

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/19/2025
NAME OF PROVIDER OR SUPPLIER Lenbrook		STREET ADDRESS, CITY, STATE, ZIP CODE 3747 Peachtree Road, NE Atlanta, GA 30319	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49396</p> <p>Based on observations, staff and resident interviews, and record review, the facility failed to ensure one of 21 sampled residents (R) (R9) call light was accessible to meet care needs, safety and fall prevention. This deficient practice had the potential to cause delayed assistance, medical attention and increase the risk for injury and safety concerns.</p> <p>Findings include:</p> <p>Review of the Electronic Medical Record (EMR) for R9's revealed diagnoses that included but not limited to dementia, impaired physical mobility, and cognitive deficits.</p> <p>Review of R9's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. Section GG (Functional Abilities and Goals) revealed, substantial /maximum assistance for shower/bath, lower body dressing, personal hygiene and mobility; dependent on staff for toileting hygiene and putting on/taking off footwear.</p> <p>Observation on 1/17/2025 at 11:20 am revealed R9 seated in her recliner near the window. The call light was on the nightstand by her bed, far from her reach and inaccessible. When asked to demonstrate how she would summon assistance, R9 struggled with the remote for her recliner. She pressed the wrong buttons, which caused the chair to recline farther from the call light. Despite several attempts, she was unable to reach the call light and expressed frustration, stating, I need to go to the restroom, and if they don't come, they'll be cleaning up a river.</p> <p>Interview on 1/17/2025 at 11:35 am with Certified Nursing Assistant (CNA) DD entered R9's room with the Surveyor. When asked how R9 could call for help with the call light so far away, CNA DD asked R9 if she could reach the call light. R9 replied, No. CNA DD then left the room to seek assistance. Shortly after, CNA EE entered the room to assist. CNA EE and CNA DD moved R9's recliner closer to the nightstand and stated they would work on a better solution to ensure R9 could access the call light.</p> <p>Interview on 1/17/2025 at 12:00 pm with the Director of Nursing (DON) stated, All call lights must be within easy reach of residents to ensure timely assistance. When a call light is not accessible, it increases the risk of harm to residents who cannot summon help.</p>

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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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49396</p> <p>Based on observations, staff interviews, record review, and review of the facility's policy titled Departmental Respiratory Therapy - Prevention of Infection, the facility failed to prevent the spread of infections by not replacing or cleaning a nasal cannula for one of five residents (R) (R9) requiring oxygen therapy. This failure had the potential to increase the risk for infection and medical complications.</p> <p>Findings include:</p> <p>Review of the facility's undated policy titled Departmental Respiratory Therapy - Prevention of Infection, under the section titled Purpose revealed, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Under the section titled Infection Control Considerations Related to Oxygen Administration revealed, 8. Keep oxygen cannulae and tubing used PRN in a plastic bag when not in use.</p> <p>Review of the Electronic Medical Record (EMR) for R9's medical record revealed diagnoses that included but were not limited to dementia, chronic rhinitis, shortness of breath, chronic obstructive pulmonary disease (COPD), and hypoxemia.</p> <p>Review of R9's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment; Section O (Special Treatments and Programs), received oxygen therapy while a resident.</p> <p>Observation on 1/17/2025 at 10:45 am revealed R9 in bed not wearing her nasal cannula. The nasal cannula was observed unbagged and lying on the floor. Certified Nursing Assistant (CNA) JJ retrieved the nasal cannula from the floor and placed it back in R9's nose without cleaning or replacing it.</p> <p>Observation on 1/17/2025 at 11:25 am revealed CNA HH entered the room, observed the situation, and reminded CNA JJ that any equipment that falls on the floor must be discarded and replaced. CNA JJ acknowledged the mistake and notified Licensed Practical Nurse (LPN) II. LPN II then replaced the nasal cannula with a new one and reminded CNA JJ of the importance of following infection control protocols.</p> <p>Interview on 1/17/2025 at 11:30 am with CNA JJ stated, I know the protocol is to discard equipment that falls on the floor, but I didn't replace it right away.</p> <p>Interview on 1/17/2025 at 11:35 am with LPN II stated, Respiratory equipment must be replaced immediately if contaminated to prevent infections. The nasal cannula was replaced as soon as I was informed of the issue.</p> <p>Interview on 1/17/2025 at 12:00 pm with the Director of Nursing (DON) stated, All respiratory equipment must be discarded if it comes into contact with non-sterile surfaces, as contamination can lead to respiratory infections. This is the expectation for all staff.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>35180</p> <p>Based on staff interviews, record review, and review of the facility's policy titled Psychotropic Medication Use, the facility failed to ensure a stop date was implemented, not to exceed 14 days for psychotropic medications for two of five residents (R) (R7 and R21) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>A review of the facility policy titled Psychotropic Medication Use, dated July 2022, under the section titled, Policy Interpretation and Implementation revealed, 12. (a.) PRN (as-needed) orders for psychotropic medications are limited to 14 days.</p> <p>1. A review of R7's clinical records revealed, diagnoses that included but not limited to personal history of mental and behavioral disorders and agitation.</p> <p>A review of R7's physician orders dated 12/17/2024 revealed, an order for lorazepam (an antianxiety medication) 0.5 milligram (mg) via (by way of) transdermal (absorbed through skin) every six hours, as needed (PRN) for agitation. The order had no stop date.</p> <p>A review of the Medication Administration Record (MAR) revealed, R7 was administered lorazepam 0.5 mg via transdermal on 12/23/2024 at 10:00 am, 12/23/2024 at 4:00 pm, 12/28/2024 at 8:00 am, 12/28/2024 at 5:00 pm, 12/29/2024 at 8:00 am, 12/31/2024 at 5:00 pm, 1/5/2025 at 9:00 pm, 1/6/2025 at 3:00 am, 1/7/2025 at 8:00 am, and 1/9/2025 at 9:00 am.</p> <p>2. A review of R21's clinical records revealed, a diagnosis that included but not limited to anxiety.</p> <p>A review of R21's physician orders dated 11/9/2024 revealed, an order for lorazepam 0.5 mg by mouth (PO)/sublingual (SL) every four hours PRN for anxiety. The order had no stop date.</p> <p>A review of the Medication Administration Record (MAR) revealed the staff administered R21 0.5 mg of lorazepam by mouth (PO)/sublingual (SL) on 11/9/2024 at 9:05 pm, 11/13/2024 at 9:15 pm, 11/14/2024 at 11:00 pm, 11/15/2024 at 12:00 am, 11/126/2024 at 7:58 pm, and 12/22/2024 at 10:00 pm.</p> <p>During an interview on 1/17/2025 at 12:50 pm with the Licensed Practical Nurse (LPN) AA revealed that she audited all charts to ensure that a 14-day stop date was applied to all psychotropic medications ordered for the residents. LPN AA confirmed no 14-day stop date for R21's lorazepam, which she stated was an oversight.</p> <p>During an interview on 1/18/2025 at 4:03 pm with the Director of Nursing (DON) revealed, that she expected all psychotropic medications to have a 14-day stop date unless otherwise indicated by the MD. The DON acknowledged that there was no 14-day stop on R21's and R7's lorazepam, and she stated it was an oversight.</p>		