

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/21/2024
NAME OF PROVIDER OR SUPPLIER  Thomson Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  511 Mt. Pleasant Road Thomson, GA 30824	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>11599</p> <p>Based on observation, staff interviews, record review, and review of the facility's policy and procedure titled Resident Rights, the facility failed to provide a dignified dining experience for two of 33 sampled Residents (R) (R24 and R100) by serving meals on styrofoam with plastic utensils and standing to assist with meal intake. This failure created the potential for the residents to be treated in an undignified manner.</p> <p>Findings include:</p> <p>Review of the facility's policy and procedure titled Resident Rights with a review date of 1/6/2023 revealed, Employees shall treat all residents with kindness, respect, and dignity.</p> <p>1. Review of R24's Admission Record located under the Profile tab in the Electronic Medical Record (EMR) noted R24 was admitted with diagnoses that included eating disorder, unspecified; and adult failure to thrive.</p> <p>Review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 9/17/2024 revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15 indicating R24 was unable to complete the interview.</p> <p>During observations of meals on 11/18/2024 at 12:24 pm, on 11/19/2024 at 12:31 pm, and on 11/20/2024 at 12:59 pm, revealed R24 was seated in front of her room with an overbed table in front of her. She was observed to be served meals in a styrofoam container. R24 was observed spitting food over the right side of her wheelchair, onto the floor and wheelchair itself, and into her lap.</p> <p>During an interview on 11/18/2024 at 2:49 pm, Licensed Practical Nurse (LPN)1 revealed, The resident spits in her food and sometimes makes herself vomit into her tray, that's why we use styrofoam. It doesn't always happen.</p> <p>During an interview on 11/21/2024 at 3:15 pm, the Director of Nursing (DON) stated, [R24] has styrofoam because she spits in her food and has wiped feces on her tray when she's finished. We can't have that. When asked if the staff had the opportunity to remove the meal at the time of completion and before R24 vomited or smeared feces, the DON did not say if that had been attempted.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of R100's Admission Record located under the Profile tab in the EMR revealed, R100 was admitted with diagnoses that included unspecified dementia, unspecified severity, with other behavioral disturbance.</p> <p>Review of the significant change MDS with an ARD of 10/31/2024 revealed a BIMS score of zero out of 15 indicating R100 was unable to complete the interview.</p> <p>During an observation of R100 on 11/18/2024 at 12:24 pm revealed the resident seated in a reclining geri chair. R100 asked for a hamburger and Registered Nurse (RN) offered to assist R100 with eating his meal. Certified Nursing Assistant (CNA)1 asked RN1 Can I get you a chair? RN1 declined the chair to sit next to R100 stating, No, I don't need a chair, and proceeded to assist him with eating his meal while standing next to him.</p> <p>During an observation of R100 on 11/20/2024 at 12:42 pm, revealed the Human Resources (HR) staff member assisted R100 with eating his lunch meal while standing next to him.</p> <p>During an interview on 11/21/2024 at 12:55 pm, HR stated, I know I should have sat next to the resident. It was kind of chaotic and he was trying so hard to get out of the chair.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39411</p> <p>Based on staff and resident interviews, record review, and review the facility's policy titled Resident Rights, the facility failed to honor the resident's right to vote for one of two Residents (R) (R83) who were reviewed for choices out of a total sample of 33 residents. This had the potential for the resident not to be able to make choices that could impact the resident's life.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Resident Rights revised 1/6/2023 revealed, Federal and State laws guaranteed certain basic rights to all residents of the facility including the right to exercise his or her rights as citizens of the United States of America.</p> <p>Review of R83's Face Sheet tab of the Electronic Medical Record (EMR) revealed she was admitted to the facility on [DATE].</p> <p>Review of R83's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/30/2024 and located in the MDS tab of the EMR, revealed she had a Brief Interview for Mental Status (BIMs) score of 15 out of 15 indicating R83's cognition was intact.</p> <p>During an interview on 11/20/2024 at 10:03 am, the Social Service Director (SSD) stated she had been employed at the facility for one week. The SSD stated that if the resident was mobile then family members could take them to vote, or an absentee ballot could be provided. The SSD stated she did not know if any residents were taken to vote or if any absentee ballots were provided to the residents. The SSD stated that voting is a resident right.</p> <p>During a follow up interview on 11/20/2024 at 10:39 am, the SSD stated that the previous SSD usually had a meeting with the residents to see who needed assistance with voting but did not know if that meeting took place or what happened to any ballots mailed to the facility.</p> <p>During an interview on 11/20/2024 at 2:14 pm, R83 stated that she really wanted to vote and usually voted in person. R83 stated that her preference was to vote in person. R83 stated there was no family to ask and staff did not know how to help her. R83 stated she felt very disappointed she did not get to take part in the voting process.</p> <p>During an interview on 11/21/2024 at 9:11 am, the Activity Director (AD) stated the SSD had always been responsible for assisting the residents to vote. The AD stated that no one asked her to assist the residents with voting and no resident had asked her about it. The AD stated that they do go over the resident's right during resident council meetings and voting is a resident right.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46592</p> <p>Based on staff interview, record review, and review of the facility's policy titled, Transfer Agreement, the facility failed to provide written hospital transfer notices for three of three Residents (R) (R11, R12, and R43) reviewed for hospitalization out of a total sample of 33 residents. The failure had the potential to cause residents to not fully understand the purpose of the hospital transfer.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Transfer Agreement revised March 2017 revealed, the agreement, facilitates the exchange of medical and other information necessary or useful in the care and treatment of residents transferred between the institutions. The policy did not indicate that the resident and/or resident representative (RR) would/does receive a copy of the information or other written notice of transfer.</p> <p>Review of the Notice of Transfer/Discharge form dated March 2017 provided by the Administrator revealed, a form which indicated the reason, time, date, and location of the hospital transfer, as well as the amount of the bed hold.</p> <p>1. Review of the Census tab located in the Electronic Medical Record (EMR) revealed, R11 was originally admitted to the facility on [DATE].</p> <p>Review of the discharge Minimum Data Set (MDS) with an assessment reference date (ARD) of 10/7/2024 located in the MDS tab in the EMR revealed, R11 was discharged with an anticipated return.</p> <p>Review of the Progress Note dated 10/7/2024 located in the EMR under the Prog Note tab in the EMR revealed R11 was transferred to the hospital due to a swollen scrotum that was warm to touch. The resident returned to the facility on [DATE]. There was no evidence found in the EMR that R11 or the RR was provided with written notice of R11's hospital transfer.</p> <p>2. Review of the Census tab in the EMR revealed, R12 was originally admitted to the facility on [DATE].</p> <p>Review of the discharge MDS with an ARD of 5/24/2024 located under the MDS tab in the EMR revealed, R12 was discharged with an anticipated return.</p> <p>Review of the Progress Note located in the EMR under the Prog Note tab revealed R12 was transferred to the hospital on 5/25/2024 due to unstable vitals and congested lung sounds. The resident returned to the facility on [DATE]. There was no evidence found in the EMR that R12 or the RR was provided with written notice of R12's hospital transfer.</p> <p>3. Review of the Census tab in the EMR revealed R43 was originally admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the MDS located under the MDS tab with an ARD of 8/26/2024 revealed R43 was discharged with an anticipated return.</p> <p>Review of the Progress Note located in the EMR under the Prog Note tab revealed R43 was transferred to the hospital on 8/26/2024 due to not responding to staff and slumping to one side. The resident returned to the facility on [DATE]. There was no evidence found in the EMR that R43 or the RR was provided with written notice of R43's hospital transfer.</p> <p>During an interview on 11/20/2024 at 10:30 am the Administrator verified there was no evidence in R11, R12, or R43's EMR that a copy of the transfer agreement was given to the resident and/or RR representative.</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46592</p> <p>Based on staff interview, record review, and review of the facility's policy titled Bed-Holds and Returns, the facility failed to provide written bed hold notices for three of three Residents (R) (R11, R12, and R43) reviewed for hospitalization out of a total sample of 33 residents. The failure had the potential to cause confusion as to what the charge would be after the bed hold expired or if they would have a bed when they returned to the facility.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Bed-Holds and Returns revised ,d+[DATE] revealed, residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. The policy revealed, the residents or their representative would receive a bed-hold notice, at the time of transfer (or, if the transfer was an emergency, within 24 hours).</p> <p>1. Review of the Census tab located in the Electronic Medical Record (EMR) revealed, R11 was originally admitted to the facility on [DATE].</p> <p>Review of the discharge Minimum Data Set (MDS) with an assessment reference date (ARD) of [DATE] located in the MDS tab in the EMR revealed R11 was discharged with an anticipated return.</p> <p>Review of the Progress Note dated [DATE] located in the EMR under the Prog Note tab in the EMR revealed R11 was transferred to the hospital due to a swollen scrotum that was warm to touch. The resident returned to the facility on [DATE]. There was no evidence found in the EMR that R11 or the RR was provided with a written bed hold notice at the time of R11's hospital transfer.</p> <p>2. Review of the Census tab in the EMR revealed R12 was originally admitted to the facility on [DATE].</p> <p>Review of the discharge MDS with an ARD of [DATE] located under the MDS tab in the EMR revealed R12 was discharged with an anticipated return.</p> <p>Review of the Progress Note located in the EMR under the Prog Note tab revealed R12 was transferred to the hospital on [DATE] due to unstable vitals and congested lung sounds. The resident returned to the facility on [DATE]. There was no evidence found in the EMR that R12 or the RR was provided with a written bed hold notice at the time of R12's hospital transfer.</p> <p>3. Review of the Census tab in the EMR revealed R43 was originally admitted to the facility on [DATE].</p> <p>Review of the MDS located under the MDS tab with an ARD of [DATE] revealed R43 was discharged with an anticipated return.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Progress Note located in the EMR under the Prog Note tab revealed R43 was transferred to the hospital on [DATE] due to not responding to staff and slumping to one side. The resident returned to the facility on [DATE]. There was no evidence found in the EMR that R43 or the RR was provided with a written bed hold notice at the time of R43's hospital transfer.</p> <p>During an interview on [DATE] at 10:30 am the Administrator confirmed there was no evidence that R11, R12, or R43 or their RR's were provided the written bed hold policy when they were transferred to the hospital.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 11599</p> <p>Based on observations, staff interviews, record review, and review of the facility's policy and procedure titled Care Plans, the facility failed to develop a person centered, comprehensive care plan for two of 33 sampled Residents (R) (R24 and R100) related to meal assistance, safety needs, and ambulation which had the potential for unmet care needs.</p> <p>Findings include:</p> <p>Review of the facility's policy and procedure titled Care Plans, dated 2015 revealed, The Care Planning/Interdisciplinary Team shall develop a comprehensive care plan for each resident . A comprehensive care plan is developed within seven (7) days of completion of the resident assessment (MDS) . Care plans shall incorporate goals and objectives which lead to the resident's highest obtainable level of independence. Goals and objectives are: Resident oriented; Behaviorally stated; Measurable; and within a specified time frame.</p> <p>1. Review of the Admission Record located under the Profile tab in the electronic medical record (EMR) revealed, R24 was admitted with diagnoses that included eating disorder, unspecified; and adult failure to thrive.</p> <p>Review of R24's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/17/2024 revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15 indicating R24 was unable to complete the interview</p> <p>Observations of meals on 11/18/2024 at 12:24 pm, 11/19/2024 at 12:31 pm, and 11/20/2024 at 12:59 pm revealed, R24 was served meals in a styrofoam container. R24 was observed to spit food over the right side of her wheelchair, onto the floor and the wheelchair, and into her lap.</p> <p>Interview on 11/18/2024 at 2:49 pm with Licensed Practical Nurse (LPN)1 stated, The resident spits in her food and sometimes makes herself vomit into her tray. It doesn't always happen.</p> <p>During an interview on 11/21/2024 at 3:15 pm, the Director of Nursing (DON) stated, [R24] spits in her food and has wiped feces on her tray when she's finished. We can't have that.</p> <p>Review of the 7/8/2024 Care Plan located in the EMR under the RAI tab revealed an identified problem of Episodes of socially inappropriate behaviors: i.e [example]: smearing feces and inappropriate toileting. [R24] was noted by CNA to squat over w/c [wheelchair] as if to toilet and had a BM [bowel movement] then noted to smear feces on wall and breakfast tray. Interventions were listed as approach resident in a calm and pleasant manner; educate resident on inappropriate behaviors and positive ways to express feelings and to communicate needs; re-direct resident as needed; resident is to wear disposal brief.</p> <p>There were no interventions to address R24's spitting or self-induced vomiting.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Admission Record located under the Profile tab in the EMR revealed, R100 was admitted with diagnoses that included unspecified dementia, unspecified severity, with other behavioral disturbance.</p> <p>Review of R100's significant change MDS with an ARD of 10/31/2024 revealed, a BIMS score of zero out of 15 indicating R100 was unable to complete the interview.</p> <p>Review of the Nursing Summary located under the Progress Notes tab in the EMR revealed R100 was hospitalized from 10/23/2024 to 10/25/2024 for pneumonia. Upon readmission to the facility on [DATE], the resident was placed on Hospice. R100 was identified to no longer be walking independently, utilized a g-chair, was unsteady on his feet, and was at an increased risk for falls.</p> <p>During an observation of R100 on 11/18/2024 at 2:13 pm revealed, he was able to get himself out of geri chair and attempted to stand. Staff quickly intervened as R100 was very unsteady.</p> <p>During an observation of R100 on 11/20/2024 at 11:55 pm, revealed the resident was agitated, was verbal cursing, and attempted to get out of the geri chair. A staff member wheeled the resident in the geri chair, up and down the hall in an attempt to calm him.</p> <p>Review of the 11/11/2024 Care Plan located under the RAI tab in the EMR revealed no problems or interventions for R100 requiring assistance to eat; no longer a Full Code after Hospice initiation; no longer ambulating independently; use of the geri chair; or the need for one-on-one supervision to prevent accidents. The care plan was not reflective of R100's current condition.</p> <p>During an interview on 11/21/2024 at 12:40 pm, the MDS Coordinator (MDSC), responsible for the development of the resident care plans, stated, I've been doing all of this by myself as we were without some staff members. I will have to get these updated.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39411</p> <p>Based on observation, staff interview, record review, and review of the facility's policy titled Sanitation, the facility failed to maintain the ice machine in a clean and sanitary manner. The deficient practice had the potential to cause illness to 103 out of 105 residents who consumed an oral diet.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Sanitation revised 11/2022 revealed, that ice machines should be drained, cleaned, and sanitized.</p> <p>During an observation of the kitchen on 11/18/2024 at 9:47 am with the Dietary Manager (DM) revealed, a black substance was observed on the plastic lining inside the ice machine. Review of the cleaning schedule revealed, the ice machine had been last cleaned on 10/21/2024. Interview with the DM revealed that maintenance was responsible for cleaning the ice machine. The DM confirmed the ice machine was not clean and stated they would have to monitor it better.</p>