

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Harborview Rome		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for 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** Based on observations, staff and resident interviews, record review, and review of the facility's policy titled Comprehensive Care Plans, the facility failed to implement the care plan for 1 of 44 sampled residents (R71). This deficient practice had the potential to prevent R71 from attaining or maintaining her highest practicable level of well-being. Findings include: Review of the policy titled Comprehensive Care Plans, revealed 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. Review of the electronic medical record (EMR) revealed R71 was admitted to the facility on [DATE], and reentered on 5/22/2025, with pertinent diagnoses including but were not limited to unspecified hypothyroidism and essential primary hypertension, residual deficits from a prior cerebral infarction, resulting in hemiplegia and hemiparesis affecting the left non-dominant side accompanied by generalized muscle weakness. Review of R71's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Section B documented adequate hearing, clear speech, and the ability to make self-understood and understand others. Vision was noted as adequate. Section GG indicated R71 uses a wheelchair and requires two or more person assistance for activities of daily living (ADLs). Review of R71's care plan dated 06/20/2025 indicated a problem statement identifying that R71 has a communication problem related to language. Goals included but were not limited to R71, being able to make basic needs known on a daily basis through the review date. Interventions included, but were not limited to: Anticipate and meet needs. Observe and document physical or nonverbal indicators of discomfort or distress and follow up as needed. Provide a translator, such as family, a tablet, or a phone with a language application, as necessary to communicate with R71 and R71's family. An observation with concurrent interview conducted on 12/3/2025 at 9:12 am with R71 revealed that she could not speak English. The family of R71 was present during the interaction but did not respond to the surveyor, as he also does not speak English. An interview conducted on 12/3/2025 at 9:29 am with Certified Nursing Assistant (CNA) CNA NN revealed R71 is a female stroke survivor with left-sided involvement who requires total care and two-person assistance for transfers using the Hoyer lift. She has been under CNA NN care for four years. R71 is dependent, she makes attempts to assist with her care when possible. CNA NN confirmed R71 does not speak English, and she uses the application family translate. An observation with concurrent interview conducted on 12/3/2025 at 11:24 am revealed that the surveyor attempted to have R71 and the family of R71 to read a question from a computer tablet. The family of R71 was unable to do so and immediately stated that he does not speak English. An interview conducted on 12/3/2025 at 2:10 pm with the Assistant Director of Nursing (ADON) revealed that staff communicate daily with the family of R71 who speaks limited English. The ADON stated that staff rely on gestures and family to communicate with R71. She confirmed that no staff members at the facility speak R71's primary language. The ADON further stated that the family was offered the (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	option to use the facility's communication tablet, but they declined. An interview conducted on 12/3/2025 at 4:14 pm with the Director of Nursing (DON) and Minimum Data Set (MDS) Coordinator OO revealed the facility's care planning process, including how concerns are identified and how focus areas, goals, and interventions are developed. They confirmed that R71 does not speak English and that staff rely on the family to translate. They stated they believed staff were using the language app for communication. The DON and MDS Coordinator OO reported the facility is in the process of creating laminated communication sheets in both English and R71's primary language to keep in her room. They both confirmed that care plan interventions should be implemented as written in the care plan.		

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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** Based on observations, staff and resident interviews, record review, and review of the facility's policies titled Hand Hygiene, the facility failed to provide proper hand hygiene for one of nine residents (R) (R5) reviewed for infection control. This deficient practice had the potential for cross contamination and the spread of infection to staff and other residents. Findings include: Review of the facility's policy titled Hand Hygiene, revised 3/1/25, section: 6 documented The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves and the second page titled Hand Hygiene Table line 14 documented Before and after handling clean or soiled dressings, linens, etc. and line 18 When during resident care, moving from a contaminated body site to a clean body site. Review of the electronic medical record (EMR) face sheet revealed resident R5 was admitted to the facility on [DATE] with diagnoses including but was not limited to hyperlipidemia, essential primary hypertension, type two diabetes mellitus with hyperglycemia, chronic systolic congestive heart failure, presence of a cardiac pacemaker, other seasonal allergic rhinitis, generalized muscle weakness, dizziness and giddiness, unsteadiness on feet, and unspecified low back pain. Review of R5's quarterly/ annual/ significant change Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 12, which indicated R5 had moderate cognitive impairment. Review of section GG, functional status, revealed R5 uses [NAME] /Wheelchair and was Independent with partial/moderate assistance. Other sections include Section H, Urinary Continence (Frequently incontinent)/Bowel ([NAME] continent); Section J, Pain Management received PRN medication/received non-medication intervention for pain/has pain occasionally; Section K, Therapeutic diet; Section M, pressure ulcer/injury/Formal assessment /Clinical assessment. Review of R5's care plan dated 6/2/2025 documented under problem: Resident is at risk for/ actual pressure ulcer due to assistance required in bed mobility. Review of the physician's Order dated 11/21/2025 documented, cleanse left upper buttock with wound cleanser. Pat dry. skin prep peri wound. Thera honey [type of wound treatment] to wound bed. Cover with silicone bordered gauze dressing. Change 3 times a week and prn [as needed] for heavy soiling or dislodgment of dressing. Observation and interview on 12/3/2025 at 1:49 pm with Registered Nurse (RN) RN GG performing wound care on R5's buttocks wound revealed, RN GG applied personal protective equipment (PPE) including gown and gloves without hand hygiene. RN GG entered R5's room, she explained the procedure and asked if the procedure could be monitored by a surveyor. R5 responded granting permission for wound care to be observed. RN GG then assisted R5 to roll on her right side and removed the left side of R5's adult brief to expose R5's buttocks wound. There was no dressing observed on the wound. RN GG then moistened gauze with wound cleanser and cleaned the wound, she then removed her gloves, did not perform hand hygiene, opened the resident specific tube of Thera-Honey and squeezed some on a clean gauze. RN GG then donned clean gloves (no hand hygiene) and applied skin prep to peri wound skin and applied the Thera-Honey on the gauze pad to the wound bed. RN GG then removed her gloves (no hand hygiene) and donned clean gloves and applied the silicone bordered foam dressing to the wound. She removed her gloves, (no hand hygiene) and put her hands in her pockets feeling for a marker to mark her date, time and initials in the dressing that was already on R5 buttocks. She then donned clean gloves (no hand hygiene) and replaced the adult brief on R5. RN GG then removed her gloves and washed her hands with soap and water. Interview with RN GG on 12/3/2025 at 2:00 pm confirmed she had alcohol hand sanitizer on her wound care tray, but she did not use it or soap and water between glove changes, after going from clean to dirty during the procedure and before donning the gown and gloves at the time of entering the room. Interview with the Director of Nursing (DON) on 12/4/2025 at 9:20 am revealed that her expectations for hand hygiene include hand washing before entering a resident room, exiting a resident room, before and after donning gloves and other personal protective equipment. She stated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she also expected the medication nurses to use hand hygiene before entering a room and when exiting a resident room.		