STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115340	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calhoun Health Care Center	1387 Highway 41 North Calhoun, GA 30701

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review and staff and resident interviews, the facility failed to ensure the timely availability of personal resident funds for three of eight residents (R) (R3, R31, and R37) reviewed for access to their funds. The facility's banking hours were limited to Monday through Friday from 9:00 AM to 3:00 PM and residents did not have access to their money outside of these hours. Findings included: The facility's banking hours, posted on the Business Office Door at the facility entrance, indicated the facility's banking hours were Monday through Friday from 9:00 AM to 3:00 PM. The sign indicated there were no banking hours on the weekend. 1. A review of R3's Admission Record, dated 08/27/24 and found in the electronic medical record (EMR) under the Profile Tab, revealed R3 was admitted to the facility on [DATE] with diagnoses including heart failure and end-stage renal disease (ESRD). A review of R3's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/22/24 and found in the EMR under the MDS Tab, indicated a Brief Interview for Mental Status (BIMS) score of 10 out of 15 (which indicated the resident was moderately cognitively impaired). During an interview with R3 on 08/28/24 at 11:36 AM, she confirmed the money in her Personal Needs Account (PNA) was only available during banking hours (Monday through Friday from 9:00 AM to 3:00 PM). She stated residents had been able to access their money on weekends in the past, but the facility was no longer doing that. She stated she would like to have access to her money every day, including on weekends. 2. Review of R31's Admission Record, dated 08/27/24 and found in the EMR under the Profile Tab, revealed R3 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes and dependence on renal dialysis. A review of R31's annual MDS with an ARD of 07/11/24, indicated a BIMS) a score of 15 out of 15 (indicating the resident was cognitively intact). (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with R31 on 08/28/24 at 11:31 AM, he stated he would like to get ten dollars per day out of his PNA. He stated he was able to access his money every day except Saturday and Sunday because the facility's bank was closed on the weekends. He stated he would like to have access to his money on the weekends. 3. A review of R37's Admission Record, dated 08/28/24 and found in the EMR under the Profile Tab, revealed R37 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease. R37's quarterly MDS with an ARD of 07/17/24, indicated a BIMS score of 12 out of 15 (indicating the resident was mildly cognitively impaired). During an interview with R37 on 08/28/24 at 11:28 AM, she stated residents did not have access to the money in their Personal Needs Accounts after 3:00 PM during the week or on weekends. She stated her son usually came to visit her on Sundays, and she would like to be able to access her money on Sundays so she could give her son money to purchase items for her when he visited. She stated, It would be good for the (facility) bank to be open on the weekends. During an interview with the Medical Record Director on 08/27/24 at 2:48 PM, she confirmed she was in charge of resident PN Accounts and stated residents were not able to access money from their personal needs accounts on the weekends or in the evening after 3:00 PM. She stated there was no one in the facility to access resident funds during those times. During an interview with the Business Office Manager (BOM) and the Administrator together on 08/27/24 at 3:43 PM, the BOM confirmed the Medical Records Director was in charge of resident PNAs. She confirmed residents did not have access to their personal funds outside of the posted banking hours. During an interview with the Administrator on 08/28/24 at 10:51 AM, she stated her expectation was residents would have reasonable access to their personal funds.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on facility policy, interviews, and record review, the facility failed to ensure accurate financial accounting and record retention for two of eight residents (R) (R31 and R37) reviewed for resident funds. Findings included: A review of the facility's policy titled, Resident Trust Policy updated on 08/27/24, indicated, [NAME] Health Care maintains a resident trust that is available, free of charge, for any long-or-short-term resident. The facility will hold, safeguard, manage, and account for the personal trust account; and 4. The resident shall have reasonable access, upon request, to their transaction records and shall receive an itemized quarterly statement of his/her accounts.? 1. A review of R31's Admission Record, dated 08/27/24 and found in the electronic medical record (EMR) under the Profile Tab, revealed R31 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes and dependence on renal dialysis. A review of R31's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/11/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 (indicating the resident was cognitively intact). During an interview with R31 on 08/25/24 at 8:37 AM, he confirmed the facility kept his money in a Personal Needs Account managed by the facility. He stated he had more than 50 dollars in his account but did not receive a quarterly statement related to his account. 2. A review of R37's Admission Record, dated 08/28/24 and found in the EMR under the Profile Tab, revealed R37 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease. A review of R37's quarterly MDS with an ARD of 07/17/24, indicated a BIMS score of 12 out of 15 (indicating the resident was mildly cognitively impaired). During an interview with R37 on 08/25/24 at 8:30 AM, she confirmed the facility managed her money per a Personal Needs Account and stated she did not remember receiving quarterly statements related to her Personal Needs Account held by the facility. During an interview with the Medical Records Director on 08/27/24 at 4:10 PM, she confirmed the facility was managing funds for R31 and R37 and confirmed neither resident was receiving quarterly Personal Needs Account Statements. She stated she had been sending the quarterly statements to the Resident Representative listed in each resident's record. The Medical Records Director further stated it was her process to send quarterly statements to the listed resident representative for any resident in the facility who had a representative listed in the record, regardless of the resident's ability to understand and manage their affairs. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 08/28/24 at 10:51 AM, she stated her expectation was cognitively intact residents capable of understanding their finances were to be provided with their quarterly personal needs account statement each quarter.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on staff interviews and record review, the facility failed to ensure resident funds managed by the facility in a Personal Needs (PN) Account were released to the resident or resident's Responsible Party (RP) within 30 days of discharge for three of eight residents (R) (R195, R197, and R199) reviewed for personal funds. Findings included: 1. A review of R195's Admission Record, dated 08/27/24 and found in the electronic medical record (EMR) under the Profile Tab, revealed R195 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease and acute and chronic respiratory failure. The record indicated the resident passed away in the facility on 07/21/23. A review of R195's Resident Fund Statement, dated 08/28/24 and provided by the facility, indicated the resident still had an active PN Account as of that date (more than 13 months after the resident's discharge from the facility). The document revealed a total balance of $4882.92 was still in the resident's PN account as of 08/28/24. 2. A review of R197's Admission Record, dated 08/2724 and found in the EMR under the Profile Tab, revealed R1975 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes. The record indicated the resident passed away in the facility on 04/21/24. A review of R197's Resident Fund Statement, dated 08/28/24 and provided by the facility, indicated the resident still had an active PN Account as of that date (more than four months after the resident's discharge from the facility). The document revealed a total balance of $233.00 was in the resident's PN account as of 08/28/24. 3. A review of R199's Admission Record, dated 08/27/24 and found in the electronic medical record (EMR) under the Profile Tab, revealed R199 was admitted to the facility on [DATE] with diagnoses including liver and colon cancers. The record indicated the resident passed away in the facility on 01/30/24. A review of R199's Resident Fund Statement, dated 08/28/24 and provided directly to the survey team, indicated the resident still had an active PN Account as of that date (almost seven months after the resident's discharge from the facility). The document revealed a total balance of $170.00 was in the resident's account as of 08/28/24. During an interview with the Medical Records Director on 08/27/24 at 4:10 PM, she confirmed in the facility and confirmed the balances remaining in R195, R197, and R199's PN Accounts. She stated she was unsure of why the residents' funds had not been returned to each resident's RP. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 08/28/24 at 10:51 AM, she confirmed the balances remaining in facility PN Accounts for R195, R197, and R199. She stated her expectation was funds held by the facility in resident PN Accounts were expected to be returned to the resident or the resident's RP within 30 days after discharge from the facility per Federal Regulation.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, and facility policy review, the facility failed to provide Form CMS-10055 (Centers for Medicaid and Medicare Services) Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) to two of three residents (R) (R145 and R146) reviewed for liability notices. This failure prevented the resident or responsible party the ability to make an informed decision related to the cost of continued therapy services. Findings included: A review of the CMS site, Form Instructions Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566 accessed at https://www.cms.gov/medicare/medicare-general-information/bni/downloads/abn-form-instructions.pdf on 06/04/24 revealed, The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Unless otherwise instructed to do so according to the specific guidance provided in these instructions, the notifier must not decide for the beneficiary which of the 3 checkboxes to select . If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: beneficiary refused to choose an option. 1. Review of R145's electronic medical records (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. A review of a document provided by the facility titled Notice of Medicare Non-Coverage indicated that R145's skilled services ended on 08/21/24. A review of R145's EMR indicated the resident remained in the facility after the end of her skilled services. There was no evidence the facility provided R145's representative with an ABN notice. 2. A review of R146's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. A review of a document provided by the facility titled Notice of Medicare Non-Coverage indicated R146's skilled services ended on 08/08/24. A review of R146's EMR indicated the resident remained in the facility after the end of his skilled services. There was no evidence the facility provided R146's representative with an ABN notice. During an interview on 08/27/24 at 5:15 PM, the Administrator stated it was the prior social services staff member who was required to give the resident and/or the representatives the ABN notices. The Administrator confirmed that R145 and R146s' representatives only received the Notice of Medicare Non-Coverage and not the ABN notice.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on facility policy, record review, and staff interviews, the facility failed to ensure notice regarding the reason for the transfer was provided, in writing for three of three residents (R) (R64, R70, and R94) reviewed for hospitalization . This failure created the potential for the residents to be uninformed about their rights related to hospital transfer and subsequent return to the facility. Findings included: The facility's policy regarding written notice of hospital transfer was requested on 08/27/24. During an interview conducted with the Administrator and the Director of Nursing (DON) on 06/28/25 at 9:25 AM, the DON confirmed the facility did not have a policy regarding written notification with hospital transfer and stated her expectation was federal regulation would be followed related to hospital transfers. 1. A review of the electronic medical record (EMR) for R64 revealed the resident was admitted to the facility on [DATE] with diagnoses including type 2 diabetes and a history of heart attack. The record indicated the resident's spouse was his Resident Representative (RP). A review of R64's Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident was severely cognitively impaired. A review of R64's Census Records dated 08/27/24 indicated the resident was out of the facility and admitted to the local hospital between 06/04/24 and 06/11/24 and again between 06/24/24 and 06/26/24. A review of R64's Progress Notes dated 06/04/24 indicated the resident was sent to the local hospital on that date related to hematuria (blood in the urine). A review of R64's Progress Notes dated 06/24/24 indicated the resident was sent to the local hospital, again, on that date related to blood clots in his urine. A review of R64's comprehensive medical record revealed nothing to indicate the resident's RP was notified, in writing, of the reason for either of the resident's transfers to the hospital. 2. A review of R70's undated 'Admission Record revealed R70 was admitted to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R70's Nursing Progress Notes dated 01/15/24 revealed (R70) presents with a recent decline in intake, pocketing meds [medications] and food with intermittent dysphagia. This nurse observed the resident having a difficult time sitting up in a wheelchair. Skin dry, pale, and ashen. Hypotensive, disoriented, and altered mental state. The resident not verbally responding per her norm. Supplemental O2 [oxygen] via nc [nasal cannula] was started on the resident. Still unable to obtain O2 sat [saturation] reading. BP [blood pressure] 88/40. Consulted with MD [physician] in-house and he gave a verbal order to send to ER [emergency room] r/t [related to] AMS [altered mental status]. The resident left at approx [approximately] 10:15 AM with EMS [emergency medical services] via stretcher " A review of R70's 'Health Status Note dated 04/12/24, revealed "Noted with lethargy . seen for f/u [follow up], noted lethargic, sitting in w/c [wheelchair] but unable to hold the head up, confused, with poor appetite, noted with dry lips and mucus membrane, attempts to hydrate inhouse failed due to pulling the IV [intravenous] access out, called RP, and discussed the resident's status states it's okay to send to ER for evaluation, No s/s [signs and symptoms] of distress ." A review of R70's EMR revealed there was no documented evidence that a written notice in writing of the reason for the transfer to the hospital was provided to R70 and R70's Responsible Party (RP) on 01/15/24 or 04/12/24. 3. A review of R94's undated Admission Record revealed R94 was admitted to the facility on [DATE]. A review of R94's Progress Note dated 06/02/24 revealed at "11:00 PM during shift change another nurse staff took vitals and pulse dropped down to 40-60 BPM [beats per minute] and O2 80. She then called on call and received an order to send the resident to the ER for eval [evaluation] . CNA mentioned to the nurse that during peri care she noticed a bulged knot coming from her incision . Resident paperwork was printed and sent with EMT [emergency medical technicians] workers for the hospital." A review of R94's EMR revealed there was no documented evidence that a written notice in writing of the reason for the transfer to the hospital was provided to R94 and R94's RP on 06/02/24. During an interview with the Administrator on 08/27/24 at 5:15 PM, she confirmed she was not able to locate any information to show written notices regarding the reason for transfer were provided to R64, R70, or R94 and/or their RPs with transfers to the hospital. She stated her expectation was these notices be provided to residents and/or their RP with each transfer to the hospital. During an interview on 08/28/24 at 9:26 AM, the Administrator confirmed she does not have a policy on transfer notices, and she was not aware that a written transfer notice was required to be provided to the resident and responsible party, so she did not enforce it.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, staff interviews, and facility policy, the facility failed to ensure the facility's Bed Hold Policy was provided in writing to three of three residents (R) (R64, R70, and R94) reviewed for hospitalization . This failure created the potential for the residents to be uninformed about their rights related to the facility's bedhold procedures. Findings included: A review of the facility's policy titled, Bed Hold Prior to Transfer Policy dated 2023, indicated, It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave; and The facility will provide written information about these policies to residents and/or resident representatives prior to and upon transfer for such absences. 1. A review of R64's Admission Record, dated 08/27/24 and found in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including type 2 diabetes and history of heart attack. The record indicated the resident's spouse was his Resident Representative (RP). A review of R64's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident was severely cognitively impaired. A review of R64's Census Records, dated 08/27/24 and found in the EMR under the Census tab, indicated the resident was out of the facility and admitted to the local hospital between 06/04/24 and 06/11/24 and again between 06/24/24 and 06/26/24. A review of R64's Progress Notes, dated 06/04/24 and found in the EMR under the Notes tab, indicated the resident was sent to the local hospital on that date related to hematuria (blood in the urine). A review of R64's Progress Notes, dated 06/24/24 and found in the EMR under the Notes tab, indicated the resident was sent to the local hospital, again, on that date related to blood clots in his urine. A review of R64's comprehensive medical record revealed nothing to indicate the facility's Bed Hold Policy had been provided to the resident's RP, in writing, related to either of his transfers to the hospital. During an interview with the Administrator on 08/27/24 at 5:15 PM, she confirmed she had not been able to locate anything in R64's record to show the facility's Bed Hold Policy had been provided, in writing, to the resident's RP related to either of his transfers to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of R70's undated "Admission Record," located in the EMR under the "Profile" tab, revealed R70 was admitted to the facility on [DATE]. A review of R70's "Nursing Progress Note, dated 01/15/24, located in the EMR under the "Prog Note" tab, revealed that Resident presents with the recent decline in intake, pocketing meds [medications] and food with intermittent dysphagia. This nurse observed the resident having a difficult time sitting up in a wheelchair. Skin dry, pale, and ashen. Hypotensive, disoriented, and altered mental state. The resident not verbally responding per her norm. Supplemental O2 [oxygen] via nc [nasal cannula] was started on the resident. Still unable to obtain O2 sat [saturation] reading. BP [blood pressure] 88/40. Consulted with MD [physician] in-house and he gave a verbal order to send to ER [emergency room] r/t [related to] AMS [altered mental status]. The resident left at approx [approximately] 10:15 AM with EMS [emergency medical services] via stretcher " A review of R70's "Health Status Note, dated 04/12/24, located in the EMR under the "Prog Note" tab, revealed "Noted with lethargy . seen for f/u [follow up], noted lethargic, sitting in w/c [wheelchair] but unable to hold the head up, confused, with poor appetite, noted with dry lips and mucus membrane, attempts to hydrate inhouse failed due to pulling the IV [intravenous] access out, called RP, and discussed the resident's status states it's okay to send to ER for evaluation, No s/s [signs and symptoms] of distress ." A review of R70's EMR under the "Misc" tab revealed there was no documented evidence that notice of bed holds was provided before/upon transfer to the hospital to R70's Responsible Party (RP) on 01/15/24 or 04/12/24. 3. A review of R94's undated "Admission Record," located in the EMR under the "Profile" tab, revealed R94 was admitted to the facility on [DATE]. A review of R94's "Progress Note, dated 06/02/24, located in the EMR under the "Prog Note" tab, revealed that "11:00 PM during shift change another nurse staff took vitals and pulse dropped down to 40-60 BPM [beats per minute] and O2 80. She then called on call and received an order to send the resident to the ER for eval [evaluation] . CNA mentioned to the nurse that during peri care she noticed a bulged knot coming from her incision . Resident paperwork was printed and sent with EMT [emergency medical technicians] workers for the hospital." A review of R94's EMR under the "Misc" tab revealed there was no documented evidence that a bed hold notice was provided before/upon transfer to the hospital to R70 on 06/02/24. During a follow-up interview with the Administrator on 08/28/24 at 9:25 AM, she stated her expectation was the facility's Bed Hold Policy was to be provided to the resident or resident's RP, in writing, each transfer to the hospital.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, and policy review, the facility failed to make a referral for a Level II Preadmission Admission Screening and Resident Review (PASARR) evaluation for one of three sampled residents (R) (R31) reviewed for PASARR Level II evaluations. Findings included: A review of a facility document titled Resident Assessment-Coordination with PASARR Program dated 02/12/22 indicated .Any resident who exhibits a newly evident or possible serious mental disorder .or related condition will be referred promptly to the state mental health.authority for a level II resident review. Examples include.A resident who exhibits behavioral, psychiatric, or mood-related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). A review of a document provided by the facility titled PASARR Level I dated 05/05/23, indicated R31 did not have a diagnosis of major depressive disorder. A review of R31's EMR titled Admission Record indicated the resident was admitted to the facility on [DATE]. A review of R31's EMR titled admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/07/23 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which revealed the resident was cognitively intact. The assessment did not identify the resident with a depression diagnosis. A review of a document provided by the facility titled, Psychiatric Diagnostic Evaluation dated 01/04/24, indicated the psychiatric provider diagnosed R31 with major depressive disorder. A review of R31's EMR titled Care Plan located under the Care Plan tab, dated 05/13/24, indicated the resident took antidepressant medication to treat his diagnosis of depression. A review of R31's EMR failed to contain evidence the facility submitted a PASARR Level II with his new diagnosis of major depressive disorder. During an interview on 08/28/24 at 9:02 AM, the Administrator stated the expectation was for social services to submit a new PASARR when there has been a new mental health diagnosis identified.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, and facility policy review, the facility failed to complete Pre-Admission Screening and Resident Reviews (PASARR) as required for two of three sampled residents (R) (R31 and R64) reviewed for PASARR status. Findings included: A review of a policy titled, Resident Assessment - Coordination with PASARR Program dated 02/12/22 indicated . The facility will only admit individuals with a mental disorder or intellectual disability whom the State mental health or intellectual disability authority has determined as appropriate for admission. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority. There was no evidence in the facility policy that addressed the facility's responsibility if the PASARR was inaccurate. 1. A review of R31's electronic medical records (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. A review of R31's PASARR Level I, provided by the facility indicated it was dated 05/05/23. During an interview on 08/28/24 at 11:34 AM, the Administrator stated her expectation was for the facility to complete another PASARR if the one from the hospital was completed over 30 days before the resident's admission. The Administrator stated that R31 was currently being seen by mental health services. 2. Review of R64's Admission Record, dated 08/27/24 and found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder (PTSD), anxiety disorder, and major depressive disorder. A review of R64's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/19/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated the resident was not exhibiting signs or symptoms of depression or behaviors during the assessment reference period. A review of R64's PTSD Care Plan, dated 05/23/22 and found in the EMR under the Care Plan tab, indicated the resident had PTSD related to his history of domestic violence and childhood abuse. Interventions included approaching the resident calmly and reassuringly, giving the resident the option to voice his feelings, inviting the resident to social functions, praising the resident when he has positive expressions, and referring the resident to a psychiatric provider/clinical social worker as needed. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R64's Psychotropic Medication Care Plan, dated 05/23/22, and found in the EMR under the Care Plan tab, indicated the resident was receiving psychotropic medications related to his diagnoses of depression and anxiety. Interventions included Administering medications as ordered and monitoring/documenting for side effects and effectiveness (of psychotropic medications). Observe for changes in mentation, behavior, mood, and affect, Psychiatric consultation/evaluation with follow-up as needed, and Review medication regime as indicated. A review of R64's Physician Order Report, dated 08/27/24 and found in the EMR under the Orders tab, indicated current orders for the resident to receive Wellbutrin (an antidepressant medication) 150 milligrams (MG) by mouth one time a day related to major depressive disorder and Zoloft (an antidepressant medication) 50 MG by mouth one time a day related to major depressive disorder. A review of R64's Level I PASARR, dated 11/18/21 and found in the EMR under the Miscellaneous Tab, inaccurately indicated the resident did not have a major mental illness diagnosis, even though the resident's PTSD, Anxiety, and Major Depressive Disorder diagnoses were all present at the time of the assessment. During an interview with the Administrator and Director of Nursing (DON) on 08/28/24 at 9:28 AM, the DON confirmed that R64's Level I PASARR was not accurate. The Administrator stated each resident's Level I PASARR was expected to accurately reflect the resident's psychiatric/mental health diagnoses. 18947

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on observation, record review, interview, and review of the facility policy, the facility failed to implement a person-centered comprehensive plan of care with measurable goals and plans related to fall prevention for three of 22 sampled residents (R31, R47, and R10). Harm was identified to have occurred on 07/18/24 when the facility failed to develop and implement a care plan for R31 that addressed his desire for more independence with ambulation and his desire for bilateral prostheses. (Cross reference F657, F689 and F688) Findings included: Review of facility policy titled Comprehensive Care Plans undated indicated . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will describe, at a minimum, the following.The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. During an interview on 08/25/24 at 8:33 AM, R31 stated he was evaluated for bilateral prostheses and a man came out about one month ago. R31 stated his goal was to get his prostheses and return home. A review of R31's electronic medical records (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. A review of R31's EMR titled Care Plans located under the Care Plan tab dated 08/29/23 indicated the resident had bilateral above-the-knee amputations. The care plan indicated the resident was to be assessed and treated by physical therapy. The goal was for the resident to exhibit adequate coping skills for the loss of his lower limbs. The care plan failed to address the resident's desire to have bilateral prostheses. During an interview on 08/28/24 at 9:02 AM, the Administrator stated R31's wishes to have bilateral prostheses and a goal to return home would be appropriately integrated into his individualized care plan. 2. A review of R47's Face Sheet, dated 08/27/24 and found in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	A review of R47's annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 07/01/24 and found in the EMR under the MDS Tab, revealed a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated the resident required partial to moderate assistance from staff to transfer in and out of her bed and indicated the resident had not experienced any recent falls as of the date of the assessment. A review of R47's Falls Care Plan, dated 01/25/24 and found in the EMR under the Care Plan tab, indicated the resident was at risk for falls related to her diagnoses of dementia, balance problems, and lack of awareness of safety needs. Interventions included Staff to ensure the bed is in the lowest position. Observations of R47 on 08/26/24 at 10:31 AM, 11:47 AM, 12:52 PM, 2:57 PM, and 4:12 PM, and on 08/27/24 at 9:05 AM, 10:26 AM, and 2:31 PM revealed the resident laying in her bed. The resident's bed was not observed to be in a low position during any of the observations. The bed was positioned at its regular height. During an interview with the Administrator and Director of Nursing (DON) on 08/28/24 at 9:11 AM, both stated their expectation was each resident's care plan be followed. They stated if an intervention, such as a low bed, was in place for a resident the intervention was expected to be implemented. 3. A review of R10's undated Admission Record located in the Profile tab of EMR revealed R10 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, and morbid obesity due to excess calories. A review of R10's annual MDS located in the MDS tab of the EMR with an ARD of 02/14/24, indicated a BIMS score of 10 out of 15 which indicated R10 was moderately cognitively impaired. The MDS recorded R10 had impairment on one side of the upper and lower extremities and required the assistance of two staff (dependent) for toileting hygiene (The ability to maintain perineal hygiene and adjust clothes before and after voiding or having a bowel movement). A review of R10's comprehensive Care Plan, dated 08/25/24, located in the Care Plan tab of the EMR, indicated ADLs [activities of daily living]: Resident has an ADL self-care performance deficit and is at risk for not having their needs met in a timely manner. [R10] requires assistance with ADLs, the amount of assistance needed varies provide her with what assistance is needed. A review of R10's CNA Kardex, dated 02/14/24, located in the Tasks of the EMR, revealed the focus area of bladder/bowel (B&B) B&B bladder incontinence - she is incontinent, depends on 2 [two] staff for cleaning and changing . B&B bowel movements she is incontinent of bowel. She depends on two staff to change and clean her During an interview on 08/26/24 at 8:49 AM, R10 stated a nurse aide was changing her briefs in the bed then she rolled out of the bed onto the floor. R10 also stated she broke her pinky finger when she fell out of bed. R10 indicated she was provided a wider bed and side rails were added to it to help with positioning. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/27/24 at 7:44 PM, Certified Nurse Aide (CNA) 4 stated she rolled R10 on her left side and while providing peri-care, R10 reached to place a bib on the bedside table, then rolled off the bed onto the floor. CNA4 also stated she was not aware R10 was a two-person assist with incontinence care until the Director of Nursing (DON) and Assistant DON informed her during an interview after the fall. CNA4 confirmed she did not review R10's CNA Kardex and was not informed in a report by other staff that R10 required two-person assistance. CNA4 acknowledged she rolled R10 away from her, not towards her, because she was not trained to do so. During an interview on 08/28/24 at 9:43 AM, the DON stated she investigated R10's fall out of the bed on 03/06/24. The DON acknowledged she determined the root cause of the fall was due to CNA4 not following the care plan which stated R10 required two staff to provide care for bladder and bowel incontinence care. During an interview on 08/28/24 at 12:02 PM, the Minimum Data Set Coordinator (MDSC) confirmed the CNA Kardex dated 02/14/24 stated R10 required two staff to perform incontinence care. The MDSC stated the CNA Kardex was in POC and all CNAs had access to it on the tablets. 18947

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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** 28604 Based on observation, interview, record review, and policy review, the facility failed to label the enteral feeding bag in accordance with professional standards of practice for enteral feeding tube administration for one of 22 sampled residents (R) (R69). This failure had the potential to result in the incorrect amount of feeding administered to the resident. Findings included: A review of R69's undated Admission Record located in the electronic medical record (EMR) revealed R69 was admitted to the facility on [DATE] with diagnoses of dysphagia following cerebral infarction, other artificial openings of gastrointestinal tract status and gastroparesis. Review of R69's Physician's Order, dated 01/03/24, located in the EMR under the Orders tab, revealed order to in the morning for PEG related to dysphagia following cerebral infarction . stop cont [continuous] feeding @ [at] 6[:00] AM/ Enteral Nutrition via Nutren 2.0 at 45/ml [milliliters] per hour for 20 hours via pump per PEG [percutaneous endoscopic gastrostomy] tube. Start infusion at 12[:00] PM and continue until 8:00 AM . and in the afternoon for PEG . stop cont Feeding @ 8[:00] AM/ Enteral Nutrition via Nutren 2.0 Cal 2.0 at 45/ml per hour for 20 hours via pump per PEG tube. Start infusion at 12[:00] PM and continue until 8[:00] AM. A review of R69's Medication Administration Record (MAR), dated August 2024, located in the EMR under the Orders tab, revealed R69 was started on the enteral feeding on 08/24/24 at 12:00 PM by Licensed Practical Nurse (LPN) 5. A review of R69's quarterly Minimum Data Set (MDS), dated [DATE], located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated R69 was moderately impaired in cognition. Observation on 08/25/24 at 9:02 AM in R69's room revealed the resident was lying in bed with the head of the bed elevated 30 degrees, and the Nutren 2.0 enteral feeding bag was hanging on the pole with no date, time started, resident's name or initials. During an interview on 08/25/24 at 9:05 AM, R69 stated LPN5 hung the bag on 08/24/24, the previous day. Observation on 08/25/24 at 9:11 AM, LPN5 verified R69's enteral feeding bag label was not completed. LPN5 stated she did not hang the bag; the night shift nurse hung it and should have completed the label when it was hung. LPN5 also stated it was important to label the feeding bag with the start date and time to determine if the resident received the correct amount of enteral feeding. During an interview on 08/26/24 at 2:57 PM, LPN4 stated she worked from 08/24/24 at 11:00 PM to 08/25/24 at 7:00 AM and was assigned to R69 but did not start or stop R69's tube feeding. LPN4 also stated she was not aware the label on the bag was not completed but she should have checked it. LPN4 indicated the rationale for completing the label on the bag was so nursing staff would know how much tube feeding was received daily. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/28/24 at 9:03 AM, the Director of Nursing (DON) stated it was a standard of practice for nursing staff to ensure the tube feeding labels were completed with the name of the resident, date and time started, and initials. The DON also stated completion of the label was done for the safety of the resident for the enteral feeding was only good for 24 hours. During an interview on 08/28/24 at 9:05 AM, the Administrator stated the DON had been employed at the facility for a couple of months and was in the process of completing competencies including correct medication administration for the nursing staff and would be training nursing staff on proper medication administration procedures. A review of the facility-provided nursing competency document titled Medication and Feeding Administration Enteral Feeding Tube, undated, revealed, . Labels Bottle with Date, Time Initials, And Pt [patient] Name, Dates, Initials and Puts Time on Tubing A review of the facility-provided policy titled Care and Treatment of Feeding Tubes, dated 02/12/22, revealed Policy: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Policy Explanation and Compliance Guidelines: Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review, staff interviews, and facility policy review, the facility failed to provide appropriate adaptive equipment as directed by Physical Therapy recommendation for one of 22 sampled residents (R) (R31) related to a bi-lateral prosthesis to prevent further potential decline in muscle strength, joint mobility, and an ability to ambulate independently. Psychosocial harm was determined to exist on 7/18/24 due to R31's emotional state when he repeatedly expressed his need for the prosthesis to promote his independence. (Cross Reference F656) Findings included: A review of a facility's policy titled Reporting of Therapy Services dated 02/12/22 indicated . Specialized rehabilitative services (physical therapy, occupational therapy, speech-language pathology services) are provided as indicated to ensure the needs of the residents are met in accordance with their comprehensive plan of care. This policy addresses how the facility reports what rehabilitative services were provided. A review of R31's electronic medical records (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] with diagnoses that included above-the-knee bilateral amputation and diabetes. A review of a facility document titled Physical Therapy (PT) Evaluation & Plan of Treatment, dated 08/01/23, indicated the resident was admitted from the hospital for abdominal pain, nausea, and diarrhea. A review of R31's EMR titled admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/07/23 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the resident was cognitively intact. The assessment indicated the resident required supervision for bed mobility and transfers from staff. A review of a document provided by the facility for R31 titled Physical Therapy (PT) Therapy Progress Report, dated 08/15/23, indicated the resident required skilled services to assess his functional abilities to increase coordination and increase his lower extremities' range of motion. A review of a document for R31 titled, Clinical Summary from Hanger Clinic, dated 08/24/23, indicated the resident was evaluated by the clinic for the use of bilateral prostheses. The clinic note revealed the resident was seen from the facility. The document indicated the resident had started the process for bilateral lower leg prostheses before while he lived in the community. The note revealed the resident was able to transfer himself since the resident was unable to transfer independently. The note continued to state his upper body had adequate strength for him to use prostheses. Finally, the note stated the resident required physical therapy to work on his hip flexion since his hips at the time of the evaluation had 30-degree contractures and the goal was to work to reduce the resident's hip contractures to 15 degrees before he could be fitted with the prostheses. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of R31's EMR titled Care Plan located under the Care Plan tab, dated 08/29/23, indicated the resident had bilateral above-the-knee amputations. The goal was for the resident to exhibit adequate coping skills for the loss of his lower limbs. A review of a document provided by the facility for R31 titled Physical Therapy Discharge Summary, dated 10/06/23, the resident made consistent progress in PT and the resident had little or no deficits with skilled therapy. There was no evidence the resident received a referral from the facility's skilled therapist to the community Hanger clinic for an evaluation for bilateral above-the-knee prostheses. A review of R31's EMR indicated the resident received restorative nursing as an intervention after his discharge from skilled services. A review of R31's EMR titled health status note written by Nurse Practitioner (NP) 2 located under the Prog (Progress) Notes, dated 11/06/23, indicated the resident voiced to NP2 asked about the status of his prostheses. There was no clinical evidence that NP2 made a referral to the community clinic. A review of R31's EMR titled Health status note written by NP2 located under the Prog Notes dated 01/03/24 indicated the resident asked for his prostheses. A review of a document provided by the facility dated 03/14/24 indicated R31 was seen by a Certified Prosthetist/ Certified Orthotic Assistant (CP/COA). The CP/COA stated in her notes the resident had acquired bi-lateral above the knees amputation and equipment was ordered for the resident's bi-lateral prostheses. The evaluation revealed the resident had improved outcomes from physical therapy and was highly motivated. The evaluation indicated the resident had improvement in his hip flexion and a decrease in his hip's tightness and was ready to proceed with stubbies (shortened prostheses used after initial ambulatory rehabilitation). Attached to this evaluation was a fax cover sheet, dated 04/16/24, which revealed the clinic requested that the facility provide a follow-up appointment for R31 to fit him with bi-lateral stubbies. There was no evidence in the clinical record which showed that the resident had a follow-up appointment made. A review of R31's EMR titled Health status note written by NP2 located under the Prog Notes, dated 05/13/24, indicated the resident requested the status of his prostheses. There was no documentation addressing the resident's request. A review of R31's EMR titled Health status note written by NP2 located under the Prog Notes tab, dated 05/15/24, indicated the resident again requested his prostheses. There was no documentation addressing the resident's request. A review of a document provided by the facility titled Order Details, dated 07/02/24 indicated NP1 wrote an order for R31 to be seen and evaluated above the knee bilateral prostheses. A review of R31's EMR titled Health status note written by NP2 located under the Prog Notes tab, dated 07/18/24, indicated the resident was crying and asking about his prostheses. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of a document provided by the facility titled Restorative Health Services Group dated 07/25/24, indicated R31 was seen by Certified Prosthetists Orthotist (CPO). The CPO evaluated the resident for bilateral prostheses and indicated the resident would be appropriate since the resident wanted to return home and be ambulatory. During an interview on 08/25/24 at 8:33 AM, R31 was emotionally distraught and stated he was evaluated for bilateral prostheses and a man came out about one month ago. R31 stated getting his prostheses would help him to be independent and that his goal was to get his prostheses and return home. During an interview on 08/26/24 at 12:11 PM, Certified Nurse Aide (CNA) 1 and CNA 2 both stated that R31 gets upset and occasionally cries because he wants to have bilateral prostheses legs. During an interview on 08/26/24 at 12:32 PM, the Director of Rehabilitation (DOR) stated she was new in her position, and stated she reviewed the skilled therapy notes for R31. The DOR stated based on her review, that the resident would be appropriate for the use of bi-lateral prostheses. The DOR stated the resident was able to stand for five to six minutes on his stumps on the mat table. During an interview with R31 on 08/26/24 at 4:20 PM, R31 allowed the DOR to screen his hips. During this observation, the DOR explained the process to the resident and lowered the head of the bed. The DOR donned (put on) personal protective equipment. The DOR slightly pushed on both stumps and confirmed the resident did not have bilateral hip contractures. During an interview on 08/27/24 at 1:09 PM, NP1 stated she was aware of R31's goal to have bilateral prostheses. NP1 stated the resident was very emotional and did not want to give him a false impression that he could function with the bilateral prostheses. NP1 confirmed she was the NP who ordered the evaluation on 07/02/24. During an interview on 08/27/24 at 1:37 PM, CNA2 confirmed she worked with R31 with restorative nursing and confirmed the resident had good trunk control and was able to sit up on the side of the bed himself. During an interview on 08/27/24 at 2:09 PM, the Director of Nursing (DON), MDS Coordinator (MDSC), and the Wound Nurse were present. The MDSC stated it was the responsibility of the facility scheduler/transportation person to arrange the residents' community appointments. According to the MDSC that staff member was on leave and unable to be interviewed. During an interview on 08/27/24 at 2:12 PM with CP/COA she confirmed she was the one who evaluated R31 on 03/14/24. The CP/COA stated when she saw R31, he had made progress, and she was pleased with how well he had done with therapy. The CP/COA stated her company had reached out to the facility but never received a follow-up appointment to measure the resident for prostheses. During an interview on 08/28/24 at 9:23 AM, Physical Therapy Assistant (PTA) 1 stated she initially worked with R31 during his initial skilled services. PT 1 stated initially the resident did not state he wanted bilateral legs but after a month of skilled therapy he began to discuss his desire to have bilateral prostheses. The clinical document, dated 03/14/24, was presented to PTA1. PTA1 stated she never saw the evaluation of R31 and the recommendation for bilateral prostheses and would have been happy to have picked him up under skilled services again.

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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** 18947 Based on observations, interviews, record review, and facility policy review, the facility failed to prevent a fall for two of three residents (R) (R10 and R47) reviewed for falls. This failure resulted in harm to R10 when the nursing assistant failed to provide incontinence care with the assistance of another staff member per the care plan; R10 fell off the bed and suffered a closed head injury, laceration to the forehead, and fracture of the fifth finger on the right hand. Findings included: 1. A review of R10's undated Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and morbid obesity due to excess calories. A review of R10's annual Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 02/14/24, indicated a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R10 was moderately cognitively impaired. The MDS recorded R10 had an impairment on one side of the upper and lower extremities and required the assistance of two staff (dependent) for toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding, or having a bowel movement). A review of R10's comprehensive Care Plan, dated 08/25/24, located in the Care Plan tab of the EMR, indicated ADLs [activities of daily living]: Resident has an ADL self-care performance deficit and is at risk for not having their needs met in a timely manner. [R10] requires assistance with ADLs, the amount of assistance needed varies provide her with what assistance is needed. A review of R10's CNA (Certified Nursing Assistant) Kardex, dated 02/14/24, located in the Tasks of the EMR, revealed the focus area of bladder/bowel (B&B) B&B bladder incontinence - she is incontinent, depends on 2 [two] staff for cleaning and changing . B&B bowel movements she is incontinent of bowel. She depends on two staff to change and clean her A review of R10's Progress Notes, dated 03/06/24, located in the EMR in the Prog [Progress] Note tab, revealed Date/Time of Fall: 03/06/24 at 9:45 PM Fall was witnessed. Who witnessed the fall: A Certified Nurse Aide (CNA) fall occurred in the resident's room. Activity at the time of the fall: pt [patient] was rolling over to get a brief put on. The reason for the fall was evident. Reason for Fall: rolled over too far on the left side. Did an injury occur as the result of the fall: Yes. Injury details: lac [laceration] to the forehead. Knot to right temporal area, swollen right pinky, wound to the top of the right foot and left foot on the bottom. Did the fall result in an ER [emergency room] visit/hospitalization : Yes. ER [emergency room] Visit/hospitalization Details: transported to the emergency room via EMS [emergency medical services] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 08/26/24 at 8:49 AM, R10 was lying in a bariatric bed with two grab bars on both sides of the bed. R10 stated on 03/06/24 a nurse aide was changing her briefs in the bed then she rolled out of the bed onto the floor. R10 also stated she went to the hospital and returned to the facility with a broken pinky finger and a cut on her head. R10 indicated she was provided a wider bed and side rails were added to the bed to help with positioning in the bed. During an interview on 08/28/24 at 11:19 AM, Family (F) 1 stated Licensed Practical Nurse (LPN) 3 informed her that R10 fell after she rolled out of the left side of the bed and hit her head on the nightstand while a nurse aide was changing her brief on 03/06/24. F1 also stated she went to the hospital with R10; R10 was discharged with a laceration on her forehead, a fracture to her pinky finger on her right hand, and a head injury. F1 indicated two staff were supposed to provide R10 incontinence care and the injuries occurred due to one CNA providing care to her. During an interview on 08/27/24 at 7:44 PM, CNA 4 stated she rolled R10 on her left side and while providing peri-care, R10 reached to place a bib on the bedside table, then rolled off the bed onto the floor. CNA4 also stated she was not aware R10 was a two-person assistant with incontinence care until the DON and Assistant DON informed her during an interview after the fall. CNA4 confirmed she did not review R10's CNA Kardex and was not informed in a report by other staff that R10 required two-person assistance. CNA4 acknowledged she rolled R10 away from her, not towards her, because she was not trained to do so; however, it would have prevented her from falling out of bed. During an interview on 08/28/24 at 9:43 AM, the DON stated she investigated R10's fall out of the bed on 03/06/24. The DON acknowledged and determined the root cause of the fall was due to CNA4 not following the care plan which stated R10 required two staff to provide bladder and bowel incontinence care and CNA4 not facing R10 towards her while performing peri-care. The DON indicated R10 was sent to the hospital, suffered a closed head injury, and had a fractured finger because of the fall. The DON indicated CNA4 was not assigned to R10 any longer and all staff were in-serviced on safe resident handling and transfers on 03/07/24. During an interview on 08/28/24 at 11:47 AM, the Administrator stated she reviewed R10's fall investigation and CNA4 was finished with incontinence care when R10 reached to put something on the bedside table and then rolled off the bed onto the floor. The Administrator also stated R10 required two staff to provide incontinence care, however, CNA4 provided it without the assistance of another staff member. During an interview on 08/28/24 at 12:02 PM, the Minimum Data Set Coordinator (MDSC) confirmed that CNA Kardex, dated 02/14/24, stated R10 required two staff to perform incontinence care. The MDSC stated the CNA Kardex was in POC and all CNAs had access to it on the tablets. During an interview on 08/28/24 at 10:49 AM, the Medical Director stated all falls were presented at the quality assurance (QA) meetings, and all staff were trained in peri-care and proper positioning of residents to prevent falls. The Medical Director also stated that the facility had to rely on the staff's adherence to the policies because they couldn't watch staff 24 hours a day, but the supervisors should monitor the CNAs for compliance with the policies. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's policy titled Fall Prevention Program, dated 02/12/22, provided by the facility, revealed Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: . 8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed 2. A review of R47's Face Sheet, dated 08/27/24 and found in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease. A review of R47's annual MDS Assessment, with an ARD of 07/01/24 and found in the EMR under the MDS tab, revealed a BIMS score of two out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated the resident required partial to moderate assistance from staff to transfer in and out of her bed and indicated the resident had not experienced any recent falls as of the date of the assessment. A review of R47's Falls Care Plan, most recently dated 01/25/24 and found in the EMR under the Care Plan tab, indicated the resident was at risk for falls related to her diagnoses of dementia, balance problems, and lack of awareness of safety needs. Interventions included Staff to ensure the bed is in the lowest position. A review of R47's Progress Note, dated 08/25/24 and found in the EMR under the Notes tab, indicated, Unwitnessed fall without injury. [R47] was trying to transfer from bed to W/c [wheelchair] and slid onto the floor. The resident has dementia and is unable to follow commands. Observations of R47 on 08/26/24 at 10:31 AM, 11:47 AM, 12:52 PM, 2:57 PM, and 4:12 PM, and on 08/27/24 at 9:05 AM, 10:26 AM, and 2:31 PM revealed the resident laying in her bed. The resident's bed was not observed to be in a low position during any of the observations. The bed was positioned at its regular height. During an observation of R47 with Certified Nursing Assistant (CNA7) and CNA8 on 08/27/24 at 4:54 PM, both staff members confirmed they were familiar with R47 and confirmed the resident's bed was not in the lowered position per her plan of care. Both CNAs stated the resident sometimes positioned her bed into the regular position after it had been lowered by staff. CNA7 stated to ensure her bed remained in the lowest position. She stated there was usually a sign at the resident's bedside to remind staff the bed was supposed to be in a low position. Both staff members confirmed there was no such sign at the resident's bedside at the time of the observation/interview. CNA7 stated she would make a new sign and hang it at the resident's bedside. During an interview with the Administrator and DON on 08/28/24 at 9:11 AM, both stated their expectation was each resident's care plan be followed to prevent future falls. They stated if an intervention, such as a low bed, was in place for a resident the intervention was expected to be implemented.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, observations, staff interviews, and policy review, the facility failed to ensure a medication error rate of less than 5% for two of six residents (R) (R54 and R79) reviewed for medication administration. Two errors were made with a total of 33 opportunities for error, resulting in a 6.06% error rate. The nurse observed administering medication to R54 failed to ensure the resident's insulin pen was primed appropriately before the administration of insulin and the nurse observed administering R79's medication did not leave the resident's insulin pen needle inserted in the resident's skin for the proper amount of time to ensure full absorption of the medication. These failures created the potential for R54 and R79 to experience negative effects related to not receiving the full dose of their insulin. Findings included: A review of the facility's policy titled Insulin Policy dated 02/01/22 indicated, It is the policy of this facility to use insulin pens to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. Prime the insulin pen. Dial two units by turning the dose selector clockwise. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. Injecting the insulin: While still pressing the plunger, keep the needle in the skin for up to six to ten seconds and then remove the needle from the skin. A review of R54's Admission Record, dated 08/27/24, and found in the electronic medical record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including type 2 diabetes. A review of R54's Physicians Order Report, dated 08/27/24 and found in the EMR under the Orders tab, indicated orders for the resident to receive Fiasp (insulin) five units subcutaneously (SC) via pen injector three times daily with meals related to the resident's diagnosis of Type 2 Diabetes. The original date of the order was indicated as 05/31/24. On 08/28/24 at 9:44 AM, Licensed Practical Nurse (LPN)1 was observed administering R54's medication LPN1 was observed to prepare the insulin pen and then inject five units of insulin into R54's right upper arm. The needle was removed from the resident's arm immediately after administering the insulin. During an interview with LPN1 on 08/28/24 at 10:09 AM she stated she was not aware the insulin pen needle was to be left inserted in the resident's skin/subcutaneous tissue for six to ten seconds to ensure full absorption of the medication. 2. Review of R79's Admission Record, dated 08/27/24 and found in the EMR under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R79's Physicians Order Report, dated 08/27/24 and found in the EMR under the Orders tab, indicated orders for the resident to receive Fiasp (insulin) per sliding scale based on the resident's blood sugar level SC via pen injector three times daily with meals related to the resident's diagnosis of Type 2 Diabetes. The original date of the order was indicated as 04/17/24. On 08/28/24 at 12:05 PM LPN2 was observed administering R79's medication. LPN2 was observed to obtain the resident's blood sugar reading, dial up the ordered 2-unit dose of insulin on the insulin pen, and then inject the two units of insulin into R79's abdomen. The insulin pen needle was not primed before the administration of the resident's insulin to ensure there was no air in the needle. During an interview with LPN2 on 08/26/24 at 12:48 PM, she stated she had never been instructed to prime the insulin pen needle before the administration of insulin. She stated sometimes she would prime the needle before administering insulin if the air was visible in the insulin pen chamber. During an interview with the Director of Nursing (DON) on 08/28/24 at 11:14 AM, she stated her expectation was the insulin pen was expected to be primed with two units of insulin before each administration of the medication to ensure air was not being injected into a resident instead of insulin. She stated the insulin needle was expected to be left inserted in the resident's skin/subcutaneous tissue for at least six to 10 seconds after inserting the needle and administering insulin to ensure full absorption of the medication.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interviews and record review, the facility failed to contain specific language in the facility's arbitration agreement for two of three sampled residents (R) (R86 and R84) reviewed for an arbitration agreement. Findings included: A review of a facility document titled Resident and Family Arbitration Agreement revealed no evidence that expressly stated that the resident/family was not required to sign the agreement as a condition of admission or to continue to receive care at the facility. 1. A review of R86's electronic medical record (EMR) titled Admission Record indicated the resident was admitted to the facility on [DATE]. A review of a document provided by the facility titled Resident and Family Arbitration Agreement dated 01/31/24, indicated R86 signed the agreement. The document did not expressly state that the resident/family was not required to sign the agreement as a condition of admission or to continue to receive care at the facility. A review of R86's EMR titled admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 02/07/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. 2. A review of R84's EMR titled Admission Record indicated the resident was admitted to the facility on 12/09/23. A review of a document provided by the facility titled Resident and Family Arbitration Agreement dated 12/08/23 indicated R84 signed the agreement. The document did not expressly state that the resident/family was not required to sign the agreement as a condition of admission or to continue to receive care at the facility. A review of R84's EMR titled admission MDS with an ARD of 12/15/23 indicated the resident had a BIMS score of 12 out of 15 which revealed the resident was cognitively intact. During an interview on 08/27/24 at 11:00 AM the Business Office Manager (BOM) confirmed she completed the admission packet, which included the facility's arbitration agreement with the resident and/or family member. The BOM read the facility's current admission agreement and confirmed the agreement did not expressly that the resident/family was not required to sign the agreement as a condition of admission or to continue to receive care at the facility. The BOM stated that she had not realized that language had to be included in the facility's arbitration agreement.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 12679 Based on interviews and review of facility documentation, the facility failed to ensure a Quality Assurance Performance Improvement (QAPI) plan was developed to drive quality assurance (QA) measures that addressed resident care and safety, quality of life, and resident choice. This failure had the potential to affect all 91 residents who currently lived in the facility. Findings included: A review of a document provided by the facility titled Quality Assurance Performance Improvement (QAPI) Plan, dated 2022 prepared by Compliance Store, indicated . Introduction . The QAPI Plan of [Facility Name] is designed to establish and maintain an organized facility-wide program that is data-driven and utilizes a proactive approach to improving the quality of care and services throughout the facility. This is a living document that will continue to be refined and revisited. It is written in accordance with the Facility's vision and mission statement. Objectives of the QAPI plan include . Establish a facility-wide process to identify opportunities for improvement through continuous attention to quality of care, quality of life, and resident safety . Address gaps in systems or processes . Ensure adequate provision of staffing, time, equipment and technical training resources . Establish clear expectations around safety, quality, rights, choice and respect . Continually improve the quality of care and services provided to our residents . The facility's QAPI plan was blank with specific facility information and failed to address the following potential quality of care issues: There was no data-driven information, such as tracking and trending, and the measurement of performance made by the facility. There was no data-driven information, such as tracking and trending, and the measurement of performance made by the facility on specific clinical concerns. There was no information to show feedback provided by staff, residents, and family members on identified potential deficient practices. During an interview on 08/28/24 at 9:02 AM, the Administrator stated she typically will present the QAPI plan, which was provided during the survey. The Administrator stated she discussed the QAPI process with the survey team. The Administrator confirmed she printed up the QAPI plan from the online Compliance Store.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on observation, interview, record review, and review of the facility's policies, the facility failed to maintain an effective infection control program for two of 22 sampled residents (R) (R10 and R89) related to R89's indwelling catheter tubing observed on the floor and R10 was COVID-19 positive, however, staff failed to don personal protective equipment (PPE) prior to entering the resident's room. This failure had the potential to spread the COVID-19 virus to other residents in the facility. Findings included: 1. A review of R10's undated Admission Record located in the Electronic Medical Record (EMR) under the Profile tab revealed that R10 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with COVID-19. A review of R10's Physician's Order, dated 08/23/24, located in the EMR under the Orders tab revealed an order for Contact precautions until date ending 09/01/24. (May remove from isolation 09/02/24) d/t [due to] COVID-19 (+) [positive]. A review of R10's comprehensive Care Plan, dated 08/26/24, located in the EMR under the Care Plan tab, revealed, . R10 has COVID-19 and is currently on isolation. A review of R10's signage outside her room door read Droplet Precautions with instructions everyone must: Clean their hands, including before entering and when leaving the room; make sure their eyes, nose, and mouth are fully covered before room entry; and remove face protection before room exit. Observation on 08/28/24 at 9:40 AM revealed Certified Nurse Aide (CNA) 5 opened R10's room door, entered the room without donning PPE then exited the room. During an interview with CNA5, she confirmed she did not wear PPE before entering the room to deliver supplies to the resident. CNA5 stated she saw the droplet sign on the door and PPE cart outside of the room and should have donned a KN95 mask before entering the room. CNA5 stated droplets meant the spread of infections through the mouth and nose. During an interview on 08/28/24 at 11:30 AM, the interim Infection Preventionist (IP) stated no recent in-services had been provided to nursing staff related to isolation precautions, however, she held a huddle with the nursing staff and discussed transmission-based precautions (TBP) of every resident daily. The IP acknowledged she placed the droplet precaution sign on R10's door and PPE cart outside of the room when R10 returned from the hospital on 08/23/24 with COVID-19. The IP indicated she expected staff to wear a gown, face mask, eye protection, and gloves before entering R10's room because COVID-19 was spread through the air. During an interview on 08/28/24 at 11:41 AM, the Director of Nursing (DON) stated she expected staff to wear PPE as directed by the signage on the door to mitigate the spread of COVID-19. During an interview on 08/28/24 at 11:44 AM, the Administrator stated she expected staff to follow all instructions in the infection control policies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Transmission-Based (Isolation) Precautions, dated 02/01/24, provided by the facility revealed Policy: It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission . Definitions: . Droplet precautions refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions . Policy Explanation and Compliance Guidelines: . 11. Droplet Precautions- a. Intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (i.e. respiratory droplets that are generated by a resident who is coughing, sneezing, or talking). b. A private room is preferential, but if not available, the resident can be cohorted with a resident with the same infectious agent . e. Healthcare personnel will wear a facemask for close contact with an infectious resident. f. Based upon the pathogen or clinical syndrome, if there is a risk of exposure of mucous membranes or substantial spraying of respiratory secretions is anticipated, gloves and gown, as well as goggles (or face shield), should be worn 2. A review of R89's Face Sheet, dated 08/27/24 and found in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including Down Syndrome and urinary retention. A review of R89's admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 07/04/24 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment was not able to be completed for the resident due to his impaired cognition. The assessment indicated the resident has both short and long-term memory impairment. The assessment indicated the resident had an indwelling catheter in his bladder. A review of R89's Catheter Care Plan, most recently dated 06/29/24 and found in the EMR under the Care Plan tab, indicated the resident had a Foley catheter in place in his bladder. The care plan indicated, Urinary drainage system (catheter) will be maintained and monitored to decrease the incidence of infection and injury to the resident through the review period. Review of R89's Physician's Orders, dated 08/25/24 and found in the EMR under the Orders tab indicated an order for the resident to have a #14 indwelling catheter inserted in his bladder related to his diagnosis of urinary retention. Observations of R89 on 08/27/24 at 9:31 AM, 11:40 AM, 12:40 PM, 2:12 PM, and 4:01 PM revealed the resident lying or sitting up in bed. The resident's bed was in the lowest position and the resident's catheter was attached to the resident's bedside. The catheter tubing was observed to be in contact with the floor during each of the observations. On 08/27/24 at 4:46 PM R89 was observed along with CNA6. CNA6 confirmed the resident's catheter tubing was in contact with the floor and stated the catheter bag and tubing should not be in contact with the floor to prevent potential infection. During an interview with the DON on 08/28/24 at 9:21 AM, she stated catheter bags and tubing were expected to be maintained off the floor to help prevent potential infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115340	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calhoun Health Care Center	1387 Highway 41 North Calhoun, GA 30701

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on interviews, record review, review of the Centers for Disease Prevention and Control (CDC) guidelines, and facility policy review, the facility failed to offer the pneumococcal vaccination in accordance with the nationally recognized standards for two of six residents (R) (R48 and R55) reviewed for immunizations. This failure had the potential to increase the risk for the residents to contract pneumonia. Findings included: A review of a facility policy titled Pneumococcal Vaccine (Series), revised 07/01/24, indicated . Policy: It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. Policy Explanation and Compliance Guidelines: . 6. The type of pneumococcal vaccine (PCV I 5, PCV20, or PPSV23) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations A review of the CDC website titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, effective 01/28/22, indicated . CDC recommends pneumococcal vaccination for all adults [AGE] years or older . For adults [AGE] years or older who have not previously received any pneumococcal vaccine, CDC recommends you . Give 1 dose of PCV [Pneumococcal Conjugate Vaccine] 15 or PCV20 . If PCV15 is used, this should be followed by a dose of PPSV 23 [Pneumococcal polysaccharide vaccine] at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak . For adults [AGE] years or older who have only received a PPSV23, CDC recommends you . May give 1 dose of PCV15 or PCV20 . The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it 1. A review of R48's Admission Record, undated, located in the Electronic Medical Record (EMR) in the Profile tab revealed R48 was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of their admission. A review of a facility-provided document titled Pneumococcal Vaccine Consent Form, dated 03/09/23, indicated R48 signed the consent form to receive a pneumococcal vaccine. A review of a facility-provided document titled Vaccine Administration Record revealed that R48 was administered the PCV15 on 05/31/23. During an interview on 08/27/24 at 11:50 AM, Registered Nurse (RN) 2 confirmed R48 should have been offered or administered the PPSV23 one year after the PCV15 was administered to complete his pneumococcal vaccinations according to the CDC guidelines. RN2 stated she wrote when the next pneumococcal vaccination was due on the consent form, but she did not transfer it to her tracking log, therefore, she forgot to offer the vaccine to R48 within the recommended timeframe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115340	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calhoun Health Care Center	1387 Highway 41 North Calhoun, GA 30701

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of R55's Admission Record, undated, located in the EMR in the Profile tab revealed R48 was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of their admission. A review of a facility-provided document titled Pneumococcal Vaccine Consent Form, dated 05/17/23, indicated R55 gave verbal consent to receive a pneumococcal vaccine. A review of a facility-provided document titled Vaccine Administration Record revealed that R55 was administered the PPSV23 on 05/30/23. During an interview on 08/27/24 at 11:50 AM, Registered Nurse (RN) 2 confirmed R55 should have been offered or administered the PCV15 or PCV20 one year after the PPSV23 was administered to complete his pneumococcal vaccinations according to the CDC guidelines. RN2 stated she wrote when the next pneumococcal vaccination was due on the consent form, but she did not transfer it to her tracking log, therefore, she forgot to offer the vaccine to R55 within the recommended timeframe. During an interview on 08/27/24 at 12:22 PM, the interim Infection Preventionist (IP) stated the former IP had not been employed at the facility since June 2024, and RN2 was overseeing the immunizations. The interim IP stated she was not aware R48 and R55 were not offered the pneumococcal vaccines per the CDC guidance. During an interview on 08/27/24 at 5:35 PM, the Director of Nursing (DON) stated she was not aware RN2 had not offered the next scheduled dose of the pneumococcal vaccine to R48 and R55 but expected the immunizations to be offered when they are due according to the CDC recommendations. During an interview on 08/27/24 at 5:50 PM, the Administrator stated she expected the staff to obtain consent for vaccines and administer the vaccines timely.