STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115384	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks - Carrollton Skilled Nursing, The	921 Old Newnan Road Carrollton, GA 30117

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50524 Based on record reviews, staff interviews, and review of the facility's policy titled, Care Plans, the facility failed to develop a Baseline Care Plan (BCP) for one of 29 sampled residents (R) (R190). Specifically, the facility failed to develop a baseline care plan that included narcotic administration. The facility census was 34. Findings include: Review of the facility's policy titled Care Plan revised 7/27/2023 documented under Procedure: New Admission Baseline Plan of Care: 1. Upon a new admission, a baseline care plan will be developed by admitting nurse/nurses in conjunction with other IDT, the patient/resident and /or patient/resident representative. The baseline care plan should be initiated in 24 hours and will be completed and implemented within 48 hours of admission. Review of Electronic Medical Records (EMR) revealed R190 was admitted on [DATE] with diagnoses including but not limited to chronic pain. Review of R190's Minimum Data Set (MDS) assessment dated [DATE] documented in Section C (Cognition) a Brief Interview for Mental Status (BIMS) score of 13, which indicated R190 had intact cognition, Section J (Health Condition) experiences pain frequently, Section N (Medications) receives opioids. Review of R190's care plan dated 11/8/2024 documented no focus areas for narcotic administration. Review of Physician Orders for R190 dated 11/7/2024 documented orders included but not limited to hydrocodone-acetaminophen - Schedule II tablet; 10-325 mg (milligrams); amt (amount): 1; oral Three Times A Day 08:00 AM, 12:00 PM, 08:00 PM for chronic pain. Neurontin (gabapentin) capsule; 400 mg; amt: 1; oral Three Times A Day 08:00 AM, 12:00 PM, 04:00 PM for chronic pain. Tizanidine tablet; 4 mg; amt: 1; oral Twice A Day - PRN (as needed) PRN 1, PRN 2 for chronic pain. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/14/2024 at 9:26 am with R190 revealed she stated she was admitted to the facility on e week ago. She stated she had constant pain which started after having cervical surgery and chronic lumbar problems. She stated she fell and fractured her right hip and right leg, so she had constant chronic pain. She stated she needed pain medication round the clock and if she did not get it on schedule, her pain got out of control. She stated the staff gives her pain meds on schedule and as needed. Interview on 11/14/24 at 9:39 am with the MDS Director revealed the BCP is to be initiated within 24 hours. Five care areas are to be initiated by nursing staff which includes falls, pain, activities of daily living (ADLs), discharge planning and advance directives. The MDS Director confirmed the BCP was not done. He stated the BCP was an initial driver which showed the direction towards the resident's goals. Interview on 11/14/2024 at 11:50 am with Licensed Practical Nurse (LPN) DD revealed she stated anybody can initiate the care plan and update it. She stated the night nurses usually did it for admissions but if they did not, MDS would check and update it. She stated if a resident's care plan was not updated, the outcome would be inconsistent in the care of the resident. Interview on 11/14/2024 at 11:56 am with the Director of Health Services (DHS) revealed she stated the nurses usually initiated and updated care plans and MDS followed up to ensure it was done. She stated if MDS did not follow up, she would do it. She stated she did not do the BCP for R190. She stated her expectations were for the nurses to update the care plan. She further stated doctor's orders still have to be followed and the care plan was done based on doctor's orders so the resident would not benefit from the doctor's orders if the care plan was not updated.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50524 Based on record reviews, staff interviews, and review of the facility's policy titled, Care Plans, the facility failed to review and revise a comprehensive care plan for one of 29 sampled residents (R) (R5) related to oxygen (O2) therapy. The deficient practice had the potential to cause R5 to not receive the necessary treatment required to provide and meet her needs. Findings include: Review of facility's policy titled Care Plans revised 7/27/2023 documented under Care Plan Review and Update: 1. Care Plan updated/ reviews will be performed within 7 days of each quarterly assessment, each acute change in condition, and as needed following each hospital stay. Review of electronic medical records (EMR) revealed R5 was readmitted to the facility on [DATE] with diagnoses including but not limited to pneumonia. Review of Minimum Data Set (MDS) dated [DATE] documented no information. Review of R5's care plan dated 10/7/2024 revealed no documentation for O2 administration since admission on 11/5/2024 to survey date 11/13/2024. Review of Physician's orders dated 11/9/2024 documented included but not limited to Oxygen: Oxygen at 2-3 LPM (liters per minute) via NC (nasal cannula) to keep sats (oxygen saturation) 90% and above PRN (as needed) Every Shift Days 07:00 AM - 03:00 PM, Evenings 03:00 PM - 11:00 PM, Nights 11:00 PM - 07:00 AM. Review of Nurses Progress Notes dated 11/9/2024 documented Received nurse report on resident returning to facility with DX (diagnosis) Pneumonia and A-Fib (Atrial Fibrillation). New medications updated on MAR (Medication Administration Record) and Dr (doctor) notified. Interview on 11/14/2024 at 9:31 am with MDS Director revealed he stated the nurses initiated care plans on admission and he checked the care plans to ensure it was done. He confirmed the care plan for R5 did not include O2 administration since her readmission to the facility on [DATE]. He stated if the care plan was not updated, the outcome could be delay in care of the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50524 Based on observations, staff interviews, and review of the facility's policy titled, Controlled Substances for HealthCare Centers, the facility failed to maintain the correct narcotic count for one of 29 sampled residents (R) (R190). The deficient practice had the potential to cause drug-control issues and potentially cause negative effects for residents. The facility census was 34. Review of the facility's policy titled Policy Controlled Substances for HealthCare Centers revised 4/30/2024 documented under Policy Statement: . Reconciliation of controlled substances will be performed at the end of each shift by licensed professional nurses . Under Accounting: 1. A physical inventory of all controlled substances is conducted at each shift change by the incoming and outgoing licensed professional nurses. 2. The inventory is documented on the Controlled Drug Shift Audit Sheet. Review of Electronic Medical Records (EMR) revealed R190 was admitted on [DATE] for diagnosis including but not limited to chronic pain. Review of R190's Minimum Data Set (MDS) assessment dated [DATE] documented in Section C (Cognition) a Brief Interview for Mental Status (BIMS) score of 13, which indicated R190 had intact cognition, Section J (Health Condition) experiences pain frequently, Section N (Medications) receives opioids. Review of R190's care plan dated 11/8/2024 documented no focus areas for narcotic administration. Review of Physician Orders dated 11/7/2024 documented orders included but not limited to hydrocodone-acetaminophen - Schedule II tablet; 10-325 mg (milligram); amt (amount): 1; oral Three Times A Day 08:00 AM, 12:00 PM, 08:00 PM for chronic pain. Neurontin (gabapentin) capsule; 400 mg; amt: 1; oral Three Times A Day 08:00 AM, 12:00 PM, 04:00 PM for chronic pain. Tizanidine tablet; 4 mg; amt: 1; oral Twice A Day - PRN PRN 1, PRN 2 for chronic pain. Observation and interview on 11/13/2024 at 12:50 pm revealed during medication administration Licensed Practical Nurse (LPN) AA checked doctor's orders and removed Hydrocodone/acetaminophen 10-325 mg 1 tablet from the medication card and administered it to R190. There were 45 tablets left on the medication card, but the narcotic book documented 46 tablets remaining. The discrepancy was pointed out to LPN AA who stated she was not aware of the discrepancy, and she recounted the tablets and checked the narcotics book again. She confirmed there were 45 tablets left on the medication card, but the narcotic book documented 46 tablets remaining. She stated she did not count the tablets on the medication card at change of shift that morning and she only signed the narcotics book. Interview with the Director of Health Services (DHS) revealed she confirmed there were 45 tablets left on the medication card, but the narcotic book documented 46 tablets remaining. She stated her expectation was that the nurses should count the narcotics and document each count at change of shifts in the Controlled Drug Record. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/2024 at 5:25 pm with the Administrator revealed she stated her expectations were for the oncoming nurse to check off the narcotics with the outgoing nurse at change of shift. She stated the nurse should ensure the pill count was correct, and it matched the count documented in the narcotic controlled drug log. It was to be signed off by both nurses and if the count was off, the DHS was to be notified. She stated if the narcotics count was not correct, the outcome could be a potentially negative affect for the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49674 Based on observation, staff interviews, and review of the facility policy titled, Food Ordering, Receiving, and Storage, the facility failed to ensure opened food items were dated. This deficient practice had the potential to affect residents receiving an oral diet. The census was 34. Findings include: Review of the facility policy titled, Food Ordering, Receiving, and Storage, reviewed 8/3/2017, revealed the Storage and Rotation Guideline section stated the facility must date and store all food items received on delivery day. During the initial Kitchen tour on 11/12/2024 at 9:50 am with the Dietary Manager (DM), observation of the walk-in freezer revealed an unlabeled and undated opened bag of frozen sweet potatoes. Observation of the walk-in refrigerator revealed an unlabeled and undated open block of Swiss cheese and one unlabeled and undated carton of heavy cream. During an interview on 11/13/2024 at 1:35 pm, the DM confirmed the unlabeled and undated food items and stated the Dietary [NAME] and Dietary Aides were responsible for labeling, dating, and proper storage of food. She further stated food items should be labeled with storage and opened dates when stored and opened. She stated labeling and dating food items was critical to maintaining food safety.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50524 Based on observations, staff interviews, and review of the facility's policy titled, Medication Administration: Hand Hygiene, the facility failed to maintain infection control practices by not ensuring hand hygiene during two of three medication administration observations. This deficient practice had the potential to increase the potential for cross-contamination and spread of infection. The facility census was 34. Findings include: Review of the facility's policy titled, Medication Administration: Hand Hygiene, review date 10/14/2024, documented Policy Statement: It is the policy of (name of facility) Pharmacy Services that partners will use appropriate hand hygiene during medication administration. Appropriate hand hygiene reduces the spread of germs and decreases the spread of infections. The Procedure section included 1. During medication administration, use hand hygiene before and after touching a patient . after touching a patient's immediate surroundings, and before and after glove removal. Observation on 11/13/2024 at 9:06 am revealed Licensed Practical Nurse (LPN) AA did not hand sanitize before and after administering medications to the residents during the medication pass. Observation on 11/13/2024 at 12:35 pm revealed LPN BB did not hand sanitize before and after administering medications to the residents during the medication pass. In an interview on 11/13/2024 at 1:27 pm, LPN AA confirmed she did not use hand sanitizer or wash her hands before and after administering medications to the residents. She stated she should have hand sanitized because it gets rid of germs and prevents germs from being carried to the residents or between them. In an interview on 11/13/2024 at 1:31 pm, LPN BB confirmed he did not sanitize his hands before and after administering medications to the residents. He stated he did not hand sanitize consistently, and sanitizing hands consistently was about infection control and preventing infection from person to person. He stated it was important to prevent residents from getting infections. In an interview on 11/13/2024 at 1:40 pm, the Director of Health Services (DHS) stated her expectations were for the staff to practice hand washing and sanitizing hands during the care of the residents and for the nurses to sanitize or wash their hands during medication administration. She stated the outcome of not performing hand hygiene could spread germs from one person to another.