

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	

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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34318</p> <p>Based on staff interviews, record review, and review of the facility documents titled Resident Fund Management Service and Burial Account, the facility failed to ensure that one of seven sampled residents (R) (R2's) burial account funds were not used to pay the care cost balance. This deficient practice had the potential to affect all residents who had a trust funds account with the facility.</p> <p>Findings include:</p> <p>A review of the Resident Fund Management Service document, dated [DATE], revealed that the Resident Fund Account was a transferring account (automatic transfer of care cost payments due the facility) with a \$70.00 monthly allowance amount.</p> <p>A review of the Burial Account document revealed that it was a deposit-only account for money to be used for burial expenses only and was revocable (it may be closed prior to death).</p> <p>A review of the Resident Statement Landscape revealed that R2 had a trust fund account for care costs and a burial account. Further review revealed on [DATE], R2's trust fund account balance was \$4185.83. On [DATE], \$4115.00 was transferred from the trust fund account to the burial account, leaving a balance of \$70.00 in the trust fund account.</p> <p>A review of the Close Transaction Report, dated [DATE] (to close R2's trust account), revealed that \$70.83 was due to R2 to close the trust fund account. A check numbered 003614, dated [DATE], from the Resident Fund Management Service (RFMS) Petty Cash Account revealed the check was made payable to R2 and had the facility's address.</p> <p>A review of the Close Transaction Report dated [DATE] (to close R2's burial account) revealed a balance of \$4115.00. There were two checks for the burial disbursement dated [DATE], check numbered 003613 for \$1998.52 with R2 as the payee and check numbered 003615 for \$2116.48 with the facility as the payee.</p> <p>A review of the Trial Balance dated [DATE] revealed R2's burial account was closed on [DATE], with a zero balance.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	

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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Petty Cash bank account statement dated [DATE], through [DATE], revealed that check numbers 003613 and 003614 were cleared as paid on [DATE], and check 003615 was cleared as paid on [DATE] from the facility's petty cash account.</p> <p>There was no evidence that the Responsible Party authorized the facility to transfer money from the burial account to pay an outstanding balance of care cost.</p> <p>A review of medical records revealed that R2 expired on [DATE].</p> <p>In an interview on [DATE] at 12:57 pm, the Business Office Manager (BOM) revealed that the only authorization she had was to transfer money from R2's trust account to his burial account and that she was not aware that the burial account funds could not be used to pay the care cost balance.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	
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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34318</p> <p>Based on staff interviews and record review, the facility failed to notify the physician of a significant change in condition for one of seven sampled residents (R) (R1) related to respiratory distress and the need for further medical treatment. On [DATE], R1 exhibited shortness of breath, tripodding (leaning forward to maximize lung expansion), and a decreased oxygen saturation of 83 percent.</p> <p>On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator, Director of Nursing (DON), and Corporate [NAME] President of Compliance and Regulatory Services were informed of the Immediate Jeopardy (IJ) on [DATE] at 4:18 pm. The noncompliance related to the IJ was identified to have existed on [DATE].</p> <p>At the time of exit on [DATE], an acceptable Immediate Jeopardy Removal Plan had not been received; therefore, the Immediate Jeopardy remained ongoing.</p> <p>Findings include:</p> <p>A review of the Electronic Medical Record (EMR) for R1 revealed a readmitted [DATE] with diagnoses including but not limited to cerebral infarction affecting the left nondominant side, hypertension, type 2 diabetes mellitus, major depressive disorder, and insomnia.</p> <p>A review of the EMR for R1 revealed no evidence that the physician or the Administrator was notified of R1's significant change in condition of respiratory distress or that R1 had expired and was pronounced.</p> <p>Interview on [DATE] at 3:07 pm with Licensed Practical Nurse (LPN) BB revealed that she made a note (progress note dated [DATE]) that stated she had called the DON and the Administrator. However, LPN BB's documentation revealed no evidence that the Administrator was notified.</p> <p>Interview on [DATE] at 3:50 pm with the Registered Nurse (RN) Supervisor revealed that R1 was coughing and saying he was going to stop smoking. RN Supervisor further stated that R1 was stressing, saying he had a hard time breathing, but he was able to talk and repeatedly said he was going to stop smoking. He further revealed that LPN CC had put oxygen on R1 at two liters per minute and took vital signs. He stated he thought LPN CC had stated R1's pulse oxygenation on room air was 89 percent. The RN Supervisor confirmed that he did not call the physician to inform him of the change in condition for R1.</p> <p>An interview on [DATE] at 9:40 am with LPN CC revealed that she did not call the physician because R1 was stable, and a report was given to the assigned night shift nurse. LPN CC stated that if it were an emergency, she would call 911 and then call the physician to tell him what she did for the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	
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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 1:34 pm with Physician QQ revealed this was the first he had heard that R1 had expired, and there was no excuse for this. Physician QQ stated that R1 was on his monthly follow-up for next week and further stated that R1 was cognitive and could verbalize his needs and what was wrong.</p> <p>Interview on [DATE] at 2:12 pm with the DON revealed that she was not aware of R1's death circumstances because the RN supervisor told her that the resident had passed in his sleep and was a Do Not Resuscitate (DNR).</p> <p>Interview on [DATE] at 3:18 pm with the Administrator revealed that he was not aware and had not been informed of R1's death circumstances until the surveyor started interviewing the staff. The Administrator stated that when he found out, he held an Ad Hoc meeting and began education on notification and documentation of changes in condition and code status.</p> <p>Cross Reference F600</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34318</p> <p>Based on staff interviews, record review, and review of the facility policy titled Freedom of Abuse, Neglect, and Exploitation; Abuse Prevention: Fast Alerts, the facility failed to protect the resident's right to be free from neglect by staff for one of seven sampled residents (R) (R1). Specifically, R1 had a significant change of condition while in respiratory distress and required further medical treatment. R1 expired less than four hours after being placed in his bed by staff.</p> <p>On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator, Director of Nursing (DON), and Corporate [NAME] President of Compliance and Regulatory Services were informed of the Immediate Jeopardy (IJ) on [DATE] at 4:18 pm. The noncompliance related to the IJ was identified to have existed on [DATE].</p> <p>At the time of exit on [DATE], an acceptable Immediate Jeopardy Removal Plan had not been received; therefore, the Immediate Jeopardy remained ongoing.</p> <p>Findings Include:</p> <p>Review of the policy titled Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts, dated [DATE], revealed Purpose. The purpose of this written Freedom of Abuse, Neglect, Exploitation: Abuse Prevention Standard is to outline the preventive and action steps taken to reduce the potential for abuse, mistreatment, and neglect of residents and the misappropriation of resident property and to review practices and omissions which if allowed to go unchecked, could lead to abuse. This standard demonstrates a Zero tolerance of Abuse of any type or manner and will address accordingly. Neglect: Failure of a facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Overview: When a nursing home accepts a resident for admission, the facility has assumed the responsibility to 1. Adequately assess the resident's condition. 3. Provide interventions or services to meet the resident's needs from the time of admission.</p> <p>A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed R1 had a Brief Interview Mental Status (BIMS) score of 15, indicating intact cognition.</p> <p>A review of the care plan for R1, with a canceled date of [DATE], revealed a focus area of Do Not Resuscitate (DNR). The interventions included notifying the medical doctor as needed, communicating resident choice, and comfort measures.</p> <p>A review of the progress notes for R1 dated [DATE] revealed Licensed Practical Nurse (LPN) BB documented that staff was alerted to the resident room in response to R1 being unresponsive. Upon entry to the room, the resident was observed lying supine in the bed with the head of the bed elevated about 30 degrees. The resident had no pulse noted, his eyes were closed with no respirations noted. The resident has a DNR code status. The DON was notified of R1's status.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A late entry dated [DATE] revealed a Registered Nurse (RN) Supervisor pronounced R1 deceased at 1:05 am. The RN Supervisor noted that he had attempted to notify the family five different times. The voicemail was not available. (Named) Funeral Home was notified.</p> <p>A review of the Electronic Medical Record (EMR) for R1 revealed that there was no evidence of documentation of vital signs or documentation of the event leading to R1's death. The last documented vital signs were taken on [DATE].</p> <p>Interview on [DATE] at 7:49 pm with Certified Nursing Aide (CNA) DD revealed that around 8:30 pm, R1 started asking for help. CNA DD stated the agency nurse assigned to R1 had left the building to get food. She stated she and CNA FF wheeled him to the front nursing station because they could not find his nurse. CNA DD further stated that two nurses (RN Supervisor and LPN CC) were at the nurse's station and assessed R1 for pulse oxygenation and vital signs. CNA DD confirmed the RN Supervisor gave R1 oxygen and told R1 to stop talking. CNA DD described the resident as sweating, shaking, and holding his chest, begging for help. CNA DD stated that she held the resident's hand and heard the two nurses discussing who would do the paperwork and stated neither nurse (RN Supervisor nor LPN CC) wanted to do the paperwork. CNA DD further revealed that the RN Supervisor stated that R1 was a DNR anyway, and both nurses (RN Supervisor and LPN CC) rolled R1 back to his room in his wheelchair and put him in the bed.</p> <p>Interview on [DATE] at 10:57 am, the RN Supervisor revealed that he returned to the facility to pronounced R1. The RN Supervisor stated that when he returned to the facility and before pronouncing R1, he did an assessment by checking the carotid pulse, using his stethoscope, and checked the apical pulse and did not find a heartbeat. He stated the resident was cool to the touch. The RN Supervisor explained that at about 8:30 pm on [DATE], the facility was having a staffing issue at shift change. He stated they had initially told LPN BB to go home, but the nurse scheduled to work did not show up, and LPN BB ended up staying at the facility.</p> <p>In a follow-up interview on [DATE] at 3:50 pm, the RN Supervisor revealed that R1 was coughing and talking, saying he was going to stop smoking. RN Supervisor stated that he thought it was a CNA who brought R1 to the front station, and R1 was stressing, saying he had a hard time breathing. He stated he was able to talk and repeatedly said he was going to stop smoking. He stated LPN CC put oxygen on the resident at two liters per minute. RN Supervisor further revealed that he was handling staffing issues, and LPN CC had said she had R1. RN Supervisor stated that R1 was taken back to his room by LPN CC and put to bed. RN Supervisor stated that he went to check on R1 before he left the facility, and his pulse oxygenation was 96 percent on 2 liters of oxygen. RN Supervisor revealed that he did not call the physician.</p> <p>However, a review of the EMR revealed no evidence that the facility staff performed vital signs or an assessment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 3:07 pm with LPN BB revealed that on [DATE], she was assigned to D Hall, and R1 was on the E Hall. LPN BB stated that when she initially got to work, R1 was at the front station and was receiving care from two nurses she identified as the RN Supervisor and LPN CC. LPN BB stated that she noticed the resident was wearing oxygen. She stated that she proceeded to her assigned area on the D Hall. She further stated that after she passed her medications on D Hall, she went to get something to eat. LPN BB revealed that she came back from lunch, and the RN Supervisor told her that R1 was complaining of being unable to breathe and had shortness of breath and that he had put R1 back in his room. The RN Supervisor had reported to her that R1 had gone out to smoke and that he put oxygen on the resident for shortness of breath and R1 seemed calmer. LPN BB further revealed that she went to pass narcotics for the Certified Medication Assistant (CMA) NN on E Hall and noticed R1 was anxious and yelling that he wanted his bed flat. LPN BB stated R1 was okay with not having the bed flat, and the resident was still talking and wanted his bed flat. LPN BB revealed that CMA NN came to her and told her that R1 was deceased. She stated when she walked into R1's room, he had one hand gripping the rail of the bed, his eyes were closed, and he had the appearance of being asleep. LPN BB stated that she checked his radial pulse and didn't feel a pulse and further revealed that when RN Supervisor and LPN CC put him in bed with oxygen, they made her think he was okay. LPN BB commented that her initial contact with R1 was only about him wanting to have the bed flat.</p> <p>In a follow-up interview on [DATE] at 1:49 pm with LPN BB, she clarified that she arrived at work at about 6:30 pm and normally goes to dinner before it is dark outside. She continued to state that her nursing note was written about 5 to 10 minutes after R1 was without signs of life. She stated when she first went on D Hall, it was during a regular medication pass to give narcotics for CMA NN since that they could not pass narcotics or chart those medications.</p> <p>Interview on [DATE] at 7:17 pm with CNA FF revealed that she was orienting CNA EE and was in a resident room. CNA FF stated she heard someone hollering down the hall, and it was R1 saying he couldn't breathe and wanted to lie down. CNA FF stated R1 was coming down the hall saying help me help me, and he couldn't breathe. CNA FF revealed she rolled him to the front nursing station because she didn't see a nurse on the back hall. CNA FF stated she informed the RN Supervisor and LPN CC that R1 was saying he could not breathe. She stated LPN CC took R1's vital signs, and his oxygenation saturation was 83 percent. She further stated that LPN CC applied oxygen to R1 via a nasal cannula. CNA FF stated that she then returned to her assignment. She stated at the end of her rounds, she observed that the RN Supervisor and LPN CC had put R1 in his bed with oxygen on and R1 was sitting in an upright position in bed. She further stated that at about 8:00 pm or 8:30 pm, she told LPN BB and CMA NN that R1 has a history of heart attacks. She stated that LPN BB stated that she would not send R1 out because the doctors would say why didn't they (nurses) do what could be done in the facility before sending him to the hospital. In a continued interview, CNA FF stated she and CNA EE told LPN BB that R1's oxygen was 83 percent. CNA FF stated that she and CNA EE checked on the resident and then went to get their meal from about 11:00 pm to 11:30 pm. CNA FF revealed when she returned from lunch that LPN BB told her to get R1's vital signs, and R1 had no pulse and no chest rise.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 9:40 am with LPN CC revealed that she was assigned to the A/C Hall from 7:00 am to 7:00 pm. She stated she passed her keys and gave a report to the front hall nurse. LPN CC stated she went to get a sheet to sign off, and R1 was in front of the nursing station with two CNAs. LPN CC further revealed that R1 looked short of breath and was sweaty, and she noticed the RN Supervisor was checking R1's vital signs. LPN CC stated she couldn't recall the specific values of the oxygen saturation but knew it was around 85 percent. She stated that, in general, R1 needed oxygen. LPN CC further stated she got the oxygen, put the resident on 3 liters of oxygen by nasal cannula, and told R1 that he was not alone. LPN CC stated that she was told that R1 was blind and had paralysis on the left side, and she told him to raise his right arm to help him breathe and stated the oxygen was helping. LPN CC further revealed that the RN Supervisor took R1 to the nurse assigned to the resident and she did not know the nurse. LPN CC stated that after 8:00 pm, she walked to the other side of the facility and asked a nurse where R1's room was. She stated the RN Supervisor was in the room alone with R1 and stated that he had reported to the night shift nurse. LPN CC revealed that she and the RN Supervisor assisted R1 into the bed and placed the head of the bed in the up position. When asked why she did not document, she stated that she was clocked out and didn't document because R1 was not her patient, and she thought he was okay. LPN CC stated she was helping the night shift nurse and did not call the physician. LPN CC further revealed that R1 was stable, and a report was given to the assigned night shift nurse. When asked if she discussed the transfer paperwork, LPN CC stated that she discussed the code status of the DNR, and if it were an emergency, she would call 911 and then call the physician to tell him what she did for the resident.</p> <p>Interview on [DATE] at 1:34 pm with Physician QQ revealed that a resident with an 83 percent pulse oxygenation should have been sent out immediately and needed an advanced level of care. Physician QQ stated that R1 had no respiratory care needs, was cognitive, and could verbalize his needs and tell you what was wrong. Physician QQ further revealed that this was the first he had heard that R1 had expired and stated that R1 was on his monthly follow-up for the next week. Physician QQ stated there was no excuse for this, and a DNR does not mean withholding care.</p> <p>Interview on [DATE] at 2:12 pm with the DON revealed that R1 should have been sent to the hospital and the physician should have been called. The DON stated that she was not aware of R1's death circumstances because the RN Supervisor had told her that R1 had passed in his sleep and was a DNR.</p> <p>Interview on [DATE] at 3:18 pm with the Administrator revealed that he was unaware of R1's death circumstances until the surveyor started interviewing the staff. The Administrator stated that once he was made aware, he held an Ad Hoc meeting and began education on notification and documentation of changes in condition and code status.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34318</p> <p>Based on staff interviews and record review, the facility failed to ensure vital signs were obtained as ordered for two of seven sampled residents (R) (R1 and R3). This deficient practice had the potential to negatively affect R1 and R3's physical health and well-being.</p> <p>Findings include:</p> <p>1. A review of R1's medical records revealed admission to the facility on [DATE], with a readmitted [DATE]. Diagnoses included but were not limited to hypertension and type 2 diabetes mellitus.</p> <p>A review of the Order Summary for R1 revealed an order dated 5/4/2023 with a start date of 5/8/2024 for vital signs to be obtained every Monday, every day shift.</p> <p>A review of the Weight and Vitals Summary revealed no vital signs were documented on any dates in May 2024. Two entries of vital signs were recorded for June 2024, dated 6/1/2024 and 6/3/2025. There was no evidence of vital signs recorded for 6/10/2024 and 6/17/2024.</p> <p>2. A review of R3's medical records revealed admission to the facility on [DATE] with a readmitted [DATE]. Diagnoses included but were not limited to hypertension and major depressive disorder.</p> <p>A review of the Order Summary for R3 revealed an order dated 1/14/2024 with a start date of 1/15/2024 to obtain vital signs every day shift every Monday for monitoring.</p> <p>A review of the Weights and Vitals Summary dated 1/1/2024 through 7/1/2024 revealed no evidence that vital signs were obtained on any dates in May 2024.</p> <p>In an interview on 7/11/2024 at 2:12 pm, the Director of Nursing (DON) revealed that staff should document vital signs during the shift and that missing documentation should be entered within 24 hours.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	
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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34318</p> <p>Based on staff interviews, record reviews, and review of the Administrator and Director of Nursing (DON) job descriptions titled Title: License Nursing Home Administrator and Title: Director of Nursing, the facility Administration failed to ensure that one of seven sampled residents (R) (R1) was free from neglect by staff when R1 was in respiratory distress asking for help. In addition, the facility Administration failed to provide oversight and monitoring of care and services to R1 for further medical treatment. This failure resulted in R1 expiring in his room alone and gripping the handrails.</p> <p>On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator, Director of Nursing (DON), and Corporate [NAME] President of Compliance and Regulatory Services were informed of the Immediate Jeopardy (IJ) on [DATE] at 4:18 pm. The noncompliance related to the IJ was identified to have existed on [DATE].</p> <p>At the time of exit on [DATE], an acceptable Immediate Jeopardy Removal Plan had not been received; therefore, the Immediate Jeopardy remained ongoing.</p> <p>Findings include:</p> <p>Review of the job description titled Title: Licensed Nursing Home Administrator revealed Job summary: The primary purpose of the Nursing Home Administrator position is to oversee the day-to-day operation of the facility and to review organizational performance. Job Duties &amp; Responsibilities: Resident Care &amp; Quality of Life. Oversee that residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents. Working conditions: Maintains a liaison with residents, their families, support personnel, etc., to assure that the residents' needs are continually met.</p> <p>Review of the job description titled Title: Director of Nursing revealed Job Summary: The primary purpose of the Director of Nursing position is to plan, organize, develop and direct the overall operation of the Nursing Department to ensure that the highest degree of quality care is maintained at all times. Job Duties &amp; Responsibilities: Administrative Functions. Review and ensure that charting documentation procedures for nursing are met according to Vanguard, state, and federal guidelines. Nursing Care Functions: Review nurses' notes to ensure that they are informative, descriptive of the nursing care, and consistent with therapy care being provided, that they reflect the resident's response to the care, and that such care is provided in accordance with the resident's wishes. Make daily rounds to observe residents and to determine if nursing needs are being met in accordance with the resident's requests. Ensure that residents who are unable to call for help are checked frequently.</p> <p>Facility Administration, specifically the Administrator and the DON, failed to protect residents and effectively oversee areas of the facility that were included in their job descriptions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	

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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. The facility failed to ensure R1 was free from neglect by facility staff while he was experiencing respiratory distress, asking for help, and needing further medical treatment. R1 expired in the facility.</p> <p>Cross refer F600.</p> <p>2. The facility failed to notify the physician of a significant change in condition for R1 who exhibited shortness of breath, tripodding (leaning forward to maximize lung expansion), and had a decreased oxygen saturation reading of 83 percent on room air.</p> <p>Cross refer F580.</p> <p>Interview on [DATE] at 1:34 pm with Physician QQ revealed that a resident with an 83 percent pulse oxygenation should have been sent to the emergency room (ER) immediately and needed an advanced level of care. Physician QQ stated that R1 had no respiratory care needs, was cognitive, and could verbalize his needs and tell you what was wrong. Physician QQ further revealed that this was the first he had heard that R1 had expired and R1 was on his monthly follow-up for the next week. Physician QQ stated there was no excuse for this, and a Do Not Resuscitate (DNR) status does not mean withholding care.</p> <p>An interview on [DATE] at 2:12 pm with the DON revealed that R1 should have been sent to the hospital and the physician should have been called. The DON stated that she was not aware of R1's death circumstances. The DON further revealed that the RN Supervisor told her in the morning meeting that R1 had passed in his sleep and was a DNR.</p> <p>An interview on [DATE] at 3:18 pm with the Administrator revealed he was not aware of R1's death circumstances until the surveyor started interviewing the staff. The Administrator stated that once he was made aware, he held an Ad Hoc meeting and began education on notification and documentation of changes in condition and code status.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/11/2024
NAME OF PROVIDER OR SUPPLIER  Southland Healthcare and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  606 Simmons St Dublin, GA 31040	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34318</p> <p>Based on staff interviews, record reviews, and review of the facility policy titled Clinical Documentation, the facility failed to ensure clinical records contained complete and accurate documentation for one of seven sampled residents (R) (R1).</p> <p>Findings include:</p> <p>A review of the facility's policy titled Clinical Documentation, dated [DATE], revealed the section titled Clinical Documentation Overview stated, Facility nursing staff documents the provision of nursing care according to nursing standards and regulatory requirement. Documentation tools are designed to demonstrate the clinical care provided to the resident and to ensure the appropriate information is available to all interdisciplinary team members regarding treatment interventions and responses. Frequency of nursing documentation is based on resident clinical status, clinical need and regulatory requirements. Components of the nursing documentation proves include but are not limited to documentation in progress notes that reflect the ongoing clinical condition of the resident.</p> <p>A review of R1's Progress Notes dated [DATE] through [DATE] revealed an entry dated [DATE] that Licensed Practical Nurse (LPN BB) was alerted by staff to the resident's room in response to the resident being unresponsive. Upon entry to the room, the resident had no pulse noted and his eyes were closed with no respiration noted. The Director of Nursing (DON) was notified of resident status.</p> <p>A late entry dated [DATE] revealed Registered Nurse (RN) AA pronounced R1 deceased at 1:05 am.</p> <p>A review of R1's medical records revealed that there was no evidence of documentation of vital signs or documentation of the events prior to R1's death. The last documented vital signs were dated [DATE].</p> <p>In an interview on [DATE] at 7:49 pm, Certified Nursing Assistant (CNA) DD revealed on [DATE] around 8:30 pm, R1 asked for assistance. She stated she assisted him to the nurse's station, and two nurses assessed him, including checking his pulse, oxygenation, vital signs, and administering oxygen. She stated R1 exhibited sweating, shaking and holding his chest. She further stated the two nurses took R1 to his room and placed him in his bed.</p> <p>In an interview on [DATE] at 2:12 pm, the Director of Nursing revealed that staff should document during the shift and enter missing documentation within 24 hours.</p>