STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115319	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fifth Avenue Health Care	505 North Fifth Avenue Rome, GA 30165

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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 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** 44832 Based on observations, staff and resident interviews, and record review, the facility failed to provide the necessary care and services to maintain good oral hygiene for one of 31 sampled residents (R) (R55) reviewed for Activities of Daily Living (ADLs). Specifically, the facility failed to provide the resident with oral hygiene supplies, staff assistance, and/or reminders to complete oral hygiene care. Findings included: A review of the electronic medical record (EMR) revealed that R55 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including but not limited to dementia with behavioral disturbance, metabolic encephalopathy, and Alzheimer's disease with late onset. A review of R55's annual Minimum Data Set (MDS) assessment, dated 5/21/2024, revealed R55 presented with a Brief Interview for Mental Status (BIMS) score of five out of 15, indicating severe cognitive impairment. Section GG (Functional Abilities and Goals) of the assessment indicated R55 was independent with oral hygiene. A review of R55's Care Plan revealed a focus area for self-care deficits related to Alzheimer's Disease and fatigue with intervention, dated 7/4/2023, directed nursing staff to assist and remind the resident to complete oral care in the morning and at night. During an observation and interview conducted on 6/19/2024 at 9:15 am, R55 was observed with a foul odor emanating from his mouth when he spoke, and an accumulation of a buildup of a thick discolored substance was observed on his teeth. The resident stated that the staff did not assist him with oral hygiene. He stated, They don't help me with a [expletive] thing! He confirmed that even if he asked, the staff did not assist with oral care. R55 was then asked whether he knew where his oral hygiene supplies (i.e., toothbrush, toothpaste, etc.) were kept and R55 stated, I have no idea. You can look in there, while pointing to his room. An observation of R55's s room and restroom revealed no oral hygiene supplies. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 6/19/2024, at 9:35 a.m. with Certified Nursing Assistant (CNA) FF, she confirmed that she was familiar with R55's care needs. When asked whether he needed reminders to brush or assistance with brushing his teeth, CNA FF stated, He does that himself. When asked whether R55 had any difficulties with his memory, CNA FF stated, Yeah, he does forget some stuff and just wanders around pretty much all day. When asked whether R55 had a toothbrush and/or toothpaste in his room so that he would be able to brush his teeth if he remembered to do so, CNA FF looked in R55's room and restroom and confirmed there were no oral hygiene supplies. During an interview on 6/20/2024 at 11:45 am, Licensed Practical Nurse (LPN) II confirmed she was familiar with R55's care needs. However, when asked whether R55 was able to remember to brush his teeth or if he was able to physically carry out that task, LPN II stated, You know, I don't know. I'd have to check. During an interview on 6/21/2024 at 10:15 am, the Assistant Director of Nursing (ADON), reviewed R55's care flow records and confirmed there was no documented evidence that R55 was assisted with oral hygiene or encouraged to complete oral care.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44832 Based on observations, interviews, and record reviews, the facility failed to provide an environment free from accident hazards for one of six residents (R)(R1) reviewed for accidents. Harm was identified to have occurred on 2/24/2024, when R1 fell from a faulty shower bed and sustained a closed right peritrochanteric femur fracture requiring admission to an acute care hospital. Findings included: A review of the electronic medical record (EMR) revealed that R1 was initially admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses included but not limited to hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side, aphasia following cerebral infarction, peripheral vascular disease, chronic pain, vascular dementia, anxiety, Alzheimer's Disease, morbid (severe) obesity, muscle weakness, and age-related osteoporosis. A review of the annual Minimum Data Set (MDS) assessment dated [DATE] and the quarterly MDS assessment dated [DATE] revealed that staff was unable to complete the Brief Interview for Mental Status (BIMS) assessment for R1, meaning the resident is rarely or never understood. A review of the progress notes revealed that on 2/24/2024 at 4:28 pm, Licensed Practical Nurse (LPN) AA was called to R1's room and it was noted the resident was on the floor, parallel to closet doors, with her right leg at a right angle and that R1 was making whining sounds. The progress note further documented that the head of the shower bed was closest to the room entrance with the foot of the bed pointing towards the window in the room; the Certified Nursing Assistant (CNA) reported they (CNA BB and CNA CC) were preparing for R1's shower; and R1 had been laying on the shower bed for a few minutes when the support part of the head section became dislodged, which caused R1 and the lift pad to slide off the bed. It was noted that during the assessment, R1 remained conscious and was pulled away from the doors with the use of the lift pad already under her; this helped to realign her right leg with her body; and R1 was transported by Emergency Medical Services (EMS) to an emergency room (ER). A review of a nursing note dated 2/24/2024 at 5:50 pm revealed the family of R1 called the facility and informed them that R1 had sustained a right hip fracture. A review of the hospital medical records dated 2/24/2024 revealed that R1 sustained a closed right peritrochanteric femur fracture. Per the record, R1's x-rays revealed a fracture of the proximal right femoral diaphysis and proximal tibial fracture with likely extension into the medial tibial plateau as a result of a fall from a shower chair at the facility. A review of a nursing note dated 2/29/2024 at 7:00 pm revealed that R1 had arrived back at the facility from the hospital at approximately 6:55 pm with an admitting diagnosis of a closed pertrochanteric right femur fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Administrator on 6/20/2024 at 10:20 am, she stated that the shower bed came assembled when it was delivered by the supplier and all they had to do was roll out the mat on top of the bed. The Administrator stated on 2/24/2024, two CNAs were adjusting R1 on the shower bed. The PVC (polyvinyl chloride) C-Clamp came undone. This caused the head of the bed to fall and R1 and the mat slid down backward onto the floor. The administrator confirmed the facility had this shower bed for approximately three months before this incident happened and there had not been any maintenance or safety inspections done on the shower bed before that incident occurred. During an interview with LPN AA on 6/20/2024 at 11:51 am, he stated that he was the floor nurse at the time of the incident when R1 fell off the shower bed. He stated that one of the CNAs who'd been helping with the transfer came to tell him that R1 had fell and their right leg was at a right angle parallel to the closet. He stated that R1 was moaning and was scared and was sent out to the hospital. A phone interview was conducted with CNA BB on 6/20/2024 at 12:08 pm. CNA BB stated that they were helping another CNA with R1. CNA BB stated when they arrived at the resident's room, they went to the resident's right side, and the shower bed and Hoyer lift were already in the room in place and ready to be used. CNA BB stated they were then at the head of the shower bed to put the hooks through the second set of [NAME] on the lift pad. The wheels had been locked on the bed, but they believed the bed position was too low so R1 was pulled up on the shower bed and then the shower mat ended up being pulled up further than the resident. CNA BB further stated that the other CNA got in front, where the resident's feet were, and then they heard a snap sound. R1 slid down with her leg above their head and their pelvis facing the closet. An interview with the Maintenance Director was completed on 6/20/2024 at 12:45 pm, and they stated that they added self-locking nuts and bolts to the C-Clamp to the shower bed for modification purposes, and stated the nursing staff don't need to raise the head of the bed to shower the residents. The bolts prevented it from moving at all. During a phone interview with CNA CC on 6/20/2024 at 3:37 pm, confirmed that they were present when R1 fell from the shower bed. They stated that they did not receive specific training related to the use of the shower bed and that they had not used that specific shower bed much since it was newer. They said that the position was adjusted higher up than the previous shower bed they used. A review of the PVC Owner's Manual for the shower bed revealed, Do not make any modifications to this device. Use only the provided casters and accessories with this device. Use of third-party casters or accessories may pose a risk to the user and void the warranty . Anticipated Usable Product Life is based on normal use with proper maintenance, cleaning, and storage. You should still inspect, monitor, and care for the devices as described in this guide, as the device may need to be replaced sooner than expected in particular situations . A review of Safety Inspection log sheets for Shower Bed/Chair was reviewed and revealed that there were no inspections done before the 2/24/2024 incident. F689 crossed reference with F908 S/S=G

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44832 Based on observations, interviews, record review, and review of the facility's policy titled Emergency Pharmacy Service and Emergency Kits, the facility failed to ensure that an emergency medication kit (E-Kit) was readily available for use in a resident emergency for one of two medication rooms (Medication Room West) observed. Findings included: A review of the facility's policy and procedure titled Emergency Pharmacy Service and Emergency Kits, dated 4/1/2016, indicated that emergency pharmacy services are available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy. An emergency supply of medications, including emergency drugs, antibiotics, controlled substances, and products for infusion is supplied by the provider pharmacy in limited quantities in portable, sealed containers, in compliance with applicable state regulations. As soon as possible the nurse records the medication on the medication order form and calls the pharmacy for replacement of the kit and flags the kit with a color-coded lock to indicate the need for replacement of kit. During an observation on 6/19/2024 at 11:18 am with the Assistant Director of Nursing (ADON) in the medication room West, a (red) color-coded E-Kit was observed in the refrigerator. Closer observation of the E-Kit revealed that it had been accessed and opened on 5/2/2024. The pharmacy record inside the E-Kit recorded Humalog (diabetes medication) was pulled out and utilized. During a concurrent observation and interview on 6/19/2024 at 11:20 am, the ADON stated that the refrigerated (red) color-coded E-Kit was opened, dated 5/2/2024, and was not replaced by the pharmacy. The ADON further stated that the process for replacing the E-Kit was to call the pharmacy and notify them of the usage and replacement needed as soon as possible to ensure there were always correct medications available.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44832 Based on interviews and record reviews, the facility failed to ensure adequate blood glucose monitoring for residents receiving insulin. This deficient practice affected one of five residents (R) (R55) reviewed for unnecessary medications. Findings included: A review of R55's medical record revealed an initial admitted [DATE]. His medical history included type 2 diabetes, metabolic encephalopathy, and Alzheimer's Disease with late onset. An annual minimum data set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 5, indicating that R55 presents with severely impaired cognition. The MDS also indicated that R55 received insulin injections. During an interview on 6/19/2024 at 9:15 am, R55 stated that facility staff were not checking his blood glucose very often and that he would like it to be checked more frequently. A review of a medical provider progress note dated 3/18/2024 revealed an entry that indicated R55 would like his sugar checked more often, says he will cooperate with labs [sic]. A preliminary review of R55's physician orders revealed no active orders to monitor his blood glucose. Orders were noted for Levemir (a long-acting insulin) 20 units to be given subcutaneously at night and Novolog (a fast-acting insulin) six units to be given subcutaneously three times daily. A review of R55's discontinued physician orders revealed an order, dated 3/19/2024 to monitor his blood glucose. The order was discontinued on 4/23/2024 when R55 was transferred to the hospital. A preliminary review of R55's blood sugar flow records revealed the last entry was on 6/15/2024 at 11:12 am. The result was 256 mg/dL. Before this entry, the last documented blood glucose check was on 4/17/2024 at 6:31 am. The result was 375 mg/dL. On 6/20/2024 at 11:45 am, an interview was conducted with Licensed Practical Nurse (LPN) II. She confirmed that she was assigned to care for R55 and she was familiar with his care needs. LPN II confirmed that R55 did receive insulin injections and stated that nursing staff monitored R55's blood sugar every morning. When asked to review R55's blood glucose monitoring orders and results, LPN II reviewed the medical record and stated she would need to do some research. On 6/20/2024 at 12:05 pm, LPN II explained that R55 was transferred to the hospital due to an unrelated event in April 2024 and that the order to monitor the resident's blood glucose was not reinstated upon his return. On 6/21/2024 at 10:45 am, an interview was conducted with R55's Attending Physician (AP). The AP confirmed that the facility could be monitoring R55's blood glucose levels if he was receiving fast-acting insulin three times daily. The AP explained that R55 did have a history of refusing to have his blood glucose checked but added that attempts should be made, and refusals should be documented.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44832 Based on observations, interviews, and record review, the facility failed to ensure expired medications were properly discarded in two of two medication rooms (Medication Room East and Medication Room West). Findings included: During an observation of the Medication Room East with a Licensed Practical Nurse (LPN) JJ on 6/20/2024 at 12:12 pm, there were 32 Acetaminophen (pain/fever medication) suppositories (an opened box) located inside the refrigerator with an expiration date of September 2023. During an observation of the Medication Room [NAME] with LPN JJ on 6/20/2024 at 12:15 pm, there were five Acetaminophen suppositories located inside the refrigerator with an expiration date of September 2023. During an interview on 6/20/2024 at 12:30 pm, LPN JJ stated that the expired Acetaminophen suppositories should not have been stored in either medication room refrigerator due to the risk of administering expired medications to the residents. A review of a record, provided by the facility, revealed that five residents (R2, R10, R33, R36, and R57) had physician's orders for Acetaminophen suppositories to be given every six hours as needed for elevated temperature.

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F 0908 Level of Harm - Actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44832 Based on interviews and record reviews, the facility failed to ensure that resident care equipment was maintained in safe operating condition for one of six residents (R) (R1) reviewed for accidents. Harm was identified to have occurred on 2/24/2024, when R1 fell from a faulty shower bed and sustained a closed right peritrochanteric femur fracture requiring admission to an acute care hospital. Findings included: A review of the electronic medical record (EMR) revealed that R1 was initially admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, aphasia following cerebral infarction, Alzheimer's Disease, and morbid (severe) obesity. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that staff was not able to conduct the Brief Interview for Mental Status (BIMS) assessment for R1 due to the resident being rarely or never understood and revealed that R1 was dependent on staff for showers/bathing. A review of the progress notes dated 2/24/2024 revealed that at 4:28 pm, Licensed Practical Nurse (LPN) AA was called to R1's room and it was noted the resident was on floor, parallel to closet doors, with their right leg at right angle. It was documented that whining sounds were heard coming from the resident. The progress note documented that there were two Certified Nursing Assistants (CNA bb and CNA CC) in the room, and they reported they were preparing R1 for a shower. They reported that R1 had been lying on the shower bed for a few minutes when the support part of the head section became dislodged, which caused R1 and the lift pad to slide off the bed. It was noted that during the assessment, R1 remained conscious, the staff used the lift pad to realign R1's right leg, and R1 was transported by Emergency Medical Services (EMS) to an emergency room (ER). A review of the nursing note dated 2/29/2024 at 7:00 pm revealed that R1 had arrived back at the facility from the hospital at approximately 6:55 pm with a diagnosis of a closed pertrochanteric right femur fracture. During an interview with the Administrator on 6/20/2024 at 10:20 am she stated that she was aware of the incident involving R1 on 2/24/2024. She stated that the shower bed came assembled when it was delivered by the supplier three months ago. She stated that, as it related to the incident involving R1, the PVC (polyvinyl chloride) C-Clamp came undone and caused the head of the bed to fall and the mat slid down backward onto the floor while the two CNAs were adjusting R1 on the shower bed. The administrator confirmed that there had not been any routine maintenance or safety inspections done on the shower bed before this incident occurred. During an interview with the Maintenance Director on 6/20/2024 at 12:45 pm, it was confirmed that there were no routine inspections of the shower bed prior to the incident on 2/24/2024. They stated that they added self-locking nuts and bolts to the C-Clamp to the shower bed for modification purposes, and stated the nursing staff don't need to raise the head of the bed to shower the residents now. The bolts prevented it from moving at all. (continued on next page)

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F 0908 Level of Harm - Actual harm Residents Affected - Few	A review of the PVC Owner's Manual for the shower bed revealed, Do not make any modifications to this device. Use only the provided casters and accessories with this device. Use of third-party casters or accessories may pose a risk to the user and void the warranty . Anticipated Usable Product Life is based on normal use with proper maintenance, cleaning, and storage. You should still inspect, monitor, and care for the devices as described in this guide, as the device may need to be replaced sooner than expected in particular situations . F689 crossed reference with F908 S/S=G