STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115313	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Brookhaven	3535 Ashton Woods Drive 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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49472 Based on observations, record review, interviews, and review of the facility's policy titled Medication Administration: General Guidelines, the facility failed to assess and determine if it was appropriate for one of eight sampled residents (R) (R36) to self-administer medications left at bedside. This failure placed the resident at risk for inappropriate and unsafe medication use. Findings include: Review of the facility's policy titled Medication Administration: General Guidelines, dated 5/31/2023, Procedure: Number 3. Patients/residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. Number 9. Only the licensed or legally authorized personnel that prepare a medication may administer it. Review of R36's clinical record revealed she was admitted to the facility on [DATE] with diagnoses including anxiety disorder, muscle weakness, lack of coordination, pain, diabetes, and mild vascular dementia. Further record review revealed no evidence that an assessment for self-administration of medications was completed, there was no physician orders for resident to have medications at bedside for self-administration, and there was no care plan addressing residents ability to self-administer medications. Review of R36's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident was cognitively intact. Observation on 5/6/2024 at 11:13 am, R36 was sitting in her room. Sitting on her bedside table was a small cup, containing eight pills. No staff members were observed in or around the residents room. Interview on 5/6/2024 at 11:13 am, R36 revealed she was waiting for water from the nurse to take her medications. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Pruitthealth - Brookhaven		STREET ADDRESS, CITY, STATE, ZIP CODE 3535 Ashton Woods Drive NE Atlanta, GA 30319	

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/6/2024 at 2:17 pm, Unit Manager/Licensed Practical Nurse (UM/LPN) AA confirmed she had left a small cup of pills (9:00 am medications) at R36's bedside. UM LPN AA stated that she should have stayed and watched the resident take her medications. UM LPN AA stated that resident complained the drinking water was too cold and wanted tap water. UM LPN AA stated that she was going to get tap water for R36 to take her medications, but needed to assist another resident, before she got back to R36's room. Interview on 5/6/2024 at 2:38 pm, Regional Nurse Consultant (RNC) KK stated the facility has provided in-services regarding medication administration, and replied that today's incident is an automatic write-up. RNC KK verified UM LPN AA left medications at R36's bedside to go and get some tap water.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on record review, interviews, and review of facility policies titled Therapy Evaluations and Specialty Services: Dental Services, Vision Services, Podiatry Services, Hearing Services, and Mental Health, the facility failed to accommodate the needs for three of five sampled residents (R) (R15, R39 and R42). Specifically, R15 had order for durable medical equipment (DME) lift chair to accommodate her mobility with transfers to decrease pain; and failed to ensure R39 and R42 had transportation arrangements for follow-up for post-surgical appointments, resulting in need for rescheduling missed appointments. Findings include: Review of the policy titled Therapy Evaluations dated 3/9/2023, revealed the policy is that all physician's orders for therapy evaluations be addressed in a timely manner by Physical, Occupational and/or Speech therapy as designated by the physician. The evaluation will include discipline-specific findings related to the patient/resident's functional status and underlying impairment and prior functional level. 1. Review of the electronic medical record (EMR) for R15 revealed she was admitted to the facility on [DATE], with diagnoses including osteoarthritis right knee, muscle weakness, and falls. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 11, indicating moderate cognitive impairment. Review of the care plan dated 11/16/2024 revealed R15 had impaired mobility/deconditioning. Interventions to care include encourage participation in therapy, monitor progress and responses to therapy, and provide assistive devices as ordered. Review of a Fall List provided by the facility revealed that R15 sustained 8 falls from August 2023 to most recent fall on 4/22/2024. Review of the Physician Order dated 9/20/2023 by Orthopedic Physician MMMM revealed a lift chair prescription is provided due to R15's arm weakness and leg weakness precluding her from being able to get out of bed safely on her own. Review of document titled The Certificate of Medical Necessity dated 10/24/2023 revealed R15 exhibited with right knee pain and the use of the hospital bed causes excessive strain on her right knee, causing significant pain. The document indicated the facility was to provide for the lift chair. Review of the Physician Order dated 4/13/2024 revealed R15 had an order for PT/OT to eval for seating and safety on the lift chair was discontinued. Interview on 5/1/2024 at 3:34 pm, R15's responsible party (RP) stated she used a lift chair with no problems prior to being admitted at the facility. The RP stated that R15 had been sleeping in her lift chair for [AGE] years. R15's RP stated that the facility is not accommodating her need for the lift chair. As prescribed by the Orthopedic Physician. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview on 5/15/2024 at 2:05 pm, Orthopedic Physician NNNN revealed R15 was seen in their office in September 2023 for arthritis in her right knee. During further interview, he stated R15 is at risk for falls and the DME lift chair should be able to prevent that from happening. He stated the lift chair was considered a reasonable accomodation for R15. A telephone interview on 5/21/2024 at 3:51 pm, Orthopedic Physician MMMM stated R15 was seen in their office on 9/20/2023, in which he wrote an order for the DME lift chair due to her arthritis in the right shoulder. Interview on 5/23/2024 at 3:01 pm, Rehabilitation Director JJJ stated R15 was never assessed for use of a lift chair. She was asked about the two different physician orders for the lift chair, and she revealed she was not aware of the physician orders for a lift chair. Interview on 5/30/2024 at 11:11 am, the Medical Director stated he was not sure why the lift chair would have been discontinued. The Medical Director stated the only reason an order would be discontinued would be if the resident didn't want it anymore or if the nurses told them the resident did not want it anymore. 2. Review of the policy titled Specialty Services: Dental Services, Vision Services, Podiatry Services, Hearing Services, and Mental Health dated 1/3/2024 documents that it shall be the responsibility of this healthcare center to provide safe and convenient transportation for the patient/resident to and from the specialty service office when necessary. Specialty Services include Dental, Vision, Podiatry, Hearing, and Mental Health services. Review of the EMR for R39 revealed she was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease, diabetes, respiratory failure unspecified with hypercapnia, muscle weakness, morbid (severe) obesity, hepatic encephalopathy, schizophrenia, and intellectual disabilities. Review of the resident's quarterly MDS assessment dated [DATE] revealed a BIMS score eight out of 15, indicating severe moderate impairment. Review of the care plan dated 5/18/2024 revealed R39 had a left toe amputation. Interventions to care include observe and report signs of infection, sepsis, and wound care as ordered. Review of the facility's February 2024 Transportation Request revealed R39 had a surgical follow-up appointment on 2/29/2024. There is a hand written notation beside her name indicating the transportation provider was a no show and that appointment had to be rescheduled for 3/7/2024. Review of the Progress Note dated 3/7/2024 revealed that the transportation arrived late to pick up resident for the rescheduled follow up appointment. R39's appointment had to be rescheduled for 3/14/2024. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/3/2024 at 10:13 am, Transportation Aide IIII confirmed that R39 had missed her appointments due to issues with the transportation service. She stated her first missed appointment was because the driver didn't show up. She stated that the facility could transport residents if they could sit in a wheelchair, but she stated R39 had to have a stretcher transport. Client Transportation Aide IIII stated R39's second missed appointment was due to the transportation van arrived late to pick up resident, and the appointment had to be rescheduled for 3/14/2024. During further interview, Transportation Aide IIII stated that every time the transport company does not show up, or is late, she would call to report them. 3. Review of the EMR for R42 revealed she was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease, quadriplegia, hypothyroidism, pressure ulcer of unspecified part of back, urinary tract infection, diabetes, and atrial fibrillation. Review of the resident's quarterly MDS assessment dated [DATE] revealed a BIMS of 15 indicating no cognitive impairment. Review of the Grievance/Complaint Form: HealthCare Center dated 10/13/2024 documented that R42 missed an appointment due to transportation not showing up the morning of the appointment. Client Transportation Aide IIII confirmed that the transportation provider did not show up.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20706 Based on observations, interviews, and review of the policies titled Resident Rights and Daily Occupied Resident Room Cleaning, the facility failed to ensure it was maintained in a safe, clean, and comfortable home-like environment in nine resident rooms on two of three halls, including the common areas and the shower rooms and equipment used for showers. The census was 110. Findings include: Review of Resident Rights revealed under Safe Environment section revealed that residents have the right to a safe, clean, comfortable, and homelike environment . Review of the policy titled Daily Occupied Resident Room Cleaning dated 10/23/2023, revealed that daily cleaning of resident's room should include sweeping the floors, damp mop floors, report any needed work orders for repair, and use disinfectant spray on surfaces. Observation on 4/30/24 at 9:50 am during initial tour of the facility revealed there was a strong malodorous odor upon entrance of building. Observation on 4/30/24 at 9:52 am, during tour of the 200-hall revealed mild odor in hallway, floors with trash on the carpet and in resident rooms, no active housekeeping staff observed providing cleaning. Interview on 5/1/2024 at 10:46 am, family member of R19 revealed that the resident's room is always dirty, and stated they seen bugs crawling in the room. Observation on 5/1/2024 at 12:05 pm, on 100-hall revealed several resident rooms with floors that appeared to have particles and trash, no housekeeping staff cleaning observed. Observation on 5/1/2024 at 12:15 pm, on 300-hall revealed rooms [ROOM NUMBER] with badly scuffed walls and trash on the floors of the resident rooms; room [ROOM NUMBER] had hole in the wall, broken blinds in the window, and rust on the legs of the bedside table, and room [ROOM NUMBER] had trash on the floor. There was no sign of housekeeping staff doing any cleaning. Observation and interview on 5/1/2024 at 4:15 pm with Maintenance Director (MD) II and the Administrator revealed shower room on 300-hall has three shower stalls. Shower bed cushion noted with multiple cracks in the cushion that residents are placed on. Observation of room [ROOM NUMBER]-B with broken blinds on window, rust on bedside table legs, and hole in the wall. In addition, there are splashed paint spots throughout the building on wood like floors that MD II confirmed has been there for couple of years now. Observation on 5/2/2024 at 10:45 am, observation of rooms [ROOM NUMBER] on the 100-hall revealed trash on resident room floors, no housekeeping staff observed cleaning. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/2/2024 at 1:15 pm, room [ROOM NUMBER]-B revealed floor appears unclean, hole in the wall near the bed, chucks and briefs thrown on a chair and floor. A brown stain on the wall near the bathroom entrance that appeared to be feces smeared on the wall. Interview on 5/2/2024 at 1:30 pm, with Housekeeping Director (HD) GGGG revealed that the paint spots on the floors throughout the building had been there for a while due to no drop cloth being used during a paint job. HD GGGG stated they have tried to remove the paint spots, and revealed that the list of daily tasks included wiping down all surfaces, sweeping and mopping all rooms and wipe down walls. The Housekeeping Director GGGG confirmed stain on wall in Rm 318-B appears to be a feces stain. Observation on 5/2/24 at 3:39 pm, room [ROOM NUMBER] revealed resident room with bare walls, area around the bed with food particles on the floor, multiple packs of bed chuck liners and briefs on bedside table instead of being in the drawers, dirty folded floor mat next to bed (not in use), bed has two 1/2 side rails with brownish stains on it. Observation on 5/6/2024 at 9:30 am, 100-hall with strong urine odor while walking through the hallway. Observation on 5/6/2024 at 5:30 pm on 300-hall shower room revealed a wig left on the countertop, with a used dirty hairbrush and cracked shower bed table mattress that is used for residents. Observation on 5/7/2024 at 1:45 pm, in room [ROOM NUMBER]-B room revealed trash on floor around the bed, wall near corner of room by window with black stain and floor baseboard loose coming off. Resident bedside table and dresser drawer pilled with multiple unused briefs thrown on top of bed side table and bed side dresser. Observation and interview on 5/8/2024 at 10:20 am, MD II confirmed in room [ROOM NUMBER] the black appearing stain on the wall and the floor baseboard coming off wall. He stated he was not aware of this stain and stated it may be scuffing marks on the wall. Interview on 5/13/2024 at 12:45 pm, with Infection Prevention BBBB revealed that both shower mattress cushions need to be replaced immediately once they are cracked. During further interview, she stated the white plastic stand is not properly cleaned and needs to be cleaned and disinfected between each resident use. Observation on 5/16/2024 at 11:11am, in room [ROOM NUMBER] revealed food crumbs behind and around the bed with bed rails that is stained and dirty for several days. Additional observation of shower room on 300-hall revealed the same cracked mattress pads observed earlier during the survey, multiple items scattered on counter-top and shower floor. Observation on 5/29/2024 at 2:15 pm, shower room on 300-hall revealed same cracked shower stretcher cushion, and items thrown randomly on the floor and countertop. Interview on 5/29/2024 at 3:30 pm, Maintenance Director II and Administrator confirmed environmental concerns identified during the survey.

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49687

Based on record review, interviews, and review of the facility policy titled Grievances: Healthcare Centers, the facility failed to ensure prompt resolutions for residents' grievances regarding missing items. The census was 110.

Findings Include:

Review of the policy titled Grievances: Healthcare Centers, revised 1/10/2024, documented the policy is to follow an established process whereby patients and/or other customers may have their grievances and complaints resolved in a prompt, reasonable and consistent manner. A grievance includes complaints with respect to care and treatment that has been furnished to a patient, as well as that which has not been furnished, the behavior of staff and of other patients, and other concerns regarding the patient's facility stay. Procedure: Number 1. If the grievance is associated with a missing item, refer to the Missing Item Policy and associated forms. Number 5. The grievance/complaint should be resolved within three business days. Number 8. The Administrator will present the grievance trends to the monthly Quality Assurance and Performance Improvement Committee.

Review of the facility grievances back to the last survey of June 2022 revealed grievances for missing personal items filed in November 2023 were not resolved until March 2024. The grievances were as follows:

1. Review of the Grievance/complaint form: Healthcare Centers dated 11/15/2023 documented R40 was missing a pocket dictionary, a pair of stripe socks, and a cotton blouse. The steps taken to investigate revealed: searched for the items in the laundry department, but the items were not found. It was documented that social services department had spoken to R40, regarding the clothing items that were not found. The items were offered to be replaced and R40 agreed to the outcome. The resolution date on this Grievance/complaint form was 11/16/2023, but a receipt of several items purchased from an online [NAME] notated 3/5/2024 as the date of purchase. The grievance was not resolved until four months after the grievance was filed.

2. Review of the Grievance/complaint form: Healthcare Centers dated 11/15/2023 documented R42 was missing one blue and white blouse. The Social Service department spoke to R42 and determined the appropriate resolution to the missing item was to replace it, and resident agreed. The resolution date documented on this Grievance/complaint form was 11/18/2023, but a receipt of several items purchased from an online [NAME] notated 3/26/2024 as the date of purchase. The grievance was not resolved until four months after the grievance was filed.

3. Review of the Grievance/complaint form: Healthcare Centers dated 11/15/2023 documented R41 was missing two pink shirts. The steps taken to investigate revealed: searched for the items in the laundry department, but the items were not found. The summary was noted that the Social Services department offered to replace the items, and R41 agreed to the outcome. The resolution date noted on this Grievance/complaint form was 11/18/2023, but a receipt of several items purchased from an online [NAME] notated 3/26/2024 as the date of purchase. The grievance was not resolved until four months after the grievance was filed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/31/2024 at 12:04 pm, Social Service Director (SSD) JJ revealed that the most common grievances filed are related to missing items. She confirmed that the identified grievances from November 2023 were noted to be resolved in November 2023, but it was identified that the residents missing items had not been replaced. The items were replaced in March 2024, with the receipts attached for proof of purchase. Interview on 5/31/2024 at 12:49 pm, SSD JJ was asked if the grievances for R40, R41, and R42 would be considered resolved within three days, when the items for each resident were not replaced until March 2024. She replied, I can't speak to why they were considered resolved in November, but upon notification to me that items hadn't been replaced, we took action to resolve at that point.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on record review, interviews, and review of the facility's policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to provide a complete and thorough investigation of allegations of abuse for two of three residents (R) (R10 and R44) reviewed. Findings included: A review of the facility's policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, revealed that interviews should be conducted with all individuals who have relevant information, utilizing open-ended questions. Written signed statements from any involved parties should be obtained (and notarized. if necessary). Statements should be gathered from the following individuals: the suspect; the person(s) making accusation(s); the patient(s) involved; reliable patients who may have witnessed the incident; and any other persons who may have information. The policy continues to document that all investigative information should be kept on file in a secured location. A review of the Electronic Medical Record (EMR) revealed that R10 was admitted to the facility on [DATE]. R10 had a Brief Interview for Mental Status (BIMS) of 11 indicating that R10 had moderate cognitive impairment. A review of the EMR revealed that R44 was admitted to the facility on [DATE] and discharged on [DATE]. During review of the Facility Reported incidents (FRIs) for R10 and R44, the five-day follow report indicated that witness statements and interviews were noted to have been conducted; however, no signed written statements or interview notes, from any involved parties were included in the reports. In an interview on 6/4/2024 at 1:45 pm, the Administrator revealed he could not find any witness statements that would corroborate the statements that was noted in the investigation documented by the Previous Administrator DDD. On 6/4/2024 at 2:28 pm, a phone interview was attempted with the previous Administrator DDD and a voicemail was left. There was no return call from the previous Administrator DDD.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49472 Based on record review, interviews, and reviews of the policy titled Minimum Data Set (MDS) Assessment Accuracy, the facility failed to ensure that a Significant Change MDS assessment was completed for one resident (R) (R8) who had been placed on Hospice services. The sample size was 44. Findings include: Review of the policy titled Minimum Data Set (MDS) Assessment Accuracy reviewed on 1/11/2024 revealed the policy is that each Minimum Data Set (MDS) reflect the acuity and the medical status of each resident in accordance with acceptable professional standards and practices. Significant Change in Status Assessment (Comprehensive) ARD (Assessment Reference Date) must be no later than the 14th calendar day after the determination of a significant change has been made. Review of the quarterly MDS assessment dated [DATE] revealed that R8 had a Brief Interview for Mental Status (BIMS) of 15, indicating that the resident was cognitively intact. Review of the Physician's Orders for R8 indicated that resident had orders for Hospice evaluation and treat on 6/1/2023 to 8/4/2023; 6/19/2023 to 8/4/2023; and 9/8/2023 to 2/22/2024. Review of the facility records showed that R8 had one Significant Change MDS completed on 6/30/2023. There were no other Significant Change MDS assessments completed for R8, reflecting the admission to Hospice services for 9/8/2023. Interview on 6/3/2024 at 11:54 am Regional Nurse Consultant KK confirmed that there was no change of condition MDS for R8. Interview on 6/3/2024 at 12:02 pm, Corporate Minimum Data Set Coordinator (MDSC) MMM stated that R8 had hospice orders three times after he was admitted to the facility. MDSC MMM stated that a significant change MDS would not be completed based on the number of change of events, but it would be based on the impact of the event on the resident. During further interview, MDSC MMM stated going on or off of hospice and a new feeding tube would be examples of when a Significant Change MDS would be completed. She stated that R8 should have been evaluated each time a hospice assessment was completed, thus yielding a significant change MDS. MDSC MMM stated the Significant Change MDS dated [DATE] for R8 was completed due to Hospice services and resident was receiving speech therapy because he was having issues with communication and dysphagia. The MDSC MMM confirmed that there was no documentation of assessments or evaluations to determine a need for a Significant Change MDS.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49472 Based on record review, interviews, and review of the policy titled Minimum Data Set (MDS) Assessment Accuracy Policy, the facility failed to ensure that resident's ethnicity and language needs were properly assessed on the MDS for one of one resident (R) (R6) reviewed. Review of the Minimum Data Set (MDS) Assessment Accuracy Policy dated 12/6/2022 documented it is the policy of the healthcare center that each MDS reflect the acuity and the medical status of each patient/resident in accordance with acceptable professional standards and practices. The assessment will be scheduled to accurately account for the acuity and complexity of the patient/resident. Each Assessment Reference Date (ARD) will be chosen to capture services rendered and reflect an accurate clinical profile of each patient/resident. Review of the clinical record revealed R6 was admitted to the facility on [DATE] with diagnoses of bacterial infection, unspecified fracture of unspecified thoracic vertebra, cognitive communication deficit, diabetes, intestinal obstruction, history of falling, hypertension, atrial fibrillation, emphysema, gastro-esophageal reflux disease (GERD) and chronic kidney disease, stage 3. Review of the admission MDS dated [DATE] revealed that resident's ethnicity was listed as White. Review of the MDS dated [DATE] revealed that resident was assessed to not want an interpreter to communicate with a doctor or health care staff. In the area of toilet use, resident was assessed as requiring extensive assistance. Resident was assessed as having a Brief Interview for Mental Status (BIMS) score of 13 indicating mild cognitive impairment. Review of the care plan for R6 showed no evidence that resident was care planned language or communication barriers. Review of the History and Physical (H and P) dated 7/6/2024 revealed that R6 was identified as a primarily Greek speaking male. Interview on 5/6/2024 at 4:26 pm, Minimum Data Set Registered Nurse (MDS RN) HH, revealed that he completes the MDS for residents, but the social worker and nursing staff complete section GG assessment. He stated the social worker usually assesses the resident for language (primary) and the determination of the language depends on the language the resident uses and most likely it is through the interview that occurs with the resident and/or family. During further interview, the MDS RN HH stated that the social worker is responsible for putting a system in place for communication when there was a language barrier. MDS RN HH moreover stated that he and the social worker code language barriers. Lastly, MDS RN HH stated that he gets his information, in reference to coding language, from the interview, assessment, hospital records, and social worker.

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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** 49470 Based on record review, policy review, interviews and review of Rule 410-10-.02 Standards of Practice for Licensed Practical Nurses, the facility failed to ensure that services were provided in accordance with professional standards of quality as evidenced by the failure to conduct weekly skin assessments to identify skin breakdown and provide treatments before pressure ulcer development for two of three sampled residents (R) (R26 and R20) reviewed for pressure ulcers. Findings include: Review of the Georgia Rule 410-10-.02 - Standards of Practice for Licensed Practical Nurses revealed that: (1) The practice of licensed practical nursing means the provision of care for compensation, under the supervision of a physician practicing medicine, a dentist practicing dentistry, a podiatrist practicing podiatry, or a registered nurse practicing nursing in accordance with applicable provisions of law. Such care shall relate to the promotion of health, the prevention of illness and injury, and the restoration and maintenance of physical and mental health through acts authorized by the board, which shall include, but not be limited to the following: (a) Participating in patient assessment activities and the planning, implementation, and evaluation of the delivery of health care services and other specialized tasks when appropriately educated and consistent with board rules and regulations. (b) Providing direct personal patient observation, care, and assistance in hospitals, clinics, nursing homes, or emergency treatment facilities, or other health care facilities in areas of practice including, but not limited to coronary care, intensive care, emergency treatment, surgical care and recovery, obstetrics, pediatrics, outpatient services, dialysis, specialty labs, home health care, or other such areas of practice. 1. Review of the clinical record for R26 revealed she was admitted to the facility on [DATE] with diagnoses including sepsis, psychotic disturbance, mood disturbance, aphasia following cerebral infarction, dysphagia, and an altered mental status. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated severe cognitive impairment. R26 was dependent on staff for all care. Section M revealed the resident was high risk for pressure ulcer but had no pressure ulcers, venous, or arterial ulcers in this assessment period. Pressure ulcer triggered as an area of concern on the Care Area Assessment Summary (CAAS). Review of R26's care plan dated 10/23/2023 revealed resident was at risk for skin breakdown. Interventions to care include keep skin clean and dry, provide incontinence care, report any signs of skin breakdown (sore, tender, red or broken areas). Review of R26's admission skin assessment dated [DATE] revealed skin was warm, dry, normal color, normal turgor, and without alterations in skin. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R26's weekly skin observations from 11/4/2023 to 12/16/2023 revealed Registered Nurse (RN) UU documented R26 had no skin or pressure injuries. Review of the Progress Note dated 10/24/2023 written by Licensed Practical Nurse (LPN) NN, documented skin observation completed and an old healed bilateral surgical scar to knees noted, and all other skin areas are intact. Per Braden score resident is not at risk for pressure injuries currently. Review of the Progress Note dated 12/22/2023, LPN AA documented R26 had redness to the right heel and dark purple discoloration to the left heel. There was redness noted to the sacral area. Review of the hospital records dated 12/26/2023 documented R26 resided in a nursing home and was admitted with an unstageable sacral decubitus with dark eschar and documented. Her left heel had purple discoloration and small area of full-thickness breakdown medially congruent with a deep tissue pressure injury (DTPI), right heel noted with a ring of non-blanchable erythema surrounding it. She had elevated troponin likely severe sepsis, acute kidney injury (AKI), dehydration (creatinine 1.32) due to poor intake, and Hypernatremia. Review of the readmission note Wound Management Detail Report dated 1/8/2024 completed by LPN NN, documented R26 had an unstageable right buttock wound with slough and eschar; wound to sacrum with necrotic tissue present; left heel and right heel wounds. These wounds were documented by LPN NN as present on readmission. Review of hospital records dated 2/3/2024, revealed R26 was readmitted to the hospital with diagnosis of pyelonephritis and sepsis secondary to urinary tract infection (UTI) and acute encephalopathy. Interview on 5/6/2024 at 2:20 pm, LPN AA revealed R26 was sent to hospital on 12/26/2023 and returned on 1/8/2024. R26's last hospitalization was on 2/2/2024 and she passed away in hospital. Interview on 5/14/2024 at 1:44 pm, Physician Assistant (PA), SS stated he observed R26 wounds for the first time on 1/18/2024. The second time he observed the wounds was on 1/25/2024 and lastly on 2/1/2024. He stated he did not verify where R26 acquired her wounds. He stated LPN NN revealed that R26 acquired wounds when she was in hospital. Interview on 5/29/2024 at 12:09 pm, the Director of Nursing (DON) revealed she believed R26's wounds were acquired at the facility and the wounds should have been prevented. She added it appeared staff were not doing full head to toe assessments. The DON added staff should have observed R26's wounds at an early stage and concluded the head-to-toe assessment tool could have prevented the pressure wounds. 2. Review of the clinical record revealed that R20 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, encephalopathy, altered mental status and hypertension. Review of the admission MDS assessment dated [DATE] revealed a BIMS score of 11, which indicated moderate cognitive impairment. Resident required moderate assistance from staff for activities of daily living (ADL) care. Section M revealed resident was admitted without pressure ulcers and documented she was at risk of developing pressure ulcers. Pressure ulcers triggered as an area of concern on the CAAS. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Skin assessment dated [DATE] revealed a Braden Scale of 20 (as being not at risk, no impairment, rarely moist and bedfast). Review of the Progress Note dated 3/1/2023 documented skin assessment shows bilateral discolorations beneath right and left breasts and resolved pressure injury scar on sacrum. Skin is otherwise clean, dry, and intact. Review of the Progress Note dated 4/25/2023 documented wound care update. Resident has developed sacral pressure wound . Resident contact notified by phone. Treatment initiated. Wound care protocols in place. Dietician notified. Review of the Skin assessment dated [DATE] documented resident has a new pressure ulcer to the sacrum that measured 4 x 5 x 5 cm (centimeters) and described as light serous exudate, slough, dark purple or rusty discoloration and stable. A second pressure injury to the left heel, described as blister, measuring 3 x 3 cm. Further review of EMR revealed that there were no weekly skin assessments done from 3/1/2023 through 4/25/2023 (eight weeks). Review of the Progress Note by [Wound Management Company] dated 4/27/2023 recorded as the first visit, documented a facility acquired stage II pressure ulcer to sacrum with measurements 5 x 4 x 0.1 cm with mild serous drainage. Further review of the note revealed the wound was discovered on 4/25/2023. Review of the Progress Note by [Wound Management Company] dated 5/1/2023 documented a facility acquired ulcer to sacrum with measurements 3.5 x 4 x 0.2 with 80% yellow/black necrotic tissue with mild drainage, not improving. Wound stage has been changed from II to unstageable for the reason covered in slough. Further review of the note revealed wound PA discussed continuing education with staff to minimize the amount of time resident spent lying on the wound and emphasized offloading to prevent wound deterioration. Staff and resident acknowledged understanding. Review of the Progress Note by [Wound Management Company] dated 5/8/2023 documented necrotic tissue in unstageable sacral wound with measurements 8 x 7 x 0.2 with 80% yellow/black necrotic tissue and mild serous drainage. Status documented as not improved. Further review of the note revealed wound PA discussed continuing education with staff to minimize the amount of time resident spent lying on the wound and emphasized offloading to prevent wound deterioration. Staff acknowledged understanding. Review of the Progress Note by [Wound Management Company] dated 5/17/2023 documented resident has been discharged from care. Interview on 5/20/2024 at 10:20 am, Licensed Practical Nurse (LP) YY revealed she is the current wound care nurse. She revealed that the initial skin assessments are done by the wound care nurse, but then the floor nurses are responsible for doing the weekly assessments, and documenting them in the EMR. LPN YY indicated that R20 had an initial skin assessment on 2/28/2023, and stated she was not assessed to be at risk for skin breakdown. During further interview, she confirmed there were no other skin assessments completed for R20 until she was seen by wound physician on 4/25/2023. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/20/2024 at 11:42 am, RN TT revealed R20's only skin assessment was done on 2/28/2023 upon admission, and confirmed there were not any other skin assessments completed for R20, until 4/25/23. Interview on 5/22/2024 at 10:10 am, RNC KK stated that she reviewed the CNA skin notes and did not find any documentation regarding skin issues for R20 prior to 4/25/2023, when her pressure ulcer was identified. Interview on 5/22/2024 at 12:14 pm, wound Physician Assistant SS stated that he could have provided bedside debridement for R20 declining sacral wound, but indicated the facility did not get consent from R20's responsible party. Cross Refer F686

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49472 Based on observations, record review, staff and resident interviews, the facility failed to provide activities of daily living (ADL) care for three of 10 residents (R) (R8, R35 and R27) reviewed for ADLs. Specifically, the facility failed to provide showers as scheduled for R8, R35, and R27. Findings include: Review of East Shower Schedule revealed showers were provided for residents on Mondays, Wednesdays, and Fridays from 7:00 am to 7:00 pm or from 7:00 pm to 7:00 am; and on Tuesdays, Thursdays, and Saturdays from 7:00 am to 7:00 pm or from 7:00 pm to 7:00 am. 1. Review of R8's Admission Record revealed the resident was admitted to the facility with diagnoses including rhabdomyolysis, type 2 diabetes mellitus with ketoacidosis with coma, hypotension, muscle weakness, cerebellar ataxia, unspecified fall, dysarthria and anarthria, degenerative disease of nervous system, and morbid (severe) obesity due to excess calories. Review of R8's care plan revealed the resident was not care planned for bathing preferences. Review of R8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Review of the Grievance/Complaint Form: Healthcare Centers from June 2022 to present revealed a grievance dated 12/29/2023 that was filed by R8's family member. The complaint documented that R8 was not getting bathed, resident was not getting oral care, and family wanted resident out of bed more often. Review of the Inservice Education Program Summary Record Form showed an inservice was provided on 12/29/2023 addressing providing oral care and giving showers as scheduled. Review of R8's Shower Forms from December 2023 to May 2024 revealed R8 received a shower on 3/21/2024, 3/28/2024, 4/16/2024, 4/18/2024, 4/23/2024, and 4/25/2024. Review of R8's Shower Forms for July 2023 revealed R8 received a shower on 7/4/2023, 7/6/2023, 7/11/2023, 7/13/2023, 7/18/2023, 7/20/2023, 7/25/2023, and 7/27/2023. Review of R8's Shower Forms for August 2023 revealed R8 received a shower on 8/4/2023, 8/8/2023, 8/10/2023, 8/15/2023, 8/17/2023, 8/22/2023, 8/24/2023, and 8/29/2023. Interview on 5/8/2024 at 2:45 pm with R8 revealed that he received his baths on Tuesdays and Thursdays. R8 stated that he was not aware he had a choice of receiving baths two or three times per week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R35's Admission Record revealed the resident was admitted to the facility with diagnoses including metabolic encephalopathy, malaise, autonomic neuropathy, aneurysm of artery of lower extremity, muscle weakness (generalized), malignant melanoma of skin, acute systolic (congestive) heart failure, methicillin resistant staphylococcus aureus (MRSA) infection, and altered mental status. Review of R35's care plan revealed a care plan for ADL functional status/rehabilitation potential-resident requires active range of motion to bilateral upper extremity three to five days per week. Further review of R35's care plan revealed the resident was not care planned for shower preferences. Review of R35's MDS dated [DATE] revealed a BIMS score of 15 indicating the resident was cognitively intact. Review of R35's Shower Forms from December 2023 to May 2024 revealed R35 received a shower on 4/9/2024, 4/16/2024, 4/18/2024, 4/19/2024, and 4/23/2024. Interview on 5/8/2024 at 4:13 pm with the Director of Nursing (DON) confirmed there were no shower sheets for R35 for the month of December 2023, January 2024, and February 2024. DON stated that bath/shower preferences were to be followed up with by the Unit Manager. The DON stated the expectation is that residents' showers will be acknowledged by the unit manager and that there would be three showers per week according to the schedule. 49687 3. Review of R27's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, tinea unguium, muscle weakness, unsteadiness on feet, hyperlipidemia, chronic kidney disease, gastro-esophageal reflux disease (GERD) and chronic pain. Review of R27's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Review of R27's care plan dated 3/5/2024 revealed R27 had ADL functional status/rehabilitation potential-resident requires one person assistance with ADL care. Interventions to care include one person assist with bed mobility, ADL's, and shower/baths as scheduled; however, R27 was not care planned for shower preferences. Review of the East Shower Schedule revealed that R27 is scheduled to receive showers on Tuesdays, Thursdays, and Saturdays between 7:00 am to 7:00 pm. Review of the February 2024 Shower Forms revealed R27 received a shower on 2/3/2024, 2/10/2024, 2/13/2024, 2/24/2024 and 2/27/2024. This indicates that R27 received five out 13 showers for February 2024. Review of the March 2024 Shower Forms revealed R27 received a shower on 3/5/2024, 3/9/2024, 3/12/2024, 3/16/2024, 3/19/2024, 3/24/2024, 3/26/2024 and 3/30/2024. This indicates that R27 received eight out of 13 showers for March 2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/30/2024 at 11:29 am, the Regional Nurse Consultant (RNC) KK revealed the facility does not have a policy on ADL care. Interview on 5/2/2024 at 12:47 pm, R27 stated he had been receiving showers only one time a week and stated he needed more than one per week. Interview on 5/6/2024 at 2:28 pm, the Unit Manager Licensed Practical Nurse (LPN) AA stated residents are supposed to be receiving showers twice a week. She stated the Certified Nurse Aides (CNAs) document on a shower sheet when the residents get their shower. During further interview, she stated the CNA they would have to record it even if they don't provide the showers, or if residents refuse. Interview on 5/8/2024 at 3:53 pm, the Director of Health Services (DHS) confirmed that R27 should have received 13 showers in the month of February 2024 and March 2024. The Survey Team was informed that there was no policy for activities of daily living (ADL) upon request.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49472 Based on observations, record review, staff and resident interviews, and review of the policy titled Activities Program, the facility failed to ensure an ongoing program of activities based on preferences for three of three residents (R) (R8, R35, R19) reviewed for activities. These residents were not provided with person-centered activities that would meet their individual needs. Findings include: Review of the policy titled Activities Program revised 9/28/2023, the policy statement revealed the center provides an ongoing program of activities designed to meet the physical, mental, and psychosocial well-being of each resident while offering a rich array of activities to the residents of the center. Procedure: Number 3. There shall be at least one different structured recreational activity provided daily each week that shall accommodate resident's needs/interests/capabilities as indicated in the care plan. Number 4. The facility posts a monthly schedule of planned activities for easy review in the center. This schedule shall include the activities, dates, times, and locations. Number 8. The activity participation will be recorded by the Activities Director/Assistant or designee in the Electronic Health Record (EHR). Participation will be completed for each resident per each activity. Review of the activity calendar for December 2023 revealed the weekend activities included a church service for the second and the 16th of December with no other activities on the other Saturdays, and there were not any activities listed for Sundays during the month. Review of the activity calendar for January 2024 revealed the weekend activities included Saturday church services on the sixth and the 20th with no other activities listed for any other Saturday for the month, and there were not any activities listed for Sundays during the month. Review of the activity calendar for February 2024 revealed the weekend activities consisted of church services on the third and 17th with no other weekend activities listed for the month. Review of the activity calendar for March 2024 revealed church services for the second and the 15th in addition to an activity listed for Sunday, the 17th; there were no other weekend activities listed for the month of March. Review of the activity calendar for April 2024 revealed on Wednesdays for the 10th, 17th, and 24th, there was only listed a 10:00 am activity; on the sixth and 20th there were church services listed for Saturdays with no activities listed on Sundays. Review of the activity calendar for May 2024 revealed weekend activities for the month showed activities for the fourth, 11th, 18th, and bingo on the 12th. Review of the facility document titled 1:1 List for East indicated R8 and R35 were to receive one to one activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of the admission record for R8 revealed he was admitted to the facility with diagnoses including rhabdomyolysis, diabetes mellitus with ketoacidosis with coma, hypotension, muscle weakness, cerebellar ataxia, dysarthria and anarthria, degenerative disease of nervous system, and morbid obesity. Review of the annual Minimum Data Set (MDS) assessment for R8 dated 5/22/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Activity preferences were documented as very important to choose his activities. Review of Activities Notes for R8, revealed a 1:1 activity on 4/9/2024 which lasted for 15 minutes. No other activities or details were provided. Interview on 5/14/2024 at 10:20 am, R8 stated I lay in bed twenty-four hours a day, seven days per week, because they don't want to fool with me. R8 revealed that staff did not offer him to go to activities and they did not do one to one visits or offer him individual activities. R8 stated that he used to want to participate in activities, but lost interest. 2. Review of R35's admission record revealed he was admitted to the facility with diagnoses including metabolic encephalopathy, malaise, autonomic neuropathy, aneurysm of artery of lower extremity, malignant melanoma of skin, acute systolic (congestive) heart failure, methicillin resistant staphylococcus aureus (MRSA) infection, and altered mental status. Review of the quarterly MDS dated [DATE] revealed that R35 had a BIMS score of 15 indicating the resident was cognitively intact. Activity preferences were documented as very important to choose his activities. Review of the Activities Notes for R35 revealed one day of activities on 4/9/2024 which was a bingo activity that lasted for 60 minutes. No other activities or details were provided. Interview on 5/14/2024 at 10:16 am, with R35, when asked if he participated in activities the resident stated, what activities? R35 revealed the only activities that he knew of were bingo and church. R35 stated that he had not been offered or assisted to go to activities. R35 stated that he did not receive 1:1 activities and was not offered any reading materials, puzzles, etc. 3. Review of R19's admission record revealed he was admitted to the facility with diagnoses including osteoarthritis, cerebellar ataxia, dysphagia, malnutrition, age-related physical debility, cognitive communication deficit, and muscle weakness. Review of the annual MDS dated [DATE] revealed R19 had a BIMS score of 14 indicating the resident was cognitively intact. Preferences for Customary Routine and Activities revealed that doing things with groups of people, doing favorite activities, and going outside for fresh air were very important to him. Activity preferences were documented as very important to choose his activities. Observation on 5/1/2024 at 12:30 pm, R19 was in bed, alert, speech unclear but able to communicate with yes and no responses. When asked if he gets out of bed, he replied no. When asked if he is offered to get out of bed he replied no. When asked if he likes to get out of bed he replied yes. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/2/2024 at 1:30 pm and 3:44 pm, R19 in bed watching television (tv), and says he was not asked to be gotten out of bed today. Observation on 5/6/2024 at 12:30 pm revealed R19 in bed, watching tv. Observation on 5/8/2024 at 1:25 pm, R19 was out of bed in the therapy room. He appeared happy to be out of bed. Interview on 5/2/2024 at 3:39 pm, R19 revealed that he never gets out of bed but would like to and stated no one offers him to get out of bed. Interview on 5/2/2024 at 3:45 pm, with Certified Nurse Assistant (CNA) CCCC, revealed that she does not recall R19 being out of bed except for his shower days on Mondays and Fridays. She further stated she does not recall R19 going to any activities and stated he likes to watch TV. When asked if she is aware of things he likes to do and if he is offered, she replied she didn't know. Interview on 5/15/2024 at 3:00 pm, the Activity Director (AD) stated that she had been in this position since August 2023, and stated she is the only staff member doing activities for the entire facility. She stated that she does activities that the residents like, such as coffee socials and bingo. She stated that she has incorporated more bingo, up to three times per week, due to the residents requesting to play more than once a week. She confirmed that the activities on the calendar were all the activities that she had for now and revealed it was a work in progress. The AD stated that she goes around and tries to get the residents to participate, and they say they do not want to come to activities. The AD confirmed that R8 and R35 were to be receiving 1:1 activities, but stated she is not always able to get around to the residents needing 1:1 activity.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49470 Based on record review, interviews, and review of the policy titled Documentation of Skin and Wound Care, facility failed to perform weekly skin assessments to identify potential skin breakdown, and implement interventions in a timely manner to prevent unavoidable pressure ulcers, for two of three residents (R) (R26 and R20) reviewed for pressure ulcers. Findings include: Review of the policy titled Documentation of Skin and Wound Care dated [DATE] revealed the policy is to provide current and timely documentation of residents condition related to skin/wound care, accurate information on residents status as it pertains to skin and interventions in place and provide detailed history of the wound assessments that have occurred in the healthcare center. Procedure: Number 1. Documentation regarding wound observations should be completed on pressure ulcers Diabetic wounds and any chronic or complex wounds (weekly) on admission or re-admissions. 1. Review of the clinical record revealed R26 was admitted to the facility on [DATE] with diagnoses including sepsis, psychotic disturbance, mood disturbance, aphasia following cerebral infarction and dysphagia. Review of the Nutrition assessment dated [DATE] completed Registered Dietician (RD) RR documented Nursing reports resident has a fair appetite since admission, and there was no facility weight available at present. RD RR documented she was adding one ounce [protein supplement] two times a day to support lean mass maintenance due to R26's potential risk of pressure injury. Review of the care plan dated [DATE] revealed resident is at risk for skin breakdown. Interventions to care include keep skin clean and dry as possible. Minimize skin exposure to moisture, provide incontinence care, and report signs of skin breakdown. Review of the Observation Detail List dated [DATE], completed by Licensed Practical Nurse (LPN) NN, revealed R26 Braden scale for predicting for pressure score of 19, indicating resident was Not at Risk - no interventions necessary for skin breakdown. Review of weekly skin observations from [DATE] to [DATE] revealed Registered Nurse (RN) UU documented that R26's skin was warm, dry, had normal color, and normal skin turgor. There was no documentation of skin or pressure injuries. There was no evidence of skin assessments being completed for week of [DATE] or [DATE]. Review of the Progress Note dated [DATE] written at 3:13 pm, Licensed Practical Nurse (LPN) NN documented R26 skin observation completed and an old healed bilateral surgical scar to knees noted, and all other skin areas are intact. Per Braden score resident is not at risk for pressure injuries currently. Review of the Progress Notes dated [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] all indicate that skin is warm and dry to touch. Normal in color. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Note dated [DATE] written at 6:28 pm, LPN AA documented R26 had redness to right heel and dark purple discoloration to left heel. Redness noted to sacral area. Barrier cream applied to sacral area. Repositioned and turned every two hours. Skin prep to both heels. Review of the Progress Note dated [DATE] written at 10:57 am, LPN AA documented skin warm and dry to touch. Normal in color. Review of the Progress Note dated [DATE] written at 11:49 am, RN QQ documented that resident was lethargic and not eating breakfast. Nurse Practitioner (NP) notified, new order to send to emergency room (ER) to evaluate and treat. 911 called, resident transferred to hospital. Review of the hospital ER records for R26 dated [DATE] documentation revealed: *sacral decubitus, present on admission and documented as wound unstageable, wound care following, dark eschar and documented debridement if worse. *elevated troponin level - likely in the setting of severe sepsis *acute kidney injury (AKI) *dehydration- (creatinine 1.32) Trend renal function *Hypernatremia - In the setting of dehydration due to poor intake * Unstageable sacral decubitus with dark eschar *wound care consult - breakdown across sacrum and bilateral buttocks upon admission. Resident resides in a nursing home and was admitted for shortness of breath. * wound assessment-hospital photograph time stamped [DATE] at 12:53 pm of resident's sacral ulcer - maroon to purple discoloration across her sacrum and bilateral buttocks. Resident had areas of partial to full thickness skin loss along sacrum and bilateral buttocks. *left heel had an area of purple discoloration congruent with a deep tissue pressure injury (DTPI). A small area of full-thickness breakdown was noted medially. right heel had what looked to be a resolving DTPI with a ring of non-blanchable erythema surrounding it. The area looked to be the result of pressure. *difficult to discern the etiology of residents wounds - pressure could not be ruled out. Interview on [DATE] at 1:44 pm, wound management Physician Assistant (PA) SS stated he first observed R26 wounds on [DATE]; again on [DATE] and on [DATE]. PA SS revealed that LPN NN stated R26 acquired the wounds when she was in the hospital, but confirmed he did not verify this information with the hospital records. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:32 am, Registered Nurse (RN) TT revealed that she was overseeing the wound care program when R26 was admitted to the facility. She revealed that the nurses are supposed to lay eyes on each resident's wounds at least once a week. The Certified Nursing Assistants (CNA) are looking at the residents several times per day, and should be reporting to the nurses anything they find abnormal, and the nurse is supposed to go and visually check the residents skin. During further interview, RN TT indicated that skin assessments are not being done consistently. She stated the nurse's have more than they can handle most times, and that makes it difficult to do everything. Interview on [DATE] at 12:01 pm, Regional Nurse Consultant (RNC) KK revealed she believed that R26's wounds were acquired at the facility, and had no explanation why there was not any documentation to indicate the presence of the wounds. During further interview, RNC KK stated R26's wounds were preventable. Interview on [DATE] at 12:09 pm, the Director of Nursing (DON) stated she believed R26's wounds were acquired at the facility and stated the wounds should have been prevented. During further interview, she stated staff were not doing full head to toe assessments, observing the wounds in the early stages of breakdown. She stated a full head-to-toe assessment could have prevented R26's wounds. Review of the death certificate indicated R26 expired on [DATE] in the hospital. The cause of death was documented as cardiopulmonary arrest, sepsis, and pyelonephritis with an unknown interval between onset and death. 20706 2. Review of the clinical record revealed that R20 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, encephalopathy, altered mental status and hypertension. Review of the admission MDS assessment dated [DATE] revealed a BIMS score of 11, which indicated moderate cognitive impairment. R20 required moderate assistance from staff for activities of daily living (ADL) care. Section M revealed resident was admitted without pressure ulcer and documented she was at risk of developing a pressure ulcer. Pressure ulcer triggered as an area of concern on the CAAS. Review of the Skin assessment dated [DATE] revealed a Braden Scale of 20 (as being not at risk, no impairment, rarely moist and bedfast). Review of the Progress Note dated [DATE] documented skin assessment shows bilateral discolorations beneath right and left breasts and resolved pressure injury scar on sacrum. Skin is otherwise clean, dry, and intact. Applied barrier cream prophylactically to sacral area. Review of the Progress Note dated [DATE] documented wound care update. Resident has developed sacral pressure wound . Resident contact notified by phone. Treatment initiated. Wound care protocols in place. Dietician notified. Review of the Skin assessment dated [DATE] documented resident has a new pressure ulcer to the sacrum that measured 4 x 5 x 5 cm (centimeters) and described as light serous exudate, slough, dark purple or rusty discoloration and stable. A second pressure injury to the left heel, described as blister, measuring 3 x 3 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of EMR revealed that there were no weekly skin assessments done from [DATE] through [DATE] (eight weeks). Review of the Progress Note by [Wound Management Company] dated [DATE] recorded as the first visit, documented a facility acquired stage II pressure ulcer to sacrum with measurements 5 x 4 x 0.1 cm with mild serous drainage. Further review of the note revealed the wound was discovered on [DATE]. Review of the Progress Note by [Wound Management Company] dated [DATE] documented a facility acquired ulcer to sacrum with measurements 3.5 x 4 x 0.2 with 80% yellow/black necrotic tissue with mild drainage, not improving. Wound stage has been changed from II to unstageable for the reason covered in slough. Further review of the note revealed wound PA discussed continuing education with staff to minimize the amount of time resident spent lying on the wound and emphasized offloading to prevent wound deterioration. Staff and resident acknowledged understanding. Review of the Progress Note by [Wound Management Company] dated [DATE] documented necrotic tissue in unstageable sacral wound with measurements 8 x 7 x 0.2 with 80% yellow/black necrotic tissue and mild serous drainage. Status documented as not improved. Further review of the note revealed wound PA discussed continuing education with staff to minimize the amount of time resident spent lying on the wound and emphasized offloading to prevent wound deterioration. Staff acknowledged understanding. Review of the Progress Note by [Wound Management Company] dated [DATE] documented resident has been discharged from care. Interview on [DATE] at 10:20 am, Licensed Practical Nurse (LP) YY revealed she is the current wound care nurse. She revealed that the initial skin assessments are done by the wound care nurse, but then the floor nurses are responsible for doing the weekly assessments, and documenting them in the EMR. LPN YY indicated that R20 had an initial skin assessment on [DATE], and stated she was not assessed to be at risk for skin breakdown. During further interview, she confirmed there were no other skin assessments completed for R20 until she was seen by wound physician on [DATE]. Interview on [DATE] at 11:42 am, RN TT revealed R20's only skin assessment was done on [DATE] upon admission, and confirmed there were not any other skin assessments completed for R20, until [DATE]. Interview on [DATE] at 10:10 am, RNC KK stated that she reviewed the CNA skin notes and did not find any documentation regarding skin issues for R20 prior to [DATE], when her pressure ulcer was identified. Interview on [DATE] at 12:14 pm, wound Physician Assistant SS stated that he could have provided bedside debridement for R20 declining sacral wound, but indicated the facility did not get consent from R20's responsible party.

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 20706

Based on observation, record review, interview, and review of the policy titled Restorative Nursing Program and Therapy Evaluations, the facility failed to provide restorative therapy services to attain or maintain the highest practicable physical, mental, and psychosocial well- being for two of four residents (R) (R19 and R27) reviewed who were referred for Restorative Therapy Services.

Findings include:

Review of the policy titled Restorative Nursing Program dated 11/4/2021 revealed that it is the policy of the facility to provide restorative nursing to the residents to maintain optimal physical, mental, and psychological functioning and well-being. Restorative nursing services are provided by qualified staff that are been trained to do such services. The nurse will complete a restorative care screening tool, determine the appropriate restorative needs and develop a care plan for each restorative service and review the resident's progress to determine discharge from the program.

Review of the facilities policy titled Therapy evaluations dated 3/9/2023 revealed Number 12. Therapy staff will educate departments on specific restorative nursing programs as indicated.

1. Review of the clinical record revealed R19 was admitted to the facility on [DATE] with diagnoses including osteoarthritis of right knee, cerebellar ataxia, dysphagia, cognitive communication deficit, abnormal posture, protein-calorie malnutrition.

Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status Score (BIMS) of 14, indicating little to no cognitive impairment. Resident had impairments to both upper and lower extremities and required maximum assistance for mobility. No Restorative services were documented.

Review of the PT Discharge Note dated 6/30/2023 revealed resident completed physical therapy services on 5/1/2023, to be discharged to the restorative exercise program. There is no evidence that the resident received those services.

Interview on 5/8/2024 at 1:25 pm, Physical Therapist (PT) DDDD, revealed that he worked with R19 in the past, but stated he was started therapy services as of 4/25/2024 due to weakness/decline with goals to assist the resident with maximizing his potential for Activities of Daily Living) ADL care needs. PT revealed that the resident has a significant amount of stiff and arthritic knee joint that may prevent him from walking and resident could benefit from a restorative care program, after active therapy services are completed.

Interview on 5/30/2024 at 11:30 am, Occupational Therapist (OC) EEEE, revealed that once a resident finishes therapy services, some are referred to Restorative Care Services for continued needs such as range of motion (ROM), use of assistive devices like splints, and for preventive care for the prevention of contractures. He also revealed that a referral is sent to restorative care nurse for those continued services and a follow-up is sometimes done by therapy depending on the restorative care need.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/30/2024 at 11:45 am, the Director of Nursing (DON) revealed the Restorative Care Nurse started six months ago and does restorative care services. Phone interview on 5/30/2024 at 11:50 am, Restorative Care Nurse FFFF revealed she was hired to do Restorative service for one day per week and stated the only restorative care that she has done are weights for the dietician, but no other restorative care is provided. Follow-up Interview on 5/30/2024 at 11:55 am, DON and Regional Nurse Consultant (RNC) KK revealed the facility does not have an active Restorative Care Program. They confirmed that they just hired a nurse that comes one day a week as the Restorative Care Nurse; however, the DON was not aware that the nurse only comes in to do weights. The DON revealed the facility has not had a Restorative Care Program since the COVID pandemic. A list of residents on Restorative Care Services was provided to the surveyor on 5/2/2024, and the DON stated she was not aware of that list. Interview on 5/30/2024 at 1:59 pm, Rehab Director JJJ revealed the facility hasn't had a Restorative Care Program since the pandemic, therefore they have not been referring residents to that program. She stated that residents are referred for restorative care services if residents need maintenance care for contractures, splinting, positioning, passive/active range of motion, walking and transfer help. During further interview, Rehab Director JJJ revealed that the rehab department has not been actively referring residents to the restorative care program since the pandemic, but plans to start again. 2. Review of the clinical record revealed R27 was admitted to the facility on [DATE] with diagnosis that including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, tinea unguium, muscle weakness, unsteadiness on feet, hyperlipidemia, chronic kidney disease, gastro-esophageal reflux disease (GERD) and chronic pain. Review of R27's quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Resident had impairments to one upper and lower extremity and required maximum assistance for mobility. No Restorative services were documented. Review of the Physical Therapy Discharge Summary dated 10/19/2023 revealed that R27 was not referred to Restorative Care Services was not recommended for this resident with left upper extremity contracture. Review of the care plan dated 4/18/2024 revealed that resident was to receive restorative care services for range of motion (ROM), sitting-standing, activities of living (ADL)'s, and safe transfers with last revised date of 4/18/2024. There was no documentation of resident receiving restorative care nursing. Interview/Observation on 6/4/2024 at 1:15 pm, R27 was in his wheelchair in the hallway. His left arm was noted to be contracted. He revealed that he does not get restorative services but maybe a few times every now and then. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/4/2024 at 10:42 am, Rehab Director JJJ, revealed R27's last treatment for rehab was on 3/1/2024. She indicated there were no recommendations for restorative care program made for upper left extremity contracture and revealed she was not aware that resident is care planned for restorative nursing program.

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49470

Based on record review, interviews, and review of the policy titled Weight Monitoring Program, the facility failed to provide care and services to maintain an acceptable parameter for the nutritional status for one resident (R) (R26), resulting in a 7.82% weight loss in The sample size was 44 residents.

Findings include:

Review of the policy titled Weight Monitoring Program dated 6/2/2023 documented the weight frequency for new admissions will be weighed weekly times four weeks and/or until weight is stable. A significant weight change is defined as: 5 percent (%) weight Loss or gain in one month; a 7.5% weight Loss or gain in three months; and a 10% weight Loss or gain in six months. Patients/residents will be placed on the Weight Monitoring Program unless the weight loss is anticipated and/or planned. Patients/residents placed on the weight monitoring program will be weighed weekly. Patients/residents with a planned/anticipated weight loss will have documentation of awareness of weight loss and a notation explaining why patient/resident is not on the weight monitoring program. If the healthcare center utilizes electronic charting, this information will be located within the electronic chart.

Review of the clinical record for R26 revealed she was admitted to the facility on [DATE] with diagnoses including sepsis, psychotic disturbance, mood disturbance, aphasia following cerebral infarction, dysphagia, and an altered mental status.

Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicated severe cognitive impairment. R26 was dependent on staff for all care.

Review of the Nutrition assessment dated [DATE] completed by Registered Dietician (RD) RR documented Nursing reports resident has a fair appetite since admission, and there was no facility weight available at present. RD RR documented she was adding one ounce [protein supplement] two times a day to support lean mass maintenance due to R26's potential risk of pressure injury.

Review of the electronic medical record (EMR) documented on 10/27/2023, Certified Nursing Assistant (CNA) WWW documented R26 weighed was 135.6 lbs.

Review of the Progress Note dated 12/22/2023 at 7:27 pm, Licensed Practical Nurse (LPN) AA documented R26 required more assistance than usual with eating.

Review of the Progress Note dated 12/26/2023 at 11:49 am, Registered Nurse (RN) QQ documented that Certified Nursing Assistant (CNA) reported that resident was lethargic and not eating breakfast. Nurse Practitioner (NP) notified, and new order to send to emergency room (ER) to evaluate and treat. 911 called, resident transferred to hospital.

Review of R26's hospital admission records dated 12/26/2023 revealed R26 appeared dehydrated (creatinine 1.32->0.93> 0.7) Trend renal function and Hypernatremia in the setting of dehydration due to poor intake.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR revealed R26 weight on 1/18/2024 was 125 pounds (lbs). Review of the Dietician Note dated 1/22/2024 at 3:37 pm, RD RR documented R26 newly obtained weight indicated 7.2% loss within significant time frame indicated, current weight 125 lbs. Cognitively impaired. Pureed diet in place, varied intakes between 25-50% observed, accepting fluids. Magic Cup to support intake adequacy and liquid protein for multiple wounds to support healing. During an interview on 5/7/2024 at 2:30 pm, the RD RR stated between December 2023 and January 2024, R26 had a significant weight loss of 7.86 percent. She ordered for R26 to have a supplement on 1/22/2024. During an interview on 5/8/2024 at 9:50 am, the Assistant Director of Nursing (ADON) revealed residents with weight loss were discussed in weekly meetings, when there was a significant weight loss the physician would prescribe an appetite stimulant or any form of intervention. The ADON stated she did not recall R26 being discussed in weekly weight loss meetings. During an interview on 5/8/2024 at 2:29 pm, the Regional Nurse Consultant (RNC) KK revealed staff are required to weigh all residents during the first four weeks after admission. RNC KK stated staff did not follow facility policy. She verified R26 was not weighed during the first four weeks after admission. KK stated staff should have placed interventions sooner. During an interview on 5/8/2024 at 10:09 am, the Director of Nursing (DON) revealed when a resident was losing weight, the Dietician communicates with the physician and nurses communicate with the physician and interventions are put in place. When there was a weight loss of 7% or higher the resident representative and physician would be notified. During an interview on 5/30/2024 at 1:08 pm, RD RR revealed she did not inquire from the family what R26's normal weight was. She stated R26 was not on a weight monitoring program.

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on record review, interviews, and review of the policy titled Therapy Evaluations, the facility failed to evaluate a therapy recommendation per two different physician's order for one of three sampled residents (R) (R15) related to providing a Durable Medical Equipment (DME) lift chair. Findings include: Review of the policy titled Therapy Evaluations dated 3/9/2023, revealed the policy is that all physician's orders for therapy evaluations be addressed in a timely manner by Physical, Occupational and/or Speech therapy as designated by the physician. The evaluation will include discipline-specific findings related to the patient/resident's functional status and underlying impairment and prior functional level. Procedure: Number 11. All therapy recommendations will be reviewed with the patient, family/caregiver and the Nursing Department, and subsequent training will be documented and recorded indicating the training components and understanding and competence with the instructions provided. Review of the Electronic Medical Record (EMR) for R15 revealed she was admitted to the facility on [DATE], with diagnoses including chronic systolic (congestive) heart failure, osteoarthritis right knee, cognitive communication deficit, muscle weakness, falls, type 2 diabetes, and bipolar disorder. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 11, indicating moderate cognitive impairment. Review of the history and physical office note dated 9/20/2023, written by Orthopedic Physician MMMM documented a lift chair prescription is provided due to R15's arm weakness and leg weakness precluding her from being able to get out of bed safely on her own. Orthopedic Physician MMMM indicated this apparently led to R15 staying in bed, increasing the risk of urinary tract infection and other debilitating issues. Review of the Durable Medical Equipment Order dated 10/24/2023 revealed an order for a Durable Medical Equipment (DME) lift chair. The Certificate of Medical Necessity documented the need for lift chair was due to R15's knee pain and the use of a hospital bed is causing excessive strain on residents right knee causing significant pain. Further review revealed the facility was to provide for the lift chair. The DME lift chair will make it easier for resident to get in and out of bed and alleviate pressure on the right knee and ease her pain. Further review of R15's EMR revealed R15 had sustained falls on 8/22/2023, 8/23/2023, 9/13/2023, 9/15/2023, 10/18/2023, 11/6/2023, 11/27/2023 and 4/22/2024. Interview on 5/1/2024 at 3:34 pm, R15's Responsible Party (RP) revealed that R15 had a lift chair prior to being admitted at the facility. R15's RP stated that resident had used a lift chair with no problems, and stated she had been sleeping in a lift chair for [AGE] years. The RP further stated that the facility was not accommodating R15's needs. (continued on next page)

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview on 5/15/2024 at 2:05 pm, the Orthopedic Physician NNNN revealed that R15 had an appointment in September 2023 for arthritis in her right knee. He stated R15 is at risk for falls and the lift chair should be able to prevent that from happening. Orthopedic Doctor, NNNN revealed he believed the lift chair was a reasonable accomodation for R15 to aide in her reduction of falls, and alleviation of pain in her knees. A telephone interview on 5/21/2024 at 3:51 pm, Orthopedic Physician MMMM confirmed R15 was in his office on 9/20/2023, and he wrote an order for the lift chair due to her arthritis in the right shoulder and knees. Interview on 5/23/2024 at 3:01 pm, Rehabilitation Director JJJ revealed the facility does not assess for DME lift chairs, and therefore R15 was never assessed to determine if she would be able to safely use a lift chair. Rehabilitation Director JJJ was asked about the physician orders from two Orthopedic Physicians for the lift chair, and she stated she was not aware R15 had two orders for a lift chair. Rehabilitation Director JJJ stated that R15 was receiving Physical Therapy (PT) on 10/19/2023 and confirms that she was not evaluated for the lift chair. During further interview, she revealed that R15 is currently receiving Occupational Therapy (OT) services due to ADL decline as of 4/11/2024.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on staff interviews and a review of the facility's documents titled, Facility Assessment [name of facility] and Facility Assessment [name of facility] 2024, the facility failed to determine its capacity and capability of the clinical staff to provide the necessary care and services for one of 43 sampled residents (R) (R10). Specifically, R10 wore an external cardiac defibrillator, and facility did not have staff educated on how to care for a resident with an external defibrillator. Findings include: Review of the facility provided Facility Assessment [name of facility], revealed the facility assessment did not include a section addressing cardiac services. A review of the facility provided Facility Assessment [name of facility] 2024 revealed a sufficiency analysis category for heart/circulation. Review of the electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, dysphagia, anemia, acute myocardial infarction, atherosclerotic heart disease, chronic atrial fibrillation, atrial flutter, ischemic cardiomyopathy, end-stage renal disease (ESRD), and hemiparesis following cerebral infarction affecting right dominant side. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed that R10 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Review of the Physician's Order dated 7/2/2023 confirmed that R10 was admitted with a wearable cardioverter defibrillator (WCD). Interview on 6/4/2024 at 11:45 am, Regional Nurse Consultant (RNC) KK confirmed that the two documents provided were the 2023 Facility Assessment and the 2024 Facility Assessment. Interview on 6/4/2024 at 12:55 pm, RNC KK stated that when R10 was admitted to the facility, they should have updated the facility assessment for 2023 to include the specialized care for wearable cardiac defibrillator. RNC KK confirmed that the facility did not update the 2023 Facility Assessment when they decided to admit R10 with a WCD and stated that the facility had the capability to update the facility assessment at any time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49472 Based on observations, record review, staff interviews, and review of the policies titled Infection Prevention and Control Program Surveillance Reporting and Hand Hygiene and Contact Precaution Compliance and review of the RN/LPN Annual Skills Fair 2023, the facility failed to ensure infection control practices were maintained to prevent the potential for infections and cross contamination. Specifically, the infection control data for August 2023 was not analyzed for trends in urinary tract infections that include appropriate corrective actions and staff failed to wash/sanitize hands after glove removal and prior to donning clean gloves during wound care for one resident (R) (R34). The census was 110. Findings include: 1. Review of the facility policy titled Infection Prevention and Control Program Surveillance Reporting revised 11/30/2023 revealed the policy is to establish and maintain an Infection Control Program that includes detection, prevention, and control of the transmission of disease and infections among residents and partner. Procedure: Number 1. Patient/resident infection cases are monitored and documented by the Infection Preventionist (IP). The IP reviews cases of infections, including tracking and analysis of the findings, and develops an action plan to resolve identified concerns. Number 5. Compliance with Infection Control practices are monitored and documented by staff competency and observation practices. The IP, Director of Health Services (DHS) and Department Managers review the compliance monitoring and initiate appropriate corrective measures. Review of the Monthly Healthcare Associated Infection Summary Report dated August 2023 revealed nine cases of urinary tract infections (UTI). Eight of the nine identified cases of UTI were for residents who resided on the 300 East Hall. During an interview on 6/4/2024 at 1:58 pm, the IP revealed he has been employed since 1/15/2024. He confirmed nine residents had a UTI during August 2023, and eight of the nine resided on the 300 Hall. He further stated the high number of UTIs was from inappropriate hand washing, and stated staff should be washing their hands between dirty and clean tasks. The IP stated he felt there was a need for continued education on hand washing, urinary catheter care, and perineal care. 49479 2. Review of the facility policy titled Hand Hygiene and Contact Precaution Compliance, revised 12/4/2023, revealed hand hygiene refers to cleaning your hands by using the organization approved alcohol-based hand rub or by washing hands with soap and water. Hand Hygiene opportunities include: 1. Hand hygiene performed before resident contact. 2. Hand hygiene performed before donning gown/gloves. 3. Hand hygiene performed after removing gown/gloves. 4. Hand hygiene performed after resident contact. Review of R34's electronic medical record (EMR) revealed resident was admitted to the facility on [DATE] with diagnoses including spastic hemiplegia, hypomagnesemia, systemic inflammatory response syndrome (SIRS), hypertension, metabolic encephalopathy, unstageable pressure ulcers to right hip, left hip, and part of back. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 5/21/2024 at 10:41 am Licensed Practical Nurse (LPN) YY who was assisted by Registered Nurse (RN) UU, performed wound care for R34. LPN YY washed her hands before the procedure, donned clean gloves, and cleansed R34's right hip wound. She then removed the soiled gloves, and without washing her hands or using hand sanitizer, she donned new gloves. LPN YY then applied the treatment to the wound, removed the soiled gloves, and washed her hands. Review of the document titled RN/LPN Annual Skills Fair 2023, indicated that LPN YY completed the annual skills fair on 9/12/2023. Under the section titled Wound Care Assessment describes the process for performing a dressing change. Step 1. Remove the old dressing Remove gloves, perform hand hygiene, and apply clean gloves. Step 2. Cleanse the wound Remove gloves, perform hand hygiene, and apply clean gloves. Step 3. Apply new dressing per order. If your gloves become soiled at any time, remove them, perform hand hygiene, and apply clean gloves. Interview on 5/21/2024 at 10:56 am, LPN YY and RN UU stated hand hygiene should be performed before and after all resident care. Both nurses revealed staff members only need to wash their hands before and after the wound care was provided, not in between glove changes. Interview on 5/21/2024 at 1:00 pm, Regional Nurse Consultant (RNC) KK stated when providing wound care, the nurse should wash their hands before performing the wound care, when going from dirty to clean, and after the wound care. She stated hand sanitizer could be used as well for hand hygiene. RNC KK stated LPN YY had not performed the wound care correctly. Interview on 6/4/2024 at 1:58 pm, Infection Control Preventionist (ICP) BBBB revealed all staff should be performing hand hygiene between dirty and clean tasks. ICP BBBB confirmed LPN YY should have performed hand hygiene before beginning the wound care, after cleansing the wound, and after the clean dressing is applied. ICP BBBB revealed there needed to be additional education and training regarding infection control practices.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49472 Based on record review, interviews, and a review of the facility policies titled Influenza (Flu) Vaccinations for Health Care Center Residents and Pneumococcal Vaccinations, the facility failed to ensure that five residents (R) (R8, R15, R16, R40, and R45) reviewed for vaccination status, received education, were offered, consented to receive, and/or refused the pneumococcal vaccination, of 44 sampled residents. Findings include: A review of the policy titled Influenza (Flu) Vaccinations for Health Care Center Residents, with a revision date of [DATE] revealed the following: * Current and newly admitted residents will be offered the influenza vaccine beginning on [DATE] of each year and it will be offered for as long as the influenza viruses are circulating, and the unexpired vaccine is available. * Residents admitted during the flu season will be offered the vaccine within two weeks of the resident's admission to the facility, if not previously vaccinated during the season. A review of the policy titled Pneumococcal Vaccinations, with a revision date of [DATE] revealed the following: * Permission or refusal to receive the vaccine within the Centers for Disease Center (CDC) guidelines will be obtained on admission using the Pneumococcal Vaccine Consent/Refusal Form. A separate consent for each type of vaccine is required. * The Immunization Record will be a part of each patient/resident's clinical record and will be used to document the date of each pneumococcal vaccine previously received by the patient/resident and/or administered by the healthcare center. If the vaccine is refused based on medical contraindications or side effects, there must be supporting documentation in the clinical record. 1. A review of the admission record revealed that R8 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis, type 2 diabetes mellitus with ketoacidosis with coma, hypotension, 2019-nCoV acute respiratory disease, cerebellar ataxia, hyperlipidemia, degenerative disease of the nervous system, hypertension, and supraventricular tachycardia. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R8 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A review of the Preventive Health Care form revealed that R8 had not received the pneumococcal vaccine, nor was there any documentation of a history of the pneumococcal vaccination being given on the Georgia Registry of Immunization Transactions and Services (GRITS) site. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of the admission record revealed that R15 was admitted to the facility on [DATE] with diagnoses including chronic systolic (congestive) heart failure, type 2 diabetes mellitus, hyperlipidemia, hyperkalemia, venous insufficiency (peripheral), hypertension, acute pulmonary edema, chronic kidney disease, calculus of kidney, acute myocardial infarction, acute and chronic respiratory failure with hypoxia, 2019-nCoV acute respiratory disease, and Candidiasis. A review of the quarterly MDS assessment dated [DATE] revealed that R15 had a BIMS score of 11, indicating the resident presented with moderate cognitive impairment. A review of the Preventive Health Care form revealed that R15 had not received the pneumococcal vaccine, nor was there any documentation of a history of the pneumococcal vaccination being given on the GRITS site. 3. A review of the admission record revealed that R16 was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation, 2019-nCoV acute respiratory disease, atrial flutter, venous thrombosis and embolism, hypothyroidism, sleep apnea, hypertension, acute embolism and thrombosis deep veins lower extremity, mild intermittent asthma, cerebral infarction, arthropathy, cough, shortness of breath, osteoarthritis, long term (current) use of anticoagulants, nonrheumatic aortic valve disorder, chronic pulmonary edema, and acute diastolic (congestive) heart failure. A review of the quarterly MDS assessment dated [DATE] revealed that R16 had a BIMS score of 15, indicating that the resident was cognitively intact. A review of the Preventive Health Care form revealed that R16 had not received the pneumococcal vaccine, nor was there any documentation of a history of the pneumococcal vaccination being given on the GRITS site. 4. A review of the admission record revealed that R40 was admitted to the facility on [DATE] with diagnoses including 2019-nCoV acute respiratory disease, wedge compression fracture of T11-T12 vertebra, type 2 diabetes mellitus, cerebral infarction due to unspecified occlusion or stenosis of a cerebral artery. A review of the quarterly MDS assessment dated [DATE] revealed that R40 had a BIMS score of 13, indicating that the resident was cognitively intact. A review of the Preventive Health Care form revealed that R40 had not received the pneumococcal vaccine. A review of the GRITS site revealed that R40 was last vaccinated with the pneumococcal vaccine on [DATE]. 5. A review of the admission record revealed that R45 was admitted to the facility on [DATE] with diagnoses of hyperlipidemia, presence of urogenital implants, long-term use of anticoagulants, functional dyspepsia, neuromuscular dysfunction of the bladder, folate deficiency anemia, acute ischemic heart disease, familial hypophosphatemia, metabolic encephalopathy, lobar pneumonia, esophageal obstruction, respiratory failure, hypoxia or hypercapnia, type 2 diabetes mellitus, hemoperitoneum, acute embolism and thrombosis of femoral vein, type 1 fracture of sacrum, subsequent encounter for fracture with routine healing, and initial encounter for closed fracture. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the quarterly MDS assessment dated [DATE] revealed that R45 had a BIMS score of 10, indicating that the resident is moderately cognitively impaired. A review of the Preventive Health Care form revealed that R45 had not received the pneumococcal vaccine. A review of the GRITS site showed that R45 was last vaccinated with the pneumococcal vaccine on [DATE]. During an interview on [DATE] at 1:59 pm, the Infection Preventionist (IP) stated that he utilized verbal information from the residents and family of residents to determine their vaccination history. He stated that he also utilized the GRITS site, and the corporate system to determine the vaccination history for residents. He confirmed that R8, R15, R16, R40, and R45 had not had the pneumococcal vaccination and there was no documentation that the residents or that the resident representatives refused.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49472 Based on observations, record review, and interviews, the facility failed to ensure that the call light communication system was functioning adequately to allow residents to call for staff assistance for five of 27 sampled residents (R) (R28, R30, R31, R35, R38). Findings include: 1. Review of the clinical record for R28 revealed the resident was admitted to the facility on [DATE], with diagnoses including hypergammaglobulinemia, shortness of breath, depression, hypertension, muscle weakness, and glaucoma. Review of the admission Minimum Set Data (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The resident had impairment to upper and lower extremities and required maximum assistance with ADL's. R28 was always incontinent of bowel and bladder. Observation on 5/2/2024 at 3:30 pm, revealed R28's call light was noted to be unplugged from the wall. The call light was pushed by the surveyor, and it did not come on. Observation and interview on 5/2/2024 at 3:32 pm, Licensed Practical Nurse (LPN) BB pushed the call light and confirmed it did not come on, and noticed that the call light was unplugged. She plugged the call light back in and pushed the button and the call light came on. LPN BB stated the call light was working now. 2. Review of the clinical record for R38 revealed the resident was admitted to the facility on [DATE], with diagnoses including right hip osteoarthritis, right artificial hip joint, aftercare following joint replacement surgery, muscle weakness, depression, hypothyroidism, and hypertension. Review of the admission MDS assessment dated [DATE] revealed a BIMS score of 15, indicating resident was cognitively intact. The resident had impairment to upper and lower extremities and required maximum assistance with ADL's. R38 was always incontinent of bowel and bladder. Observation on 5/6/2024 at 10:05 am, revealed R38's call light was noted to be unplugged from the wall. Interview on 5/6/2024 at 10:05 am with R38 revealed she had a hip replacement on 4/29/2024. She stated she had been pushing the call light for the last couple of days and no one came to assist her when she needed assistance. 3. Review of the clinical record for R30 revealed the resident was admitted to the facility on [DATE], with diagnoses including encephalopathy, dementia, muscle weakness, hypotension, hypertension, and glaucoma. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission MDS assessment dated [DATE] revealed a BIMS score of 5, indicating severe cognitive impairment. The resident had impairment to upper and lower extremities and required moderate assistance with ADL's. R30 was always incontinent of bowel and bladder. Observations on 5/6/2024 at 11:06 am revealed R30's call light was out of her reach, lying on the floor at the bedside. 4. Review of the clinical record for R35 revealed he was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, diabetes, aneurysm of artery of lower extremity, neuropathy, irritable bowel syndrome, end stage renal disease (ESRD), and congestive heart failure (CHF). Review of the quarterly MDS assessment dated [DATE] revealed that resident had a BIMS of 15 indicating that the resident was cognitively intact. Interview on 5/8/2024 at 2:50 pm, resident stated that his call light works just fine, but indicated that he has to wait anywhere from five to 12 hours, before someone will come change him. 49479 5. Review of the clinical record for R31 revealed the resident was admitted to the facility on [DATE], with diagnoses including heart failure, difficulty in walking, muscle weakness, lack of coordination, hypertension, hyperlipidemia, and history of right femur fracture. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 9, indicating moderate cognitive impairment. The resident required moderate assistance with ADL's. R31 was always incontinent of bowel and bladder. Observations on 5/6/2024 at 11:17 am, revealed R31's call light was out of reach. The call light was hanging from the side rail and close to the floor. Interview on 5/13/2024 at 4:00 pm, the Director of Nursing (DON) stated that residents need to have access to functioning call lights to ensure their needs are attended to. During further interview, she stated that call lights are to be within residents reach at all times, so that they can alert staff if assistance is needed. Interview on 5/13/2024 at 4:41 pm, the Administrator revealed the facility did not have a policy relating to the call light communication system.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on record review and staff interviews, the facility failed to ensure that clinical staff were educated related to the use of a wearable cardioverter defibrillator (WCD) for one of 43 sampled residents (R)(R10). This failure had the potential to place R10 at risk of not receiving necessary care and monitoring for cardiac instability. Findings include: Review of the electronic medical record (EMR) revealed that R10 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, acute myocardial infarction, atherosclerotic heart disease, chronic atrial fibrillation, atrial flutter, ischemic cardiomyopathy, and end-stage renal disease. Resident was admitted with a WCD. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed that R10 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Review of the Physician's Order revealed an order dated 7/18/2023 to change battery daily for resident's wearable cardioverter defibrillator (WCD). Review of the July 2023 Medication Administration Record (MAR) did not indicate that R10's WCD battery was changed daily. Interview on 5/21/2024 at 3:19 pm, Certified Nursing Assistant (CNA) VVV stated I do not know what a WCD is. Interview on 5/21/2024 at 3:24 pm, CNA FF revealed she did not know what a WCD was and that they would cover it with plastic and resistant tape and wipe around the area if a resident had a WCD and needed to shower. Interview on 5/21/2024 at 3:45 pm, CNA KKK revealed she couldn't remember anything related to a WCD and stated that it had been years since she had a resident with a WCD. Interview on 5/21/2024 at 4:02 pm, CNA ZZZ stated I am not familiar with what a WCD does. I think you would do the same as a port and cover it up for a shower. I would ask the nurse. Interview on 5/21/2024 at 11:18 am, Licensed Practical Nurse (LPN) OOO revealed a WCD requires a prescription from the doctor that monitors the resident's heart. LPN OOO stated that the training was done by an outside vendor that sent in a technician to provide in-service training for the staff on how to use the WCD. LPN OOO stated the staff should ensure the WCD is functioning, and stated that any problems with the WCD should be recorded on the MAR/TAR. During further interview, LPN OOO stated If it doesn't have any problems, there's nothing to do with it. But, if something goes wrong with it, I will call my supervisor. (continued on next page)

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/23/2024 at 12:14 pm, LPN PPP confirmed that she did not know what a WCD was. LPN PPP stated she did not receive any education about a WCD. Interview on 5/23/2024 at 12:24 pm, LPN OO revealed that R10 was in the facility in July of 2023 and confirmed he had a WCD. LPN OO stated a WCD is a jacket that a person would wear to regulate someone's heart. LPN OO stated staff are to follow the orders on the MAR, when it comes to monitoring a WCD, making sure that the WCD is charged, and/or the lights are working. LPN OO revealed for a person with a WCD, during a shower, LPN OO would get clarification from the physician; it should be in the electronic MAR for standing orders. Interview on 5/21/2024 at 11:30 am, Regional Nurse Consultant (RNC) KK revealed the facility does not have a policy on the use of a WCD. During further interview, RNC KK stated when the facility receives a resident with a WCD, the company comes out and provides an in-service on the procedures for care. She stated that the main thing was that if the alarm goes off, they should ask the resident how they are feeling, not to touch the resident, and call 911.