STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115348	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Etowah Landing	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interviews, record review, and a review of the facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment, the facility failed to implement infection prevention and control practices for two of five sampled residents (R) (R50 and R23). In addition, the facility failed to ensure proper cleaning, disinfection, and separation of reusable resident care equipment for two of two units. This failure created the potential for cross-contamination and transmission of infection.Findings include: A review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised July 2014, documented Policy Statement: Resident- care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard. 1. During an observation on 04/12/2026 at 2:50 PM, R50 was observed in bed, and the bed was in the lowest position. A catheter bag was observed hanging on the bed rail, resting on the floor. Licensed Practical Nurse (LPN) RR confirmed that the catheter bag was on the floor and confirmed that it should not be touching the floor. She was observed to move it to a position so that it was not resting on the floor. During an observation on 04/13/2026 at 9:50 AM, R50 was observed in bed, and the bed was in the lowest position. Again, the catheter bag was observed hanging on the bed rail, resting on the floor. Certified Nursing Assistant (CNA) LL confirmed that R50's catheter bag was on the floor. She stated that she knows it isn't supposed to be on the floor, but that it is probably because his bed must be in the lowest position. She stated that she has not even gotten to his room today to provide him with care. 2. During an observation outside of R23's room on 04/11/2026 at 9:41 AM, the privacy curtain was pulled and approximately 18 inches from the floor. The resident nearest the door was observed to have an oxygen (O2) concentrator actively on. The water bottle from the O2 concentrator was observed empty and on the floor. The Staffing Coordinator was interviewed at this time, and she confirmed that R23 has a tracheostomy (trach) and that the bottle on the floor should not be empty and should not be on the floor. During an interview with R23 on 04/11/2026 at 9:44 AM, he stated that he hasn't had a water bottle in a couple of weeks, and he has asked for the bottle to be replaced. During an observation and interview with the Respiratory Therapist (RT) on 04/11/2026 at 9:49 AM, she was observed to go into R23's room, remove the old water bottle, and replace it with a full bottle. Upon exiting the room, the RT confirmed that the water bottle should not be on the floor and that it (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should be changed daily. She confirmed that the bottle that she removed did not have a date or label as to when it was last changed. She stated that the resident was not on the respiratory caseload. He is on the nursing case load, so they should be providing the trach care and respiratory services to the residents. 3. Observation on 04/11/2026 at 8:15 AM, revealed the clean and soiled utility room was observed to be divided by a blue strip on the floor, intended to separate the clean and soiled equipment, with designated clean and soiled entrances. During the observation, used/dirty equipment was observed throughout both sides of the room, including oxygen concentrators, pulse oximeters, suction machines, folding chairs, IV poles, and vital sign machines. There was no method to distinguish clean from contaminated equipment. Further observation revealed that no equipment was covered, bagged, or labeled as clean, no cleaning or disinfectant supplies were present, and no Personal Protective Equipment (PPE) for use during the disinfectant process. Interview on 04/11/2026 at 8:50 AM with the weekend supervisor, Licensed Practical Nurse (LPN) CC verified the findings in the clean and soiled utility room. She stated that all equipment in the room was considered dirty at that time because she could not determine which items were clean and which were dirty. LPN CC stated the equipment would not be used until cleaned. The LPN CC further stated that cleaning supplies and bags would be placed on the soiled side of the room. She stated that the nurses and the respiratory therapist share responsibility for cleaning the equipment, and together they spot-check the room and clean it when necessary. Interview on 04/11/2026 at 9:30 AM with the Respiratory Therapist (RT) revealed while observing the clean and soiled utility room, the dirty equipment would not be on both sides of the clean and dirty room. She stated that normally the equipment would come in through the soiled entrance, be disinfected, then pushed to the clean side, and bagged, making it ready for use. The RT stated that cleaning the equipment was done with nursing staff and whoever could get to it first. She was unsure why the dirty equipment was combined with the clean and stated that she grabs a bottle of wipes from the office and bags from the PPE hanging apparatus, then returns the wipes to the office after cleaning the equipment. RT confirmed there was no indication of what was clean or dirty. 4. Observation and Interview on 04/11/2026 at 8:15 AM in the Spring Hall revealed two oxygen concentrators sitting beside a vending machine, and the resident common area, which were visibly soiled and dirty. The weekend supervisor, LPN CC confirmed the oxygen concentrators were dirty and needed to go to the soiled utility room. Additionally, an observation of two resident recliners and wedges was visibly soiled in the Spring hallway. LPN CC stated the process is to clean the recliners in the resident rooms before bringing them to the hallway, and that the wedges should have been bagged, tied, and taken to the soiled utility for cleaning. LPN CC confirmed the wedges were soiled and stated she would bag them and take the wedges to the soiled utility.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a clean and homelike environment on two of three units (Meadows Unit and the Springs Unit) related to an unclean room and broken bathroom tissue holder, lack of use of proper bed linen, unclean packaged terminal air condition (PTAC) units, and lingering malodorous odors. The deficient practice had the potential to affect resident comfort and safety.Findings include:During multiple observations on 04/11/2026 and 04/12/2026, the Packaged Terminal Air Conditioners (PTAC) units in the Meadows Dining Room had a thick covering of dust buildup.During an observation on 04/11/2026 at 8:40 AM, the resident in room [ROOM NUMBER]A was observed lying in the bed with a flat sheet not visible on the mattress underneath her upper body. The flat sheet was observed on the bed, bunched up under the resident's lower body, buttocks, and lower extremities. During an observation on 04/11/2026 at 9:52 AM, the resident in room [ROOM NUMBER]C was observed sleeping on a mattress without a fitted sheet or standard linens in place. There was no fitted sheet or secured linen. A blue striped pillow was on the bed without a pillowcase. During multiple observations on 04/11/2026 at 10:16 AM, 04/11/2026 at 2:31 PM, and 04/12/2026 at 8:55 AM, the floor in room [ROOM NUMBER] was dirty with food particles and was sticky throughout the walking area; the wall was splattered with a brown substance behind the B bed, there was a strong urine odor in the room and bathroom, and the tissue holder in the bathroom was broken and/or missing a cover.During observations on 04/11/2026 at 10:16 AM, 04/11/2026 at 2:31 PM, and 04/12/2026 at 8:55 AM, the resident in 20A bed was observed lying in bed. The upper and lower mattresses were exposed. There was a flat sheet on the bed that had slid to the middle of the mattress and was bunched up under the resident.During an observation on 04/11/2026 at 10:24 AM, and 04/11/2026 at 2:30 PM, the resident in room [ROOM NUMBER]C was observed in her room lying in bed. There was a top sheet on the mattress being used as a fitted sheet, so it was halfway on the bed with the mattress exposed on the bottom and top. The resident was lying halfway on the bare mattress. The resident was determined not to be a resident interview candidate.During an interview on 04/12/2026 at 7:21 AM, CNA PP stated there were plenty of sheets and linens for the standard beds, but those sheets don't fit the larger beds or oversized beds. CNA PP stated, The flat sheet won't stay in place, the resident ends up sleeping on the bare mattress, and they stick to the mattress. That can't be comfortable. CNA PP verified that the resident in room [ROOM NUMBER]C was sleeping on the mattress without a fitted sheet and verified that the bed needed larger linens. During an interview with the resident in 20A bed on 04/12/2026 at 8:55 AM, he stated that he was told the facility doesn't have the fitted sheets for his bed (the resident has a bariatric bed). He further stated that the housekeeping staff doesn't clean his room every day. He confirmed that no one came in yesterday to clean his room.During an interview on 04/12/2026 at 9:00 AM, Certified Nursing Assistant (CNA) SS stated that they are sometimes short of linen, including the fitted sheets. She confirmed that the resident in room [ROOM NUMBER]A had a flat sheet on his bed.On 04/12/2026 at 9:04 AM, the Housekeeping Supervisor (HKS) stated that she had been in the position of HKS for almost four months. She stated that there are a total of eight housekeepers and two laundry aides. She stated that the staff has plenty of linen. An observation of the clean linen closet, the housekeeping laundry room, and the new supplies storage room with the HKS revealed that the facility had enough fitted sheets and other linen. The HKS revealed that the housekeeping staff are expected to clean each room at least once per day and that some of the rooms are cleaned twice a day.During an interview with the Staffing Coordinator on 04/12/2026 at 9:25 AM, she stated that she orders linen, and the facility has plenty of linen. The staff just choose to place the flat sheets on the beds when they make the bed. She stated that regular mattresses should have a fitted sheet, but air mattresses don't have fitted sheets. She confirmed that the mattresses in room [ROOM (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NUMBER]A and room [ROOM NUMBER]C were regular and should have a fitted sheet. During an observation and interview with the HKS on 04/12/2026 at 9:30 AM, she confirmed that room [ROOM NUMBER] was not clean and stated that the housekeeping staff was going to clean the room. Two housekeeping staff were observed entering room [ROOM NUMBER]. During an interview and observation with the Maintenance Director on 04/12/2026 at 9:38 AM, he stated that he has a maintenance book on the conference room door so that staff can place information related to areas of concern in the facility. He confirmed that the tissue holder in the bathroom of room [ROOM NUMBER] was missing a cover/broken. He stated that they have an Ambassador Program at the facility and that the Social Services Director was the Ambassador for room [ROOM NUMBER]. A review of the maintenance book revealed no entries related to the tissue holder needing repair. During an interview with CNA TT on 04/12/2026 at 10:00 AM, she stated that it is easier to put a flat sheet under the resident in room [ROOM NUMBER]C because she sometimes doesn't roll, and with her not feeling well, she thought it was easier to use the flat sheet. During a tour of the Meadows Dining Room on 04/12/2026 at 12:28 PM, the Maintenance Director verified that dirty filters were to be washed with soap and water monthly on a rotating basis and replaced quarterly. He provided a maintenance report that showed the PTAC serial numbers, but no documentation of which PTAC unit filters were cleaned or replaced.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure that three of seven medication and treatment carts (Springs Medication Cart #1, Springs Medication Cart #2, and Meadows Treatment Cart #1) were locked and secure when not in use. The deficient practice increased the risk of unauthorized access to medications and diversion.Findings include:During entry into the facility on [DATE] at 7:30 AM, the Springs Medication Cart #1 and the Springs Medication Cart #2 were observed unlocked and unattended. Two staff members were observed seated behind the Springs Nursing Station. During an observation on 04/11/2026 at 7:40 AM, during the initial tour of the facility, the Meadows Treatment Cart #1 was observed unlocked and unattended. At that time, Licensed Practical Nurse (LPN) AA confirmed that the treatment cart was left unlocked and unattended. She stated that the wound care nurse must have left it open the day before.A review of the Medication Cart/Storage document (undated) revealed that there are five medication carts and two treatment carts. A review of the Medication Storage Policy with a revised date of April 2007, documented that the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility policy titled Care of Fingernails/Toenails, the facility failed to ensure Activities of Daily Living (ADL) care was provided for two of eight sampled residents (R) (R2 and R9) related to fingernail care. The deficient practice placed R2 and R9 at risk of diminished quality of life.Findings include:1. During an observation on 04/11/2026 at 2:54 PM, and 04/12/2026 at 11:29 AM, R9's fingernails were observed to be long with a heavy accumulation of brown debris under the nail bed. A review of the electronic medical record (EMR) revealed that R9 was admitted to the facility on [DATE], with diagnoses included, but not limited to unspecified dementia, anxiety and depression.The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R9 was dependent on staff for the ability to maintain personal hygiene and maximum assistance with showering/bathing. A review of the care plan revised 02/26/2026, documented R9 required staff assistance for ADL care and specified to check nail length, trim and clean on bath day, and as necessary. Report any changes to the nurse.A review of the care record, progress notes and Kardex did not show documentation that R9 refused fingernail care. 2. During an observation on 04/11/2026 at 10:20 AM and 3:36 PM, R2 was observed in bed with long fingernails that were jagged, green and dirty. During an observation on 04/12/2026 at 9:16 AM, the wound care nurse demonstrated that R2's right hand was contracted and her fingers were bent with the fingernails digging into the palm of her hand. The fingernails on both hands were long, with rough edges and had debris under the nails and on the fingers. R2 stated her fingernails needed to be trimmed because of how my hands are.A review of the EMR revealed that R2 was admitted to the facility on [DATE]. Diagnoses included, but not limited to Non-Alzheimer's Dementia, diabetes, and pneumonia. The MDS comprehensive assessment dated [DATE] showed R2 was dependent on staff to maintain personal hygiene, bathing and grooming.A review of the care record, progress notes and Kardex did not show documentation that R2 refused fingernail care. An interview on 04/12/2026 at 11:30 AM, Licensed Practical Nurse (LPN) OO stated the Certified Nursing Assistant's (CNA's) should do nail care with shower or bathing. LPN OO stated if care was refused it was to be documented in the electronic health record. LPN OO verified R9's fingernails were overgrown with visible accumulation of brown debris beneath the nail beds. An interview on 04/12/2026 at 3:12 PM, the Director of Nursing (DON) stated if staff are unable to clean or clip fingernails, they should let the nurse know or document it and stated, I have not seen any documentation over the past couple of weeks to show any refusals for R2 or R9. The DON stated, R2 refused a shower on March 24 and once in February, but there was nothing documented about fingernails. An interview on 04/13/2026 at 8:56 AM, CNA KK stated both R2 and R9 required staff to complete ADL care for them including nail care. CNA KK asked R9 if he would like his nails cleaned and trimmed and he agreed. CNA KK stated R2 really doesn't refuse anything. An interview on 04/13/2026 at 8:56 AM, LPN QQ confirmed R9's fingernails were long, with thick debris on the side of the nailbed, and under the nails. LPN QQ stated that [referred to growth and debris] was over a while and the R9 deserved better. R9 agreed to have his nails cleaned and trimmed. A review of the facility policy titled Care of Fingernails/Toenails, with an effective date of 2001, revised October 2010, documented nail care includes daily cleaning and regular trimming. The procedure included soaking the hand in warm soapy water for approximately five minutes then rinse the hand with clear, warm water. Dry the hand with the towel, gently remove the dirt from around and under each nail, trim the fingernails in an oval shape, smooth the nails with a nail file or emery board. Documentation specified to include the date and time that nail care was given, the condition of the resident's nails and nail bed, and difficulties cutting the residents nails, any problems or complaints made by the resident, if the resident refused the treatment, the reason why and the intervention taken.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled Restorative Nursing Policy and Procedure, the facility failed to ensure that one of two sampled residents (R) (R2) received restorative services to prevent contractures and/or to prevent a decrease in range of motion (ROM) mobility. The deficient practice increased the risk that R2 would experience worsening contractures.Findings include: During an observation on 04/11/2026 at 10:20 AM, and 3:36 PM, R2 was observed in bed with the left hand visible on top of the blanket. R2's left hand was observed in a contracted, flexed position, with the fingers tightly drawn together. No splints were observed in the room. During an observation on 04/12/2026 at 9:16 AM, the wound care nurse demonstrated R2's lack of ROM in the right hand which was closed and contracted. R2's fingers were bent with the fingernails digging into the palm of her hand. No splints or washcloths were rolled in R2's hands. The wound care nurse confirmed no splints were in use or visible.A review of the electronic medical record (EMR) revealed that R2 was admitted to the facility on [DATE]. Diagnoses included Non-Alzheimer's Dementia, diabetes, and pneumonia. The Minimum Data Set (MDS) comprehensive assessment dated [DATE], showed R2 was dependent on staff to maintain personal hygiene, bathing and grooming. Review of the physician order dated 08/25/2025, instructed staff to clean bilateral hands and apply rolled washcloths daily and prn (as needed) and splint/cast: Check skin under/around splint for impairment, irritation, injuries, warm skin/fingers, skin color and document yes or no if issues noted; every day and night shift.A review of the restorative program progress note dated 03/23/2026, documented Resident continued on restorative nursing programs for passive range of motion (PROM) to bilateral lower extremities (BLE) and bilateral resting hand splints at night only for 6-8 hours, no signs or symptoms of skin redness or irritation noted. Requires total dependence from staff for both programs. Resident denies pain with PROM or splint, continue restorative plan of care.A review of the therapy progress note dated 01/13/2025, documented the recommendation for discharge from therapy to restorative nursing for continued bilateral upper extremity (BUE) range of motion to shoulders, elbows and wrists and splinting to bilateral hands for 6 hours at night.A review of the care record for April 2026 failed to show documentation that R2 received restorative nursing for splinting identified as staff will assist/cue resident with PROM 15 minutes a day, 7 days a week/physical prompts/ encouragement as needed to prevent contractures for 13 of 13 days reviewed in April. On 04/12/2026 at 7:01 AM, during an interview with Certified Nursing Assistant (CNA) II stated she worked 3rd shift. CNA II stated R2 was supposed to have a splint on her hand and confirmed R2 was not wearing the splint. She demonstrated the splint was in the nightstand drawer and not applied to R2's hands. On 04/12/2026 at 7:23 AM, during a telephone interview, CNA PP stated she was assigned to R2 and worked the night shift. CNA PP stated R2 did not refuse any care. CNA PP stated she did nothing with R2's hands.On 04/12/2026 at 7:53 AM, CNA HH stated range of motion/splinting for restorative was supposed to be done by the CNA assigned. CNA HH stated she has never heard of R2 refusing anything.On 04/12/2026 at 3:12 PM, the Director of Nursing (DON) stated R2 was evaluated monthly to determine if the current program should continue, change or be discontinued. The DON stated R2 was on the restorative program for passive range of motion to both upper extremities, and resting hand splints bilaterally at night. The assigned CNA was responsible for providing range of motion, putting the splints on and taking them off. R2's program was last updated 01/16/2025. The DON stated she was the restorative nurse and documented restorative program progress monthly. The DON stated care plan requires the CNA to document on the restorative nursing section to show what was done for the residents during their assigned shift. The DON confirmed no one signed off for splinting last night which meant no one did it. The DON stated the CNA should have done splinting and range of motion. The DON stated there was no documentation that showed R2 refused to wear the hand (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	splints. The DON stated CNAs are trained in range of motion during the hire process but did not have any resident specific training regarding splinting or range of motion.During an interview on 04/12/2026, the Rehabilitation Director (RD) stated therapy did not provide CNA training for restorative, range of motion or splinting and that would fall to the nursing program. The RD stated R2 was being evaluated today. The last recommendation at that time was bilateral upper extremity (BUE) range of motion and splinting, BUE resting hand splints at night only for 6-8 hours. On 04/13/2026 at 8:53 AM, CNA LL stated she was assigned to care for R2. CNA LL stated she had not been trained on splinting or range of motion specific to R2 and had not put the splint on her.On 04/13/2026 at 8:56 AM, R2 was observed sleeping in bed, no washcloth or roll was observed in R2's visible left hand. Licensed Practical Nurse (LPN) RR assigned to R2 verified the resident was not wearing hand splints/roll.On 04/13/2026 at 8:59 AM, CNA KK stated R2 required total care and was unable to use her hands. CNA stated physical therapy would come in to do therapy. CNA KK stated she had not had training to perform range of motion or splinting for residents in general or specific to R2.On 04/13/2026 11:06 AM, the MDS Coordinator stated R2 was admitted with contractures and required restorative services to prevent the contractures from worsening. MDS Coordinator stated staff needed to keep R2's hands clean and dry and put rolled washcloths in both hands. R2 was supposed to get passive range of motion 15 minutes per day 7 days per week, and it should be done on day shift. If R2 refused splinting, there should be a note written by the DON.On 04/13/2026 11:30 AM, during an interview the DON stated the restorative program is reviewed once a year with all staff and upon hire. The therapy department is part of teaching what the different programs are. The staff person responsible would be the CNA for that resident for that shift. Therapy decided to re-evaluate R2 for the correct splints today after I showed them the splints we found.Review of the facility policy titled Rehabilitative Nursing Care, revised July 2013, documented under Policy Statement: 4. Rehabilitative nursing care is performed daily for those residents who require such service. Such program includes but is not limited to: . f. Assisting residents with their routine range of motion exercises; .h. Others as prescribed by the resident's Attending Physician.