STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115291	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Health Center of Augusta	3618 J Dewey Gray Circle Augusta, GA 30909

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 29015 Based on observation, staff interviews, and review of the facility's policies titled, Resident Rights and Confidentiality of Personal and Medical Records, the facility failed to ensure personal information was kept confidential for two residents (R) (R19 and R20) of 20 sampled residents. Specifically, the residents' medication cards containing resident information were left unattended on top of the 400-unit Medication Cart. Findings include: Review of the facility's policy titled, Resident Rights, dated February 2021, documented .3. The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA [Health Insurance Portability and Accountability Act] compliance officer. Review of the facility's policy titled, Confidentiality of Personal and Medical Records, revision date of 3/1/2023, documented This facility honors the resident's right to secure and confidential (sic) personal and medical records. This includes the right to confidentially of all information contained in a resident's records, regardless of the form of storage or location of the record. Personal and medical records include all types of records the facility might keep on a resident, whether they are medical, social, funds account, automated, or other .resident's personal or medical information shall not be left unattended or viewable by unauthorized persons .will be disposed of in a way that will not compromise resident's personal or medical information. During an observation conducted on 4/24/2024 from 9:15 am to 9:33 am of the 400-hall, there were two empty resident medication cards on the top of the medication cart, facing up with resident information exposed, and left unattended. There were residents, staff, and visitors walking in the hall during the observation. Review of R19, and R20's medication card, revealed it contained the resident's name, room number, physician name, and medication prescribed. During an interview on 4/25/2024 at 9:33 am, Licensed Practical Nurse (LPN) 5 confirmed the medication cards were inappropriately left unattended. LPN5 demonstrated that the top of medication cards containing the resident's information was supposed to be torn off and placed in the cart to dispose of appropriately. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/2024 at 1:00 pm, when questioned what his expectations were for the empty medication cards containing resident information, the Administrator stated he would expect the nurse to tear the top off the medication card and throw away the rest of the card, keeping the residents' information private.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 12679 Based on interviews, record review, and review of the facility's policy titled Resident and Family Grievances, the facility failed to ensure their grievance procedures were followed for one of one resident (R) (R 3) reviewed for grievances of 20 sampled residents. Findings include: Review of the facility's policy titled, Resident and Family Grievances, dated 1/30/2023, indicated .It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal .The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form .Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow-up .All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgement of complaint/grievance .In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum .The date the grievance was received .The steps take to investigate the grievance .A summary of the pertinent findings or conclusions regarding the resident's concerns(s).A statement as to whether the grievance was confirmed or not confirmed. Any action taken or to be taken by the facility as a result of the grievance .The date the written decision was issued . Review of R3's EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 1/18/2024 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which revealed the resident was moderately cognitively impaired. Review of a document provided by the facility titled Concern Form, dated 3/9/2024, indicated Resident Representative (RR) 1 filed a grievance with the facility and identified the following concerns: late medication administration, dirty environment, broken toilet seat, and the resident had not been changed timely. On the back of the document, the Administrator verified that the resident's room was clean, and the resolution was to have the Housekeeping Supervisor check the room daily. The concern form indicated the Regional Nurse verified R3's medication was administered timely. There was a section which revealed the date on which the individual was to be notified and it was blank. The date of follow-up and the day that the individual was met with, and these areas were blank. An area on the document had an area whether or not the individual was satisfied with the resolution and again this was blank. During an interview conducted on 4/23/2024 at 12:07 pm, RR1 stated she completed a grievance and had no follow-up provided by the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 10:30 am, the Social Services Director (SSD) stated she was provided the Concern Form and would log it into her binder for tracking. The SSD stated she did not remember if there was resolution since there had been two different Director of Nursing (DON) since March 2024. The SSD stated the grievance process was to write up the resolution and to have it signed off by the family and the Administrator. During an interview on 4/24/2024 at 10:19 am, the Regional Nurse, who was previously the interim DON, stated she would get involved with the grievances and the first thing she would do would be to write up a response on the Concern Form and then pass it back to the SSD. The Regional Nurse stated the handwriting was not hers on the Concern Form and she must have received a telephone call from the DON at that time. The Regional Nurse stated she did not remember the details of her involvement. During an interview on 4/25/2024 at 1:24 pm, the Administrator stated he attempted to get the resolution done for a resident and/or their representative within 72 hours. The Administrator did not provide an explanation of why the Concern Form was not completed except to state he had met with the family and the medication issue was handled by the clinical staff.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 29015 Based on observation, staff interviews, record review, and review of the facility's policy titled Pressure Injury/Wound Treatment Management, the facility failed to ensure that one of two Resident (R) (R 16) observed for pressure ulcer treatment, had a dressing maintained for a stage IV sacral ulcer. Specifically, there was no dressing covering R16's sacral pressure ulcer leaving it exposed to urine and feces. Findings include: Review of the facility's policy titled, Pressure Injury/Wound Treatment Management dated 3/1/2022, documented To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders .3. Dressing changes may be provided outside the frequency parameters in certain situations: a. Feces has seeped underneath the dressing, b. The dressing has dislodged, c. the dressing is soiled otherwise, or is wet. Review of R16's undated Admission Record located in the electronic medical record (EMR) under the Profile tab, indicated R16 was admitted to the facility with diagnoses that included pressure ulcer of sacral region, stage four, type two diabetes with hyperglycemia, and morbid obesity. Review of R16's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 3/22/2024 indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R16 had intact cognition. Further review of the MDS indicated the resident was always incontinent of urine, and frequently incontinent of bowel. Review of R16's Care Plan located in the EMR under the Care Plan tab, dated 2/1/2019 and revised 7/18/2023, revealed .has a chronic pressure ulcer to sacrum .interventions included but not limited to, two-person assistance with all bed mobility and ADL (activities of daily living) care, treatment as ordered. Further review of the care plan, dated 10/30/2018 and revised 8/28/2019, documented .has potential for further pressure ulcer development r/t [related to] decreased mobility, incontinence. Interventions included but not limited to observe dressing daily to ensure it is intact and adhering. Report lose (sic) dressing to treatment nurse. During an observation and interview on 4/24/2024 (Wednesday) at 2:38 pm, during the wound care observation, the Wound Care Nurse (WCN) confirmed the wound was open to air and had no wound dressing intact. The WCN was asked if the wound was supposed to have a dressing applied to the wound. The WCN replied, The Nurse Practitioner (NP) made rounds on Monday and applied a dressing to the wound. The resident receives wound care on Monday, Wednesday, Friday, and as needed. The WCN was asked what should have occurred with the wound if the dressing fell off during care. The WCN stated if the dressing became soiled or fell off, nursing should have either replaced it or notified her to take care of it. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 3:33 pm, the Assistant Director of Nursing (ADON) was asked what her expectations of the staff were when a resident's wound dressing became soiled or dislodged. The ADON stated her expectation was for the staff to alert the nurse, and for nursing to replace the dressing. During an interview on 4/24/2024 at 3:45 pm, Certified Nurse Aide (CNA) 5 was questioned if she was aware R16's wound dressing was off. CNA5 stated no, she was unaware of that, but would let the nurse know if this had happened when changing the resident. During an interview on 4/24/2024 at 3:48 pm, CNA4 was questioned about what she would do if the resident's dressing came off or was soiled during incontinent care. CNA4 stated she would notify the nurse as soon as possible. During an interview on 4/24/2024 at 3:53 pm, the Administrator was questioned on his expectations of the staff when a wound dressing is soiled, dislodged, or missing. The Administrator responded he would expect the CNA to inform the nurse so they could reapply a dressing.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 12679 Based on staff interview, record review, and review of a policy provided by the facility titled Maintenance of Clinical Records, the facility failed to ensure that clinical records were complete and contained accurate documentation for three Residents (R) (R 3, R1, and R4) out of 20 sampled residents. Findings include: Review of a policy provided by the facility titled, Maintenance of Clinical Records, dated 3/1/2023, indicated . This facility will maintain clinical records for each resident in accordance with acceptable standards of practice that reflects the current plan of care and services provided .In accordance with accepted professional standards of practices, the facility must maintain medical records on each resident that are . Complete .Accurately documented . 1. Review of R3's electronic medical records (EMR) titled Admission Record located under the Profile tab, indicated the resident was admitted with diagnoses that included chronic pain, left hand contracture, and gastrostomy status. 1. Review of R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/18/2024 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which revealed the resident was moderately cognitively impaired. Review of R3's EMR titled physician Orders located under the Orders tab, dated 1/33/2024, indicated the resident was to receive gabapentin 400 milligrams (mg) via gastrostomy-tube (G-tube) four times a day related to chronic pain. Review of R3's Medication Administration Record (MAR) for March 2024, located under the Orders tab, indicated the gabapentin was not documented as administered on the following times and dates: at 5:00 PM on 3/3/2024, 3/20/2024, and at 9:00 pm on 3/24/2024. There were no corresponding nursing notes which would indicate the reasons for the blank areas on the MAR. Review of R3's MAR for April 2024 located under the Orders tab, indicated the gabapentin was not documented as administered on the following dates: at 5:00 pm on 4/5/2024, 4/6/2024, 4/10/2024, 4/14/2024, and on 4/1520/24. There were no corresponding nursing notes which would indicate the reasons for the blank areas on the MAR. During an interview on 4/25/2024 at 9:15 am, the Regional Nurse stated the missing days for the gabapentin should have been documented as given and the medical record was to be accurate. 29015 2. Review of R1's undated Admission Record located in the EMR under the Profile tab, indicated the resident was admitted with diagnoses that included necrotizing fasciitis, cystitis, and acute respiratory failure with hypoxia. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Documentation Survey Report, dated March 2024 and provided by the facility, under the Intervention/Task for Nutrition-Amount Eaten revealed there was no documentation of what R1's intake was for 3/11/2024, 3/15/2024, 3/16/2024, 3/17/2024, and 3/20/2024. 3. Review of R4's undated Admission Record located in the EMR under the Profile indicated the resident was admitted with diagnoses that included chronic kidney disease, type two diabetes, and congestive heart failure. Review of R4's Documentation Survey Report, dated January 2024 and provided by the facility, for the task revealed there was no documentation of personal hygiene, and bladder elimination, being completed on the 7:00 am-7:00 pm shift on 1/1/2024, 1/3/2024, 1/5/2024, 1/7/2024, 1/12/2024, 1/17/2024, 1/22/2024, 1/23/2024, 1/24/2024, 1/26/2024, 1/27/2024, and 1/28/2024. Additionally, there was no documentation on the amount eaten at 6:00 pm on 1/3/2024, 1/9/2024, and 1/13/2024. Review of R4's Documentation Survey Report, dated March 2024 and provided by the facility, for the task revealed there was no documentation for the amount eaten on 3/14/2024, 3/18/2024, and 3/24/2024. Further review of R4's complete EMR revealed there was no documentation of the resident not being out of the facility during the afore-mentioned dates/times. During an interview on 3/25/2024 at 1:28 pm, the Administrator confirmed the missing documentation. The administrator stated his expectation was for the care provided to be documented appropriately.