

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Etowah Landing		STREET ADDRESS, CITY, STATE, ZIP CODE  809 South Broad Street Rome, GA 30161	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, resident and staff interviews, and facility policy review, the facility failed to send a written notification of hospital transfer to the resident and/or resident representative (RR) for three of three residents (Resident (R) 22, R56, and R62) reviewed for hospital transfer of 27 sample residents. This failed practice had the potential to affect the residents and their RR by not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Transfer or Discharge Documentation, an initiation date of 2001 and a revision date of 12/16, indicated .details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider . When a resident is transferred or discharged from the facility, the following information will be documented in the medical record .That an appropriate notice was provided to the resident and/or legal representative.</p> <p>1. Review of R22's electronic medical record (EMR) located under the Census tab revealed that R22 was discharged to the hospital on 2/6/2025 and returned to the facility on 2/11/2025. There was no record in the EMR of the facility providing a written notice of transfer to the resident or the RR.</p> <p>2. Review of R56's Census tab in the EMR revealed R56 was originally admitted to the facility on [DATE].</p> <p>Review of R56's Medical Diagnosis tab in the EMR revealed that R56 had diagnoses including metabolic encephalopathy, Alzheimer's disease, repeated falls, difficulty walking, and other lack of coordination.</p> <p>Review of the Care Plan under the Care Plan tab in the EMR revealed R56 had a focus with interventions related to a risk for falling initiated on 10/7/2022.</p> <p>Review of the MDS [Minimum Data Set] tab in the EMR revealed R56 had Discharge Return Anticipated MDS completed on 1/22/2025.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a nurse note, dated 1/21/2025 and located under the Progress Note tab in the EMR, revealed R56 had a witnessed fall in her room. The Occupational Therapist witnessed R56 slide from her bed, in the lowest position, onto her fall mat. The resident had hit her head on the nightstand and complained of hip pain. R56 was sent to the hospital for evaluation.</p> <p>Review of a Nursing Home to Hospital Transfer Form dated 1/21/2025 and supplied by the DON revealed R56 had gone to the hospital due to a fall. This form was given to the transportation personnel upon arrival at the facility. This was not provided to the resident or the RR.</p> <p>3. Review of R62's undated admission Record located under the Profile tab in the EMR indicated R62 had originally been admitted to the facility on [DATE]. R62's diagnoses include resistance to multiple antimycobacterial drugs, dehydration, atrial fibrillation, dementia, depression, anxiety disorder, hypertension, heart failure, and chronic obstructive pulmonary disease.</p> <p>Review of R62's quarterly MDS located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 5/16/2025 indicated R62 was coded as having a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R62 was moderately cognitively impaired.</p> <p>Review of R62's eInteract-Nursing Home to Hospital Transfer Form, dated 4/14/2025 and located under the Assessment tab in the EMR reflected R62 had been transferred to the emergency room (ER) on 6/3/2025 at 10:45 am for altered mental status.</p> <p>Review of R62's eInteract-Nursing Home to Hospital Transfer Form, dated 5/5/2025 and located under the Assessment tab in the EMR reflected R62 had been transferred to the ER on [DATE] at 11:12 am for fever.</p> <p>Review of R62's eInteract-Nursing Home to Hospital Transfer Form, dated 5/20/2025 and located under the Assessment tab in the EMR, reflected R62 had been transferred to the ER on [DATE] at 7:15 pm for chest pain.</p> <p>Review of R62's eInteract-Nursing Home to Hospital Transfer Form, dated 6/3/2025 and located under the Assessment tab in the EMR, reflected R62 had been transferred to the emergency room (ER) on 6/3/2025 at 11:21 am for chest pain.</p> <p>During an interview on 6/12/2025 at 12:23 pm, R62 was unable to recall if a written notification of hospital transfer was received.</p> <p>Review of R62's medical record revealed documentation of written notification of the reason for the transfer to the hospital could not be located.</p> <p>During an interview on 6/12/2025 at 10:31 am, the Director of Nurses (DON) stated that they send the interact form with the emergency personnel. The DON stated that they did not have a form to send to the residents or the family, but they called them.</p> <p>During an interview on 6/12/2025 at 10:35 am, the Social Services Director (SSD) stated that nursing did all of the transfer forms. The SSD also stated that she was not sure about a written transfer notice being sent to the family, but she sent a list of residents transferred to the ombudsman every month.</p> <p>(continued on next page)</p>		

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F 0628  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During an interview on 6/12/2025 at 1:28 pm, the Assistant Director of Nurses (ADON) stated they called the resident's representative and documented in the nursing notes in the EMR.		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, staff interview, and facility policy review, the facility failed to ensure one 27 sampled residents (R) (R287) was free from significant medication errors when R287 did not receive diltiazem (Cardizem), a blood pressure medication, as ordered by the physician on 10 days. This failure had the potential to cause adverse reactions of high blood pressure.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Administering Medications, revised December 2012, revealed Medications must be administered in accordance with the orders .</p> <p>Review of R287's admission Record located in the Profile tab of the electronic medical record (EMR) revealed R287 was admitted to the facility on [DATE] for a 14-day respite stay, with diagnoses including heart disease, dementia, and hypertension. R287 discharged home on [DATE].</p> <p>Review of R287's Physician Orders located under the Orders tab of the electronic medical record (EMR) and dated 10/1/2024, revealed R287 was to receive diltiazem, 120 milligrams (mg), two tablets to equal 240 mg once daily for the treatment of hypertension (high blood pressure).</p> <p>Review of R287's pharmacy Consultation Report, dated 10/2/2024, located under the Scanned Documents tab of the EMR, revealed the recommendation to change the immediate release formulation of diltiazem to the extended-release formulation, diltiazem 24-hour extended release 240 mg once daily. The recommendation was accepted by the physician and signed on 10/3/2024.</p> <p>Review of R287's Physician Orders located under the Orders tab of the EMR and dated 10/3/2024, revealed R287 was to receive diltiazem 24-hour extended release, 240 mg capsule once daily. The medication was entered into the computer by the Director of Nursing (DON) on 10/3/2024 but scheduled not to begin until 10/14/2024 and the old order for diltiazem 120 mg, two tablets (immediate release) once daily was discontinued on 10/3/2024.</p> <p>Review of R287's Medication Administration Record (MAR), dated October 2024, located under the Orders tab of the EMR, revealed no documentation that R287 had received diltiazem on 10/4/2024 through 10/13/2024 as ordered by the physician. It also showed documentation of R287's vital signs that included R287's blood pressure was 128/68 on 10/2/2024 and 10/3/2024 and increased to 140/97 on 10/4/2024.</p> <p>Review of R287's Progress Notes tab revealed no documentation that the medication was discontinued or held by the physician.</p> <p>During an interview on 6/11/2025 at 11:05 am, the Director of Nursing (DON) reviewed R287's clinical record and confirmed that diltiazem 24-hour extended release, 240 mg, should have been started on 10/4/2024 instead of 10/14/2024 and should have been administered once daily. The DON stated that she made an error and entered a start date of 10/14/2024 instead of 10/4/2024, and considered diltiazem to be a significant medication and should have been administered.</p>		