3/2024 at 8:50 am, the Administrator confirmed that the Styrofoam containers and plastic restaurant bag did not have a resident name or date. The Administrator revealed that nursing staff have been educated on labeling and dating resident food items and expected nursing staff to label and date resident foods before placing in the resident refrigerator. 4. Observation on 8/3/2024 at 9:20 am of the three-compartment sink revealed the facility was using a quaternary (a solution that uses four compounds) sanitizing solution to sanitize dishware. Two posters were located on the wall over the sink, one poster stated dishware immersion time one minute. The second poster indicated step four was to submerge in sanitizer sink for one to two minutes. Continued observation of Dietary [NAME] BB sanitize the lid to the food processor revealed he removed it from sanitizing solution and placed it on the drying rack. Interview on 8/3/2024 at 9:20 am with dietary cook BB revealed that he normally submerges dish items in the sanitizing solution for 20-30 seconds which is what the DM and the Department of Health told him. The dietary cook confirmed that the posters over the sink did state to submerge for at least one minute in the sanitizing solution. Dietary cook BB stated that he should have kept the dishware in the sanitizing solution for a longer time to sanitize. Interview on 8/3/2024 at 9:40 am, the DM confirmed that the facility was using a quaternary sanitizing solution in the three-compartment sink. The DM confirmed that the posters on the wall above the sink indicated to submerge/immerse dishware in the sanitizing solution for at least one minute. The DM revealed she excepted dietary staff to have placed dishware in the sanitizing solution for at least one minute.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35180 Based on observations, staff interviews, and review of the facility policies titled, Enhanced Barrier Precautions and Bed Baths, the facility failed to utilize proper infection control techniques while providing care to one of 35 sampled residents (R) (R75) on Enhanced Barrier Precautions (EBP). The deficient practice had the potential for staff to spread infection to other residents in the facility. Findings included: A review of the undated facility policy titled Bed Baths under Policy Explanation and Compliance Guidelines revealed: staff should change the basin water, obtain a clean washcloth, perform hand hygiene and don (put on) new gloves after washing and before rinsing the resident. Additionally, cleaning would begin at the face and work over the body, with the groin and buttocks cleaned last. A review of the facility policy titled Enhanced Barrier Precautions dated 4/1/2024 revealed under Policy Explnation and Compliance Guidelines: .3. b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . 4. High-contact resident activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: any skin opening requiring a dressing. A review of the Medical Doctor's (MD) orders dated 6/18/2024 revealed that Enhanced Barrier Precautions (EBP) were ordered for R75. Staff were to don gloves and a gown before contact with the resident for high-contact resident care activities, which included bathing/showering, changing linens, providing hygiene, changing briefs, or providing indwelling Foley catheter care. A review of R75's care plan revealed that the resident was care planned for EBP related to a Foley catheter. The care plan indicated that staff would be compliant with the enhanced barrier precautions as ordered. Interventions included having staff wear gowns and gloves for the following High-Contact resident care activities: bathing/shower, brief changing, incontinent care, and linen changes. An observation of R75's room on 8/2/2024 at 10:05 am revealed a sign outside the door indicating the resident was on EBP. The signage included instructions for all staff to don gowns and gloves when providing direct care. During an observation of catheter care on 8/2/2024 at 10:19 am, CNA AA cleaned R75's catheter site and groin area with a washcloth, soap, and water. CNA AA then used the same washcloth to clean R75's entire front body. CNA AA then rinsed the soap from R75 with the same water used to wash R75. During the same observation, CNA AA did not don a gown while providing the resident with a bed bath, incontinent care, linen change, and dressing. R75 was on Enhanced Barrier Precautions due to an indwelling catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	08/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Infection Control Preventionist (ICP) on 8/2/2024 at 3:45 pm, she stated it was her expectation for any staff providing care to a resident on EBP to wear the proper PPE. The ICP indicated that staff should wear gowns and gloves when caring for residents on EBP. The ICP stated that all staff had received EBP training, signs were posted on any resident's rooms that were on EBP, and the signage indicated the proper PPE required. The ICP said that staff were trained to use separate water basins for washing and rinsing a resident when providing bed baths or incontinent care. The staff was also trained to use a clean washcloth after utilizing a washcloth on any peri areas. During an interview with Certified Nursing Assistant (CNA) AA on 8/2/2024 at 4:00 pm, CNA AA confirmed she had not donned a gown when providing R75 with direct care. She stated she did not know she was supposed to use PPE when caring for residents with Foley catheters, feeding tubes, PICC (peripherally inserted central catheter) lines, or IVs (intravenous). Per CNA AA, she did not see the sign on R75's door, and she had never read it. Additionally, CNA AA confirmed she used the same washcloth she cleaned R75's Foley and groin area to bathe the rest of his body. CNA AA stated she thought it was okay to use the same washcloth, provided she used another washcloth to rinse the resident. The CNA AA confirmed she used the same basin of water for washing and rinsing R75 and added she did not know she needed to use a clean basin of water to rinse the soap from R75.