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	06/05/2025

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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and review of the facility's policy titled Residents' Rights Regarding Treatment and Advance Directives, the facility failed to provide the resident and/or their representatives with written information of the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for one of six Residents (R) (R59) reviewed for Advanced Directives. This failure created the potential the resident wishes would not be followed if the resident was unable to speak for themselves. Findings include: Review of the facility's policy, titled, Residents' Rights Regarding Treatment and Advance Directives dated 3/1/2025 revealed, Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate advance directives. Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed on advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive .9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care . Further review of the facility's policy revealed the policy failed to specify providing information in a written format. Review of R59's undated admission Record located in R59's electronic medical record (EMR) under the Profile tab revealed R59 was admitted to the facility on [DATE] and was re-admitted on [DATE]. Review of R59's EMR revealed no documentation that R59 had an Advance Directive or that the facility provided written information to the resident, or the resident representative concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. During an interview on 6/4/2025 at 10:15 am, the Director of Nursing (DON) stated, Resident R59 came to the facility under the previous ownership, and we do not have any record of R59 being given any information about advance directives.

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
	115291	A. Building B. Wing	06/05/2025

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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update one of two Residents (R) R80 care plan interventions to include measures to prevent pressure ulcers. Specifically, R80 had acquired three pressure ulcers after readmission from the hospital and his care plan had not been revised with interventions to prevent the development of pressure ulcers. Findings include: Review of R80's Clinical Census in the Electronic Medical Record (EMR) under the Clinical Census tab revealed admission date of 1/2/2025, hospitalization on 2/13/2025 and readmission on [DATE]. Review of R80's Medical Diagnosis in the EMR under the Medical Diagnosis tab revealed diagnoses multiple fractures of ribs on the right side, lumbar vertebra fracture, prostate cancer, and diabetes mellitus type 2. Diagnoses added 2/13/2025 to 2/17/2025 hospitalization included deep vein thrombosis (DVT) of the right lower leg, and pneumonia. Review of R80's Care Plan in the EMR found under the Care Plan tab dated 1/14/2025 indicated at risk for altered skin integrity related to diagnoses, incontinent at times, elderly, and fragile skin. Interventions included, Handle gently during transfers and ADLs [activities of daily living],Observe skin during ADLs for any changes in skin condition, notify nurse of any changes, Position properly in bed & [and] [wheelchair] to avoid skin tear or friction, Weekly skin assessments as scheduled. There were no further interventions after R80 was readmitted from the hospital on 2/17/2025 and once the sacral pressure ulcer, right heel pressure ulcer, and a left hip pressure ulcer developed 3/19/2025 . Review of R80's Braden Scale for Predicting Pressure Sore Risk dated 1/9/2025 in the EMR under the Assessments tab revealed a score of 20 which indicated he was not at risk of developing a pressure ulcer. Review of the EMR revealed no further Braden scales had been completed after his 2/17/2025 readmission due to a deep vein blood clot and pneumonia. Observations on 6/2/2025 at 10:30 am, 1:00 pm, and 4:00 pm revealed R80 lying in bed on his back. His heels were not elevated on a pillow. He had a low air loss mattress in place. Observations on 6/3/2025 at 9:00 am, 11:30 am and 3:30 pm revealed R80 lying in bed on his back. His heels were not elevated on a pillow. He had a low air loss mattress in place. Observation on 6/4/2025 at 3:00 pm revealed R80 lying in bed on his back. His heels were not elevated on a pillow. He had a low air loss mattress in place. (continued on next page)

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	06/05/2025

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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/4/2025 at 12:37 pm, the Wound Care/Registered Nurse (WC/RN) revealed when R80 was admitted on 0102/25 he was able to get in and out of bed independently. He would walk to meals and to activities independently. After his hospitalization from 2/13/2025 to 2/17/2025 he did not get out of bed. His cognition declined. Staff need to reposition him often. She stated that he was to have his heels elevated when he was in bed. Interview on 6/4/2025 at 12:35 pm, Licensed Practical Nurse (LPN)1 stated that after R80 returned from the hospital, he refused to get up due to pain. He is repositioned with wedges and usually more to his left side. There was no place in his EMR for staff to document when he was repositioned. Review of R80's significant change Minimum Data Set (MDS) in the EMR with an Assessment Reference Date of 2/19/2025 under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R80 was moderately cognitively impaired. Review of the Behavior section revealed he rejected care one to three days out of seven days. Review of his Functional Abilities section revealed re required he needed substantial or maximal assistance with rolling left and right. Review of the Skin Conditions section revealed he had no pressure ulcer or injury, and he was at risk of developing pressure ulcers or injuries. Review of R80's admission MDS in the EMR with an ARD of 3/17/2025 under the MDS tab revealed a BIMS score of five out of 15 which indicated R80 was severely impaired. Review of the Behavior section revealed he rejected care one to three days out of seven days. Review of his Functional Abilities section revealed he needed substantial or maximal assistance with rolling left and right. Review of the Skin Conditions section revealed he had no pressure ulcer or injury, and he was not at risk of developing pressure ulcers or injuries. Review of R80's quarterly MDS in the EMR with an ARD of 3/24/2025 under the MDS tab revealed a BIMS score of 3 out 15 which indicated R80 was severely cognitively impaired. Review of the Behavior section revealed he had not rejected care. Review of his Functional Abilities section revealed he needed substantial or maximal assistance with rolling left and right, sit to lying, and lying to sitting on the side of the bed. Review of the Skin Conditions section revealed he had a pressure ulcer or injury, and he was at risk of developing pressure ulcers or injuries. There was one unstageable pressure ulcer and one unstageable pressure ulcer due to a deep tissue injury listed. (continued on next page)

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	06/05/2025

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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R80's Progress Notes in the EMR found under the Progress Notes tab revealed notes dated 3/19/2025 at 9:44 am which indicated, Skin intact Sacral area reddened R/T [related to] incontinence. Butt cream applied as needed. Note dated 3/20/2025 at 9:54 am indicated, .large purple colored area on his Rt [right] heel, reddened area noted on sacral area, treatment team informed of findings. Note dated 3/21/2025 indicated, Resident will be followed in PAR [patient rounds] for wounds. Stage 2 sacrum and DTPI [deep tissue pressure injury] to sacrum. Wounds are new as of 3/20. Treatment [treatment] is Zinc, lotrisome, antifungal daily. DTPI to Rt heel. Note dated 3/28/2025 indicated, Unstageable sacral wound. Wound being treated with honey with calcium alginate covered with foam 3x/week. DTPI to right heel. Treated with betadine gauze covered with ABD [abdominal] pad daily. Wounds are stable. Will continue POC [plan of care]. Note dated 4/4/2025 at 10:18 am indicated, Resident with acquired pressure ulcer to sacrum improving now . resident with acquired pressure ulcer to right heel also improving Note dated 4/18/2025 at 11:10 am a note Resident followed this week on PAR for a Sacral wound, unstageable which is showing improvement with Santyl and foam dressing changes daily and for a stage 3 wound to his Right Heel which is not showing improvement and is being treated with Santyl and rolled gauze. Note dated 5/16/2025 at 11:32 am indicated, Patient being followed by PAR for unstageable wound to sacrum. Wound is not improving. Stage III wound to right heel. Wound has not improved. Treatment changed to calcium alginate and rolled gauze. 3x/week. Will continue POC.

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	06/05/2025

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

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure one of five Residents (R) (R80) who was at risk for acquiring a pressure ulcer had preventative measures in place to avoid the development of pressure ulcers. Specifically, R80 acquired three pressure ulcers after his readmission to the facility. Findings include: Review of R80 ' s Clinical Census in the Electronic Medical Record (EMR) under the Clinical Census tab revealed admission date of 1/2/2025, hospitalization on 2/13/2025 and readmission on [DATE]. Review of R80 ' s Medical Diagnosis in the EMR under the Medical Diagnosis tab revealed diagnoses multiple fractures of ribs on the right side, lumbar vertebra fracture, prostate cancer, and diabetes mellitus type 2. Diagnoses added 2/13/2025 to 2/17/2025 hospitalization included deep vein thrombosis (DVT) of the right lower leg, and pneumonia. Review of R80 ' s Care Plan in the EMR found under the Care Plan tab dated 1/14/2025 indicated at risk for altered skin integrity related to diagnoses, incontinent at times, elderly, and fragile skin. Interventions included, Handle gently during transfers and ADLs [activities of daily living],Observe skin during ADLs for any changes in skin condition, notify nurse of any changes, Position properly in bed & [and} [wheelchair] to avoid skin tear or friction, Weekly skin assessments as scheduled. There were no further interventions after R80 was readmitted from the hospital on 2/17/2025 and once the sacral pressure ulcer, right heel pressure ulcer, and a left hip pressure ulcer developed 3/19/2025 . Review of R80 ' s Braden Scale for Predicting Pressure Sore Risk dated 1/9/2025 in the EMR under the Assessments tab revealed a score of 20 which indicated he was not at risk of developing a pressure ulcer. Review of the EMR revealed no further Braden scales had been completed after his 2/17/2025 readmission due to a deep vein blood clot and pneumonia. Observations on 6/2/2025 at 10:30 am, 1:00 pm, and 4:00 pm revealed R80 lying in bed on his back. His heels were not elevated on a pillow. Observations on 6/3/2025 at 9:00 am, 11:30 am and 3:30 pm revealed R80 lying in bed on his back. His heels were not elevated on a pillow. He had a low air loss mattress in place. Observation on 6/4/2025 at 3:00 pm revealed R80 lying in bed on his back. His heels were not elevated on a pillow. Interview on 6/4/2025 at 12:37 pm, the Wound Care/Registered Nurse (WC/RN) revealed when R80 was admitted on [DATE] he was able to get in and out of bed independently. He would walk to meals and to activities independently. After his hospitalization from 2/13/2025 to 2/17/2025 he did not get out of bed. His cognition declined. Staff needed to reposition him often. She stated that he was to have his heels elevated when he was in bed. (continued on next page)

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	06/05/2025

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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/4/2025 at 12:35 pm, Licensed Practical Nurse (LPN)1 stated that after R80 returned from the hospital, he refused to get up due to pain. He was repositioned with wedges and usually more to his left side. There was no place in his EMR for staff to document when he was repositioned. Review of R80 ' s significant change Minimum Data Set (MDS) in the EMR with an Assessment Reference Date of 2/19/2025 under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R80 was moderately cognitively impaired. Review of the Behavior section revealed he rejected care one to three days out of seven days. Review of his Functional Abilities section revealed he required substantial or maximal assistance with rolling left and right. Review of the Skin Conditions section revealed he had no pressure ulcer or injury, and he was at risk of developing pressure ulcers or injuries. Review of R80 ' s admission MDS in the EMR with an ARD of 3/17/2025 under the MDS tab revealed a BIMS score of five out of 15 which indicated R80 was severely impaired. Review of the Behavior section revealed he rejected care one to three days out of seven days. Review of his Functional Abilities section revealed he needed substantial or maximal assistance with rolling left and right. Review of the Skin Conditions section revealed he had no pressure ulcer or injury, and he was not at risk of developing pressure ulcers or injuries. Review of R80 ' s quarterly MDS in the EMR with an ARD of 3/24/2025 under the MDS tab revealed a BIMS score of 3 out 15 which indicated R80 was severely cognitively impaired. Review of the Behavior section revealed he had not rejected care. Review of his Functional Abilities section revealed he needed substantial or maximal assistance with rolling left and right, sit to lying, and lying to sitting on the side of the bed. Review of the Skin Conditions section revealed he had a pressure ulcer or injury, and he was at risk of developing pressure ulcers or injuries. There was one unstageable pressure ulcer and one unstageable pressure ulcer due to a deep tissue injury listed. Review of R80 ' s Progress Notes in the EMR found under the Progress Notes tab revealed notes dated 3/19/2025 at 9:44 am which indicated, Skin intact Sacral area reddened R/T [related to] incontinence. Butt cream applied as needed. Note dated 3/20/2025 at 9:54 am indicated, .large purple colored area on his Rt [right] heel, reddened area noted on sacral area, treatment team informed of findings. Note dated 3/21/2025 indicated, Resident will be followed in PAR [patient rounds] for wounds. Stage 2 sacrum and DTPI [deep tissue pressure injury] to sacrum. Wounds are new as of 3/20. Treatment [treatment] is Zinc, lotrisome, antifungal daily. DTPI to Rt heel. Note dated 3/28/2025 indicated, Unstageable sacral wound. Wound being treated with honey with calcium alginate covered with foam 3x/week. DTPI to right heel. Treated with betadine gauze covered with ABD [abdominal] pad daily. Wounds are stable. Will continue POC [plan of care]. Note dated 4/4/2025 at 10:18 am indicated, Resident with acquired pressure ulcer to sacrum improving now . resident with acquired pressure ulcer to right heel also improving Note dated 4/18/2025 at 11:10 am indicated, Resident followed this week on PAR for a Sacral wound, unstageable which is showing improvement with Santyl and foam dressing changes daily and for a stage 3 wound to his Right Heel which is not showing improvement and is being treated with Santyl and rolled gauze. Note dated 5/16/2025 at 11:32 am indicated, Patient being followed by PAR for unstageable wound to sacrum. Wound is not improving. Stage III wound to right heel. Wound has not improved. Treatment changed to calcium alginate and rolled gauze. 3x/week. Will continue POC. Interview on 6/4/2025 at 4:30 pm, the Director of Nursing (DON) stated that there was not a policy on the prevention of pressure ulcers.

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	06/05/2025

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

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to arrange podiatry services for two (residents (R) 15 and 33) of two residents reviewed in the sample of 30 residents. The facility failed to ensure at risk residents receive appropriate foot care services. Findings include: Review of R33's Face Sheet found in his electronic medical record (EMR) under the Face Sheet tab revealed the resident was originally admitted to the facility on [DATE] with diagnoses that included anxiety, depression, and difficulty walking. Review of R33's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/10/25 in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R33's cognition was moderately impaired. During a review of R33's EMR, a document located under the Documents tab revealed a podiatry visit on 08/30/22. The document indicated that the facility requested podiatry services for R33 in relation to his toenails. The document also indicated that R33 had pain, limited mobility, and the nails were long and thickened. The document noted that his toenails were graded as moderate and indicated that the resident had these symptoms for a few years. The document revealed the results of the physical exam of R33's toenails and determined that first left and right nails were mycotic with 2 millimeter (mm) of thickness with subungual debris. It is also noted that they are thickened, yellowed, and causing pain. The second through fifth toenails, bilaterally, are elongated and dystrophic, meaning to exhibit abnormal changes in appearance. The document confirmed that the debridement occurred bilaterally to toenails one through five. This included reducing the length and thickness, using manual clippers and electric grinder. Per the document, the consulting physician recommended, ongoing preventive routine debridement of the devitalized or contaminated tissue. Debridement will relieve the pressure form the necrotic presence on the nail and provides for better cosmetic appearance. Debulking the nail does help, in combination with other treatments, in that it can decrease the fungal load of the nail itself to decrease [NAME] of infection and breakdown of skin. For a higher cure rate, I have recommended treating the patient's fungal infection with an oral and/or topical anti-fungal medication unless clinically contraindicated. The document also revealed a 9-week follow-up appointment with a consultant podiatrist, but no evidence of an appointment was located in the EMR. Review of R33's care plan found under the Care Plan tab of the EMR revealed that the resident requires assistance with grooming, bathing, and personal hygiene due to self-care impairment. Interventions included providing nail care as needed, initiated 04/28/23. 2. Review of R15's Face Sheet, found in the EMR under the Face Sheet tab revealed the resident was originally admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus with diabetic polyneuropathy and nail dystrophy. (continued on next page)

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	06/05/2025

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

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R15's annual MDS with an ARD of 03/22/25 in the EMR under the MDS tab revealed a BIMS score of 15 out of 15 which indicated R33's cognition was intact. During an interview with R15 on 06/02/25 at 10:30AM, he stated that his toenails are extremely long and sometimes painful. R15 added that the facility used to have someone who would trim their toenails but that it's been a while since anyone has addressed them. Review of a document found under the Documents tab of the EMR, revealed a consultant podiatry encounter that occurred on 01/30/23. The document confirmed that the facility requested for R15 to have his bilateral toenails evaluated and that all affected nails were debrided to reduce length and thickness using manual clippers and an electric grinder. The consultant also recommended additional follow up of the condition is recommended on a routine basis per routine foot care guidelines for an at-risk patient. Treatment is not recommended if not performed by a qualified medical specialist. Interview on 06/03/25 at 1:58PM, the Regional Nurse Consultant (RNC) 2 stated that podiatry comes to the facility monthly, unless there is an acute concern. When asked how residents are seen she added that she would need to find the roster. During an interview with Certified Medication Aide (CMA) 3, on 06/03/25 at 2:03PM she confirmed that the nurse aides do provide nail care for residents during hygiene care, unless the resident is a diabetic. If they are a diabetic, they are seen by podiatry. The Nursing Home Administrator supplied a binder that was labeled Podiatry List Book. Inside the binder was a single sheet of paper with a handwritten list of residents, titled, List Residents for Podiatry Upcoming. Neither resident R33 or R15 were on the list. During an on 06/03/25 at 3:33PM, the Social Services Director (SSD) stated that the facility recently got a new podiatry provider that will start seeing residents on 06/05/25. When asked if she could provide any documentation of provider visits other than what could be found in the EMR, the SSD stated that she could not, but admitted that there has not been a podiatry provider in the facility for some time and she cannot recall if there was a podiatry provider visit since the new Administrator took over in June of 2024.

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	06/05/2025

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

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents respiratory equipment was maintained and stored appropriately for one of two resident (Resident (R) 83) reviewed for respiratory care out of 30 sampled residents. These failures placed the resident, who has a tracheostomy, at risk for environmental contamination which could lead to respiratory infections. Findings include: Review of the facility's policy titled, Oxygen Administration dated 03/01/23 revealed .Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated .Keep delivery devices covered in plastic bag when not in use . Review of R83's admission Record located in the resident's electronic medical record (EMR) under the Profile tab, revealed R83 was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage, chronic respiratory failure, gastrostomy, and tracheostomy. Review of R83's Physician Order dated 06/02/25 and located in the resident's EMR under the Orders tab revealed Give O2 5L [liter] via trach, mask continuous with humidified air every shift. Change respiratory supplies and set-up every night shift and every Sunday, dated 06/16/24.Clean O2 concentrator filter once weekly on Sunday during the night shift and as needed, dated 06/11/24. During an observation on 06/02/25 at 3:43 PM revealed R83's oxygen concentrator was dirty with dried particles and was sticky. The air filter was covered in white dust. During an observation and interview on 06/04/25 at 3:31 PM, Licensed Practical Nurse (LPN 4) revealed the oxygen concentrator was still dirty with dried particles and sticky. The air filter was covered in white dust. LPN4 stated, The suction tubing is outdated and the Yankauer suction tip is not bagged. This concentrator is dirty. It should have been cleaned and all tubing changed on Sunday evening. During an interview on 06/05/25 at 5:37 PM, the Administrator revealed Infection control is very important for this resident due to having a tracheostomy. Policies and procedures need to be followed.

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	06/05/2025

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

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one of one Resident (R)107 reviewed for pain in the sample of 30 residents had his pain managed by ensuring the fentanyl transdermal patches had been available, his pain had been assessed in a consistent manner, and his physician had been notified of the missed pain management medication. This failure resulted in R107 experiencing pain when repositioned. Findings include: Review of the facility's policy titled, Pain Management dated 3/1/2024 revealed The facility must ensure that pain management is provided to residents who require such services .Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. Facility staff will observe for nonverbal indicators, which may indicate the presence of pain. Those indicators include but are not limited to: .facial expressions (e.g. grimacing, frowning, fright, or clenching of jaw) .negative vocalizations (e.g. groaning, crying, whimpering, or screaming.) .The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. Reviewing the resident's current medical conditions (e.g. pressure injuries, diabetes with neuropathic pain, immobility, infections, amputation, oral health conditions, post CVA (stroke) venous and arterial ulcers, and multiple sclerosis) .Current prescribed pain medications, dosage and frequency . Review of R107's Clinical Census in the Electronic Medical Record (EMR) under the Clinical Census tab revealed he had been admitted on [DATE]. Review of R107's Medical Diagnosis in his EMR under the Medical Diagnosis tab revealed his diagnoses included malignant neoplasm of the colon (colon cancer), secondary malignant neoplasm of the bone (bone cancer), secondary malignant neoplasm of the lung (lung cancer), chronic pain syndrome, pressure ulcers to the right hip, and back. Review of R107's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date of 5/6/2025 revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated he had moderate cognitive impairment. Observation of R107 on 6/2/2025 at 1:30 pm revealed he shook his head yes when asked if he had pain. He was unable to state that he was in pain. He was moaning and grimacing. Licensed Practical Nurse (LPN) 2 gave him his scheduled medications and was aware that he indicated he had pain. LPN 2 did not provide any pain medication for him at that time. The Wound Care/Registered Nurse asked LPN2 on 6/2/2025 at 1:30 pm to administer R107 pain medications prior to his wound care treatment. LPN 2 provided the pain medication at 2:42 pm. (continued on next page)

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	06/05/2025

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

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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of R107's May and June 2025 Medication Administration Record (MAR) in the EMR under the Orders tab revealed R107 had not received the fentanyl transdermal patch 25 micrograms/hour (mcg/hr) apply one patch every three days (slow-release pain medication) The medication had been ordered by his physician on 5/17/2025. The pain medication was not available on 5/17/2025, 5/20/2025, 5/29/2025, 6/1/2025, and 6/4/2025. R107 had an order for hydromorphone 1 milligram (mg) per 1 milliliter (ml) give 5 ml every 6 hours as needed for pain ordered during three different time periods; from 5/2/2025 through 5/6/2025, 5/6/2025 with a parameter to give for a pain level between 7 and 10 out of 10, and it was revised on 5/20/2025 without the pain level restrictions. R107 received the hydromorphone 1 mg only once a day. The medication had been ordered that he could receive hydromorphone 1 mg every 6 hours as needed for pain. Review of a pharmacy packing slip dated 5/20/2025 revealed that two fentanyl 25 mcg transdermal patches had been delivered. There were no more packing slips that the Director of Nursing (DON) was able to provide. Interview on 6/5/2025 at 3:52 pm, the DON and Registered Nurse (RN)1 revealed they were not aware R107's fentanyl patches had not been available for the dates of 5/17/2025, 5/20/2025, 5/29/2025, 6/1/2025, and 6/4/2025. RN1 agreed he had a significant amount of pain when he was repositioned, which was often due to his pressure sores. She had tried to ensure he received the hydromorphone on a regular basis. She did not realize he was only receiving the medication one time a day. His physician had not been informed of his pain control issues due to the resident not having the ordered fentanyl patches available.

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	06/05/2025

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the facility's policy titled, Medication Administration and review of the facility provided document titled Primary Pharmaceutical Provider Contract, the facility did not ensure medications were available for two of two Residents (R) (R107 and R220). This failure placed residents at risk for complications from missing medications. Findings include: Review of the facility's policy titled, Medication Administration dated 6/1/2024 revealed there was not a procedure for when a medication was not available. Review of the Primary Pharmaceutical Provider Contract dated 5/1/2025 revealed the pharmacy would Provide drugs and supplies as required for patients/residents and Nursing Facility in accordance with facility policy and procedures .Provide a regular delivery on Monday thru Saturday and after-hours deliveries 24 hours per day 7 days per week for new emergency or 'stat' orders not available in emergency kits or thru back-up pharmacy. 1. Review of R107's Clinical Census in his Electronic Medical Record (EMR) under the Clinical Census tab revealed he had been admitted on [DATE]. Review of R107's May 2025 Medication Administration Record (MAR) in the EMR under the Orders tab revealed he had not received medications including fentanyl transdermal patch 25 micrograms/hour (mcg/hr.) apply one patch every three days (slow-release pain medication.) The medication had been ordered by his physician on 5/17/2025. The pain medication was not available on 5/17/2025, 5/20/2025, 5/29/2025, 6/1/2025, and 6/4/2025. Flomax 0.4 milligram (mg) (medication for urinary retention) ordered on 5/2/2025. The medication was not available on 5/22/2025 and 5/29/2025. Levofloxacin 750 mg (antibiotic medication) ordered on 5/15/2025 through 5/31/2025. The medication was not available on 5/15/2025, 5/16/2025, and 5/21/2025. Zolpidem Tartrate, (sleep medication), 10 mg every night. The medication was not available on 5/16/2025 and from 5/19/2025 through 5/31/2025 and 6/2/2025 through 6/4/2025. Observation and interview on 6/2/2025 at 1:30 pm of the 400-wing medication cart revealed there were no fentanyl 25 mch/hr. transdermal patches or narcotic sheet for R107. Licensed Practical Nurse (LPN)2 was not sure where the patches would have been. Interview on 6/5/2025 at 3:52 pm, the Director of Nursing (DON) and Registered Nurse(RN)1 revealed they were not aware R107's fentanyl patches had not been available for the dates of 5/17/2025, 5/20/2025, 5/29/2025, 6/1/2025, and 6/4/2025. They were also not aware of the other medications listed above had not been provided to him. They stated that the new automated medication dispensing system did not have any narcotics that could have been supplied. Phone interview on 6/5/2025 at 4:35 pm, R220's Family Member (FM)1 stated that R220's medications had not been available to R220 when she was admitted . She was upset that the medication were not available. (continued on next page)

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	06/05/2025

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R220's Clinical Census in the EMR under the Clinical Census tab revealed she had been admitted on [DATE] and was discharged on 4/30/2025. Review of R220's April 2025 MAR in the EMR under the Orders tab revealed she had not received amiodarone 200 mg (medication for irregular heartbeat), amlodipine besylate 10 mg (medication for blood pressure), and metoprolol succinate ER 25 mg (medication for blood pressure), and Keppra 750 mg for (medication for seizures) at 9:00 am on 4/17/2025. She had not received Eliquis 5 mg (blood thinner medication) on 4/16/2025 at 9:00 am and 9:00 pm and on 4/17/2025 at 9:00 am. Interview on 6/5/2025 at 3:52 pm, the DON revealed she had not been aware R220 had not received her medications as ordered. The missing medications had not been reported to her by the staff or the resident.

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	06/05/2025

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

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 - Some	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** Based on observation, interview, and review of the manufacturer's recommendations, the facility failed to ensure insulin pens or vials had pharmacy labels, were dated when opened, and were not used after the expiration date for two of two medication carts (100 hall and 200 hall). This deficient practice increased the risk of insulin used after the expiration date to be less effective which had the potential to cause high blood sugar levels. Findings include: Review of the manufacturer's recommendations for insulin glargine, Humalog, and Lispro from [Name] and Company revealed when the insulin vial and/or insulin pen was removed from refrigeration it was only effective for 28 days. Review of the manufacturer's recommendations for insulin Novolog and Aspart from Novo Nordisk revealed when the insulin vial and/or insulin pen was removed from refrigeration it was only effective for 28 days. Review of the manufacturer's recommendations for Toujeo Solostar from Sanofi revealed when the insulin vial and/or insulin pen was removed from refrigeration it was only effective for 28 days. Observation and interview on [DATE] at 8:35 am with Licensed Practical Nurse (LPN)3 during the inspection of the west wing medication carts revealed two carts that were used just for insulin, tracheostomy supplies, and tube feeding supplies. Observation of the 100-hall cart revealed one insulin glargine 3 milliliter (ml) prefilled pen with no pharmacy label and when it had been opened and three insulin lispro vials that had not been dated when they had been opened. Observation of the 200-hall cart revealed three insulin aspart flex pens, one had expired on [DATE], one had expired on [DATE], and one had expired on [DATE]. One Toujeo SoloStar insulin pen with no open date or expiration date. Three insulin lispro insulin pens in which one had expired on [DATE], one expired on [DATE], and one with no dates. Two Humalog insulin vials with one that was dated as opened on [DATE] and one with no open or expiration date. One Novolog insulin vial with an opened date of [DATE]. LPN3 stated that the above insulins should have been discarded when expired or labeled when opened. She did not know who was responsible to ensure the insulin had been dated and/or removed when it had expired. Interview on [DATE] at 10:44 am, the Director of Nursing (DON) revealed, her expectations were that the nurse who took the insulin out of the refrigerator would correctly label the vial or pen with the opened date and expiration date. The DON revealed the nurse should always check the expiration date prior to giving.

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	06/05/2025

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

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. Based on observation and interview, the facility failed to ensure all items in the refrigerator, and freezer were sealed, labeled, and dated. These failures had the potential to affect 110 of 112 residents who received their meals from the kitchen at risk of foodborne illnesses. Findings include: During an observation on 6/2/2025 at 8:40 am with the kitchen cook (Cook 1) revealed the following observations: Located in the kitchen were four large plastic containers with lids that each contained breadcrumbs, thickener, flour, and sugar. The containers were not labeled and dated. The Walk-In Refrigerator contained metal containers of watermelon, ketchup, and cucumbers. These items were outdated and dated 5/27/2025. There was no labeling or dating on a bowl of icing, two sandwiches, one bag of sliced cheese, one bag of ham, poured glasses of iced tea and a cooked pan of broccoli. The pan of broccoli was not sealed to prevent air from touching the broccoli. The Walk-In Freezer contained one box of biscuits that were not sealed exposing the biscuits to air. Interview on 6/5/2025 at 5:32 pm, the Administrator revealed that staff must be educated on labeling and dating. The Administrator stated, we go over and over this.

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	06/05/2025

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

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. Based on observation, interview, and review of the facility's policies titled, Personal Protective Equipment and Handwashing/Hand Hygiene, the facility failed to ensure two of two staff (Certified Nursing Assistants (CNA) (CNA1 and CNA2) wore a gown and performed hand hygiene before, in-between, and after glove changes when they provided personal care to one Residents (R) (R107) who was on Enhanced Barrier Precautions (EBP); one of one Wound Care/Registered Nurse (WC/RN) failed to perform hand hygiene before, in-between, and after glove changes during wound care for R97; and two of two Certified Medication Aides (CMA) (CMA1 and CMA2) failed to sanitize the wrist blood pressure (B/P) cuffs between residents' use for R72 and R82. Findings include: Review of the facility's policy titled, Personal Protective Equipment (PPE) dated October 2018 revealed personnel who perform tasks that may involve exposure to blood/body fluids are provided proper PPE .PPE required for transmission-based precautions is maintained outside and inside the resident's room as needed. Review of the facility's policy titled, Handwashing/Hand Hygiene dated October 2023 revealed hand hygiene is indicated, immediately after glove removal. 1. Observation on 6/2/2025 at 3:30 pm revealed there was a sign on the R107's door that indicated what type of PPE was to be worn for EBP which included wearing a protective gown and gloves when providing any care that had the potential exposure to any type of body fluids. Observation on 6/2/2025 at 3:45 pm, CNA1 and CNA2 provided R107's personal care. R107 was on Enhanced Barrier Precautions (EBP) since he had an indwelling urinary catheter, and he had pressure ulcers. During the care CNA1 and CNA2 did not don a gown. CNA1 had completed indwelling urinary catheter care, removed her gloves, and without performing hand hygiene don new gloves, then with the assistance of CNA2 positioned R107 on his left side, pulled the incontinence brief down, and provided perineal care. R107 had a large amount of bowel movement. She discarded several wipes and pairs of gloves during the care. She did not perform hand hygiene between any of the doffing and donning of clean glove changes. CNA2 assisted with rolling R107 over to his right side to ensure it had been cleaned. She pulled the new brief out from under him and assisted to fasten the brief. CNA1 and CNA2 did not change their gloves prior to touching the blankets, side rails, bed controller, and call light. They both removed their gloves and did not perform any hand hygiene prior to leaving R107's room. 2. Observation on 6/2/2025 at 4:45 pm of Wound Care (WC)/Registered Nurse (RN) during the dressing change for R97 revealed without any hand hygiene, WC/RN donned on gloves, removed R97's soiled dressing from his bottom, disposed of it, doffed his gloves, and with no hand hygiene donned a new pair of gloves. He then cleansed the wound, retrieved a pair of clean gloves from his pocket, and put them on without hand hygiene. He applied a new dressing, disposed of the soiled dressing and the gauze he cleansed the wound, doffed his gloves with no hand hygiene prior to leaving the room. 3. Observation on 6/4/2025 at 8:30 am revealed, CMA2 used a wrist blood pressure (B/P) cuff and obtained R54's B/P. After the B/P was obtained she placed the cuff back on top of the medication cart. She used the same B/P cuff at 8:53 am to obtain R72's B/P. She had not sanitized the B/P cuff between the residents. (continued on next page)

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	06/05/2025

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

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	Observation on 6/4/2025 at 9:24 am, CMA1 used a wrist B/P and obtained R82's B/P. After the B/P was obtained she placed the cuff back on top of the medication cart. She did not sanitize the B/P cuff after she used it for R82. In an interview on 6/4/2025 at 2:51 pm, the Infection Preventionist revealed that staff had training on PPE and hand hygiene. She agreed the procedure the staff used did not follow the facility's policies. In an interview on 6/5/2025 at 3:00 pm, CNA2 confirmed that they did not wear a gown when they provided R107's personal care. She revealed she did not realize that she had not performed hand hygiene for her glove use. In an interview on 6/5/2025 at 4:30 pm, the Director of Nursing (DON) revealed that staff had received infection control education not long ago. She agreed that the proper infection control practices had not been maintained.

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	06/05/2025

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

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Deficiency Text Not Available