STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115363	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Rome	1345 Redmond Circle Rome, GA 30165

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident and staff interviews, and review of the facility policy titled, Promoting Maintaining Resident Dignity, the facility failed to promote care in a manner that maintained or enhanced each resident's dignity, respect, and individuality for two of eight sampled residents (R) (R8 and R S). Specifically, staff were standing while feeding a resident. In addition, staff members did not knock or identify themselves before entering residents' rooms. Findings include: Review of the facility policy titled Promoting Maintaining Resident Dignity revised date 4/1/2024 revealed under Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Under Compliance Guidelines: .10. Respect the residents' living space. Maintain resident privacy. Review of the admission Record for R8 revealed he was admitted to the facility with a diagnosis of but not limited to dyskinesia (uncontrollable and involuntary movements) of esophagus. Review of R8's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was assessed as eight which indicated cognition was moderately impaired. Section K (Swallowing and Nutritional Status) revealed R8 was assessed as having no swallowing disorder and no signs and symptoms of swallowing problems. Nutritional status triggered as an area of concern on the Care Area Assessment Summary. Review of the care plan initiated 5/16/2025 revealed that R8 is at risk for nutritional need related to a mechanical soft diet. Intervention to be implemented included setting up each meal tray and assisting R8 as needed. Observation on 6/11/2025 at 12:43 pm revealed Certified Nursing Assistant (CNA) GG feeding R8 lunch. The resident was leaning to the left side slouched down in the bed. CNA GG was standing feeding R8. Observation on 6/11/2025 at 12:52 pm revealed Licensed Practical Nurse (LPN) HH walking into room [ROOM NUMBER] without knocking or identifying herself before entering the resident room. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/11/2025 at 12:54 pm revealed LPN HH walking into room [ROOM NUMBER] without knocking or identifying herself before entering the resident room. Observation on 6/18/2025 at 9:02 am revealed Staffing Coordinator II walking into room [ROOM NUMBER] without knocking or identifying herself before entering the resident room. Observation on 6/11/2025 at 12:50 pm of the Treatment Nurse (TN) JJ and CNA GG repositioning R8. TN JJ or CNA GG did not pull the curtain or shut the door to provide R8 with privacy from the visitor in the room or the surveyor in the hall. Interview on 6/11/2025 with CNA GG, she stated R8 was not her assigned resident for the day, and she was helping with feeding the residents. CNA GG was asked if she always stood up to feed the residents and CNA GG answered Yes. Interview on 6/11/2025 at 12:54 pm with LPN HH revealed she did not knock when the residents' door was open. She stated, I just walk in. Interview on 6/18/2025 at 9:32 am with the Staffing Coordinator II revealed she was aware that she should knock before entering a resident's room. She stated that this was the resident's home and she should knock and announce herself before entering. Interview on 6/18/2025 at 12:28 pm with R S revealed the staff would enter the room without knocking or announcing themselves. An interview on 6/18/2025 at 5:53 pm with the Director of Nursing (DON) revealed the staff were educated on a regular basis on resident rights that included knocking on the residents' doors, announcing themselves before entering the room.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and family interviews, and review of the facility policies titled, Baseline Care Plan and Care Planning-Resident Participation, the facility failed to ensure that one of two Residents (R) (R1) reviewed for participation in care plan meetings were invited to and participated in a scheduled 72-hour care plan meeting. In addition, the family representative for R1was not invited to ensure that the care plan was individualized and met R1's personal goals and preferences. Findings include: Review of the facility policy titled Baseline Care Plan revised date 3/1/2025 revealed under Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Under Policy Explanation and Compliance Guidelines: . 4. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. 5. A supervising nurse or MDS nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. This will be provided by completion of the comprehensive care plan. 7. If the summary was provided via telephone, the nurse shall indicate the discussion, sign the summary document, and make a copy of the written summary before mailing the summary to the resident/ representative. Review of the facility policy titled Care Planning-Resident Participation revised date 3/1/2025 revealed under Policy Explanation and Compliance Guidelines: The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan. Review of the admission Record for R1 revealed she was admitted to the facility with diagnoses of but not limited to dysphagia and gastro-esophageal reflux disease. Review of R1's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was assessed as 15, which indicated cognition was intact. Review of R1's electronic medical record (EMR) attached under the Miscellaneous Documents tab revealed a document titled Care Plan Meeting Sign Sheet dated 1/7/2025 revealed there was no indication that the resident or family were invited or attended the care plan meeting. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview on 6/6/2025 at 9:35 am with R1's family revealed the family stated there was never an invitation to a care plan meeting or any type of meeting with the facility until she inquired on 1/7/2025. She stated she received a phone call from the facility on 1/7/2025 informing her that R1's therapy would be discontinued. The family stated she told the caller she had not received any phone calls about her mom (R1) or if she was progressing with therapy. The family member revaled the caller told her she was under the impression she had spoken with someone and told the family member someone would call her back. She revealed on 1/9/2025 there was a conference call with the physical therapist, occupational therapist, and speech therapist. The family member stated there were no other disciplines to her knowledge present during the telephone conference. An interview on 6/11/2025 at 1:00 pm with Resident Assessment Coordinator EE revealed the department was responsible for the resident assessment and care plans. She stated a care plan meeting should be conducted 72 hours after the resident was admitted to the facility and 14 days after a comprehensive and quarterly MDS assessment was completed. She stated the residents were invited by a visit to the residents' room. The family/responsible party were called and invited. She stated the Discharge Planner was responsible for documenting the care plan meetings. The Resident Assessment Coordinator confirmed that R1 did not have a 72-hour care plan meeting or a care plan meeting 14 days after the admission MDS assessment was completed. An interview on 6/17/2025 at 2:23 pm with the Speech-Language Pathology (SLP) revealed she did not remember having a specific care plan meeting for R1. The SLP stated she remembered discussing with the family advancing R1's diet. The SLP was asked if the information was discussed in a care plan meeting, and the SLP responded and asked the surveyor, Did the facility even hold a care plan meeting?

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F 0684 Level of Harm - Minimal harm or potential for 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** Based on observations, record review, and staff interviews, it was determined that the facility failed to ensure quality care and services in accordance with professional standards for one Resident (R) (R1). Specifically, the facility failed to provide timely assistance to one resident (R1) who was in respiratory distress. Findings include: Review of the admission Record for R1 revealed she was admitted to the facility with diagnoses of but not limited to dysphagia and gastro-esophageal reflux disease. Review of the resident's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was assessed as 15, which indicated cognition was intact. Section K (Swallowing and Nutritional Status) revealed R1 was assessed as having no swallowing disorder and no signs and symptoms of swallowing problems. Nutritional status triggered as an area of concern on the Care Area Assessment Summary. Review of the care plan initiated 12/17/2024 revealed that R1 is at risk for nutritional need related to a therapeutic diet. Intervention to be implemented included observe R1 for signs of dysphagia (difficulty swallowing): not limited to coughing, choking, and refusing to eat during meals. Review of the hospital Discharge summary dated [DATE] revealed the second day of hospital admission the patient (R1) had an episode of aspiration (inhaling into airway/lungs) of scrambled eggs on 12/5/2024 and required intubation (placement of a breathing tube). The patient had a diagnostic bronchoscopy and bronchoalveolar lavage (a medical procedure where a bronchoscope is used to wash the airways and collect a fluid sample from the lungs for diagnostic purposes) from right lower lobe on 12/5/2024 that revealed a remnants in the distal trachea and right lower lobe which were suctioned. The patient was extubated (breathing tube removed) on 12/6/2024 but had another aspiration event that same day and required re-intubation on 12/6/2024. The patient was able to be weaned off the ventilator on 12/8/2024. The patient after extubating had problems with swallowing. The resident (R1) was discharged from the hospital to __ facility. Review of the Medication Review Report (physician order) dated 12/16/2024 revealed: full code and Regular diet, Pureed texture, Honey consistency. Review of the Medication Review Report (physician order) dated 12/18/2024 revealed: occupational therapy (OT) clarification Order: Skilled OT 5 times a week for 30 days may include: therapeutic exercise, therapeutic activities, neuromuscular reeducation, manual therapy, self-care retraining, wheelchair management training, Orthotic (devices worn in shoes to relieve symptoms related to various foot and ankle conditions) fitting and training, Skilled instruction to resident, caregivers and staff. Review of the Medication Review Report (physician order) dated 12/26/2024 revealed Regular diet, Mechanical Soft texture, Regular/Thin consistency. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Review Report (physician order) dated 12/27/2024 revealed: Late entry for 12/17/2024 Clarification Orders: skilled speech therapy (ST) 5 times a week times 4 weeks for treatment of swallowing dysfunction and/or oral function for feeding, caregiver education for Dysphagia unspecified diagnosis code R13.10. Review of the Occupational Therapy (OT) note dated 1/17/2025 revealed: Self feeding TD (treatment dependent) plus: patient coughed-wet cough then was breathing through her mouth and appeared to be ready to throw up, attained basin for her to throw it up and she did not then tried to get a reading on the pulse ox (oximeter-device to measure oxygen level), unable, notified her nurse and nurse took over. Review of Nurses Note dated 1/20/2025 revealed: 1:00 pm Nurse entered room. Resident found in bed sitting upright with eyes opened and unresponsive. Nurse notified supervisor. Emergency services called. Resident transferred to __ Hospital. The family was notified at 1:15 pm. Review of R1's __ Death Certificate revealed R1 was pronounced dead on 1/17/2025. The immediate cause (final disease or condition resulting in death) hypoxic (inadequate levels of oxygen in the tissues and cells of the body) respiratory failure and aspiration of food. A phone interview on 6/6/2025 at 9:35 am with R1's family revealed the facility called on 1/17/2025 around 1:00 pm. The family was informed that mom (R1) was found unresponsive. The facility also informed the family, We worked on her and could not get her back. The family asked the caller what happened. The family was informed that R1 choked while eating lunch and was unresponsive afterwards. The family could not identify the caller but stated it was not the nurse. An interview on 6/6/2025 at 11:33 am with Licensed Practical Nurse (LPN) BB revealed around 1:00 pm Occupational Therapist AA came to the nursing station and requested that she come to R1's room because the resident wasn't looking too well. LPN BB revealed upon arriving at the room, the resident was not responding and had no pulse. LPN BB stated she left the room and went to find the Unit Manager (UM). She stated when she returned with the UM, R1 was placed in a supine (lying on one's back with face upward) position and chest compressions and ventilation were started with an Ambu bag (medical device that forces air into the lungs of patients who are not breathing or struggling to breathe) on R1. An interview on 6/6/2025 at 12:57 pm with LPN BB confirmed that she did not document the events that took place on 1/17/2025 in R1's EMR. She stated she was so overwhelmed that day and left work without charting the incident. She also revealed she spoke with the Nurse Practitioner (NP) on the phone and failed to write an order for R1 to be transferred to the hospital. An interview on 6/17/2025 at 3:05 pm, OT AA stated R1 was treated on 1/17/2025. The OT was assisting R1 with getting food from the plate to the mouth with her hand on R1's hand in a guiding motion as part of R1's therapy. She stated during the therapy session R1 began to cough (wet cough) and mouth breathing. The OT stated she attempted to get a pulse oximeter reading and was unsuccessful. The OT stated she did not stay with R1. The OT stated she left the room to get LPN BB. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/18/2025 12:51 pm with Certified Nursing Assistant (CNA) CC revealed she has been educated on resident mealtimes and what to do if you find a resident unresponsive. She stated during mealtimes all residents' doors must remain open. She stated the reason for leaving the doors open was to listen out for residents' that may start coughing while eating. She stated if a resident became unresponsive, the staff could not leave but call out for help. She revealed that R1 was one of her assigned residents. CNA CC stated R1 did not have a suction machine in her room. An interview on 6/18/2025 1:32 pm with CNA DD revealed she has been educated by the facility on what to do if a resident became unresponsive. She stated she was educated never to leave the resident but call out for help. An interview on 6/18/2025 at 5:53 pm with the Director of Nursing (DON) revealed she was unaware that the OT was providing therapy services to R1 on 1/17/2025 when the resident became unresponsive. The DON stated the expectation of the staff was if a resident became unresponsive, the staff was educated to call out for help and not leave the room. The DON stated a staff person should always be with the resident.