STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115293	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts at Pooler Inc	508 South Rogers Street Pooler, GA 31322

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to follow professional standards of practice in regard to following a physician's order to obtain a blood pressure prior to the administration of a blood pressure medication for one of six residents (R) (R16) reviewed for medication administration out of 16 total sample residents. This failure had the potential for R16 to be administered blood pressure medication unnecessarily and to experience adverse effects by receiving the blood pressure medication when not needed. Findings include: Review of the facility's policy titled, Medication Administration Overview, dated 2/1/2024, indicated . Verify physician's orders for medication to be administered . Perform needed evaluations prior to administering specific medications (e.g., pulse, blood pressure, blood glucose) . Review of Lippincott Manual of Nursing Practice, dated 2018, page 75, revealed .Departure from Standards of Care . Failure to monitor . a patient's clinical status adequately . Failure to implement a physician's, advanced practice nurse's, or physician assistant's order properly . Review of R16's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R16 was admitted to the facility on [DATE] with the diagnosis of hypertension. Review of R16's admission Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 6/3/2025 indicated R16 had short and long-term memory loss, with being moderately impaired in making daily decisions. Review of R16's Care Plan located under the Care Plan tab in the EMR indicated R16 had a Focus of The resident has .hypertension . Interventions included Give anti hypertensive [sic] medications as ordered . Review of R16's Physician's Orders located under the Orders tab in the EMR indicated R16 had an order, dated 6/16/2025, for Sotalol 80 milligrams by mouth two times a day for hypertension. Hold for systolic blood pressure less than 110 or diastolic blood pressure less than 70. Review of R16's Medication Administration Record (MAR) located under the Orders tab in the EMR indicated R16 was administered Sotalol 80 milligrams by mouth two times a day beginning on 6/16/2025 at 9:00 pm through 7/1/2025 at 9:00 pm. There were no documented blood pressures taken prior to the administration of this blood pressure medication. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/2/2025 at 2:30 pm, Licensed Practical Nurse (LPN) 3 stated, I haven't been taking the resident's blood pressure before I give this medication [blood pressure medication] to the resident. LPN3 reviewed the EMR and the physician's order for this medication and stated, The nurse putting this order in [the electronic record system] did not put in it right. They forgot to put in that the blood pressure needed to be taken each time when administering this medication to [R16]. During an interview on 7/2/2025 at 2:45 pm, the Regional Director of Nursing (RDON) stated, The nurse should have followed the physician's order to obtain the blood pressure prior to the administration of the medication. This is a standard of practice to obtain the blood pressure prior to the administration of this medication when it was ordered by the physician to be done.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and staff interview, the facility failed to ensure a physician-ordered antibiotic was available for administration from the pharmacy for one of two residents (R) (R3) out of a total sample of 16 residents. This failure had the potential for R3 to have adverse effects from not receiving the antibiotic as ordered by the physician. Findings include: Review of R3's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R3 was admitted to the facility on [DATE] with the diagnosis of osteomyelitis of the vertebra in the thoracic region. Review of R3's admission Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 9/14/2024 indicated R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 was cognitively intact. Review of R3's Physician Orders located under the Orders tab in the EMR indicated R3 had an order, dated 9/7/2024, for Cefazolin Sodium Solution Reconstituted 1 GM [gram] Use 2 gram intravenously [IV] every 8 hours for infection until 10/11/2024 [sic]. Review of R3's Medication Administration Record (MAR) located under the Orders tab in the EMR and dated September 2024, indicated on 9/9/2024 at 12:00 am, R3 received his first dose of cefazolin IV since being admitted to the facility on [DATE]. The IV antibiotic was scheduled to be given on 9/7/2024 at 4:00 PM and then again on 9/8/2024 at 12:00 am, 8:00 am, and 4:00 pm. These doses were not documented as being given. Review of R3's EMR in its entirety did not indicate R3 had any untoward effects from not receiving the IV antibiotic as ordered by the physician. During an interview on 7/1/2025 at 11:42 am, the Pharmacist stated, The first delivery of the medication was on 9/8/2024 at 7:36 pm, this would have been a stat [urgent] delivery. Someone from the facility had called the after-hours pharmacist, and they filled it. That was the first time we had heard about this order. The order had hung up in [the electronic record system] because someone at the facility has to confirm the order. From our records, the order was confirmed by someone there at the facility on 9/9/2024, and then we received the transmission of the order and sent the rest of the order they would need for this medication. During an interview on 7/1/2025 at 12:30 pm, Licensed Practical Nurse (LPN) 3 stated, I was called into work a night shift and noted that [R3] did not have an antibiotic in the med [medication] room to be given. I called the pharmacy and asked them to send this to me, and I gave it around midnight on 9/9/2024. After looking back in the computer to see if the antibiotic was ordered, I saw that no one had confirmed the order that was put into [the electronic record system], so I did that. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/1/2025 at 3:00 pm, the Director of Nursing (DON) stated, The nurse is to place the order into [the electronic record system] and then another nurse checks the order and then confirms the order for the pharmacy to send us the medication that has been ordered by the doctor. The nurse can fax the order to the pharmacy to ensure we get the medication, and the pharmacy will send a three-day supply and then once a nurse confirms it in the computer the pharmacy will send the rest of the remaining medication needed for a 30-day supply. I wasn't here at that time, but this is the process that should have been used.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to follow the parameters order for a blood pressure medication in which the medication was given to one of six residents (R) (R3) reviewed for medication administration out of 16 total sample residents. This failure had the potential for R3 to receive unnecessary medications. Findings include: Review of the facility's policy titled, Medication Administration Overview, dated 2/1/2024, stated, To administer the following according to the principles of medication administration, including the right medication, to the right resident/patient at the right time, and in the right dose and route .Verify physician's orders for medications to be administered . Perform needed evaluations prior to the administering specific medications (e.g., pulse, blood pressure, blood glucose) . Review of R3's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R3 was admitted to the facility on [DATE] with the diagnosis of hypertension. Review of R3's admission Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 9/14/2024 indicated R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 was cognitively intact. Review of R3's Physician Orders located under the Orders tab in the EMR indicated R3 had an order, dated 9/18/2024, for Amlodipine Besylate Oral Tablet 5 mg [milligram] Give 1 tablet by mouth one time a day for Blood Pressure Hold for SBP [systolic blood pressure] < [less than] 130 [sic]. Review of R3's Medication Administration Record (MAR) located under the Orders tab in the EMR and dated September 2024, indicated on 9/20/2024 through 9/22/2024, R3's blood pressure was documented as 111/92 for each of those dates and received Amlodipine Besylate five mg on each of those dates. R3's MAR, dated October 2024, indicated R3's blood pressure was documented as 123/75 on 10/4/2024, 10/6/2024 through 10/11/2024. R3 received Amlodipine Besylate five mg on each of those dates when the mediation should have been held. During an interview on 7/1/2024 at 12:30 pm, Licensed Practical Nurse (LPN) 3 stated, I can't tell you why the blood pressures were the same on those dates. But looking at the blood pressures, the medication should not have been given. During an interview on 7/1/2024 at 3:00 pm, the Director of Nursing (DON) stated, The resident's blood pressure should be taken prior to each of the administration times the resident is to receive the blood pressure medication. According to the blood pressure documentation, the medication should have been held and not given to the resident. I expect the nurses to follow the physician's orders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and facility policy review, the facility failed to place a resident with an open wound in Enhanced Barrier Precautions (EBP) and failed to follow infection control guidelines for EBP during a dressing change for one of one resident (R) (R9) reviewed and observed for pressure wounds out of a total sample of 16 residents. This failure had the potential to increase the risk and spread of infections throughout the facility to a vulnerable population. Findings include: Review of the facility's policy titled, Enhance Barrier Precautions, dated August 2022, indicated . Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply . Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs . wound care (any skin opening requiring a dressing). Review of R9's undated Face Sheet located under the Profile' tab in the electronic medical record (EMR) indicated R9 was admitted to the facility on [DATE] with the diagnosis of dementia. Review of R9's Significant Change Minimum Data Set (MDS) located under the MDS tab in the EMR, indicated R9 had a stage four pressure ulcer that was acquired while in the facility. During an observation on 7/2/2025 at 9:15 am, Licensed Practical Nurse (LPN) 1 was observed performing a dressing change to R9 while wearing only gloves. It was also observed that no personal protective equipment (PPE) was available in R9's room or outside of the resident's room for easy access for staff to use when delivering care to R9. During an interview on 7/2/2025 at 9:45 am, LPN1 was asked if R9 should be in EBP due to having an open wound. LPN1 stated, Yes, she should be, and I should have worn a gown when doing the dressing change. During an interview on 7/2/2025 at 2:00 pm, the Director of Nursing (DON) stated, When I walked past the door and looked in, I saw that the nurse was not wearing a gown. This resident has an open wound, and the staff should have been performing care per the enhanced barrier precautions guidelines.