STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115403	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quinton Mem Hc & Rehab Center	1115 Professional Blvd. Dalton, GA 30720

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 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, staff and resident interviews, record review, and review of the License Practical Nurse and Registered Nurse (Charge Nurse) Job Descriptions, the facility failed to ensure residents received care in accordance with physician orders for one of 39 sampled residents (R) (R6). Specifically, the facility failed to ensure lab tests, and assessment of hemorrhoids were conducted as ordered by the physician. The deficient practice had the potential to place R6 at increased risk of adverse clinical outcomes related to blood loss.Findings include:Review of the facility's Licensed Practical Nurse (LPN) and Registered Nurse (RN) job descriptions documented, Reviews duties of collection of lab specimens and interpreting results. Maintain effective lines of communication with attending physicians. Charting of information regarding patient progress, ailments, medication symptoms, and observations. Addresses with supervising nursing staff, the progress of patients and how to proceed with care. They may be required to perform physical assessments of patients under the RN's direction. They may be required to draw blood and obtain fluids to submit for lab work.Review of the electronic health record (EHR) revealed R6 was admitted to the facility on [DATE] with diagnoses including, but not limited to, condition end stage renal disease, chronic obstructive pulmonary disorder (COPD) and dependency on renal dialysis.Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R6 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated severe cognitive impairment. Section I, Active Diagnoses, lists R6 primary medical condition as end stage renal disease, chronic obstructive pulmonary disorder (COPD) and dependency on renal dialysis.Review of the care plan revised 07/22/2025 revealed R6 had a Focus on anemia with a documented Goal, which was revised on 04/29/2026 and stated, Resident will remain free of signs and symptoms of complications related to anemia through review date. Interventions included, but not limited to, Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated.Review of the physician orders dated 05/08/2026 for R6 revealed the following:CBC & CMP {complete blood count test for anemia and complete metabolic panel test for overall body function status}Occult Stool {test for blood in the stool}Nursing to assess patient for external hemorrhoids and unusual bleeding.Review of the EHR, including the Lab Summary for R6 dated May 2026 revealed, there was no lab testing obtained as ordered on 05/08/2026.Review of the EHR revealed there was no documented assessment by nursing for R6 involving external hemorrhoids and bleeding as ordered on 05/08/2026.On 05/20/2026 at 3:50 PM, the Assistant Director of Nursing (ADON) confirmed that nurses are responsible for ensuring that orders and care plans are followed. She stated that it was her expectation that nursing staff were to receive and acknowledge orders from the nurse practitioner and medical director. The ADON stated the expectation was nurses were to perform orders, review findings and share with the medical team.Interview with the Nurse Practitioner (NP) on 05/21/2026 at 11:15 AM, the NP stated her expectation for performance of orders was that they were conducted with residents as ordered or NP was notified of delay reasons, unless the order was for a stat {immediate} lab. The NP stated typically they should be done within a few hours of order placement. She indicated that stool samples can take some time based on the resident's status. She added that she does a monthly check on those with chronic conditions, noting any changes of condition. The NP (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	added that the medical team was made aware of delays or failures to collect labs as ordered. She stated she was aware of the situation with the orders for R6 and a review was being conducted.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of facility's electronic Work Order system's cleaning schedule titled, Oxygen Concentrators: In-House Maintenance, the facility failed to ensure respiratory equipment was maintained in a clean and sanitary manner by not cleaning the oxygen concentrator filter for two of 30 residents (R)(R58 and R67), on respiratory care. This deficient practice had the potential to cause ineffective oxygen delivery, respiratory complications, and increased risk of infection.Findings Include:Record review of facility's electronic Work Order System's cleaning schedule titled, Oxygen Concentrators: In-House Maintenance, dated 05/15/2026 documented under section titled, Cleaning the Cabinet Filter - Risk of Damage: To avoid damage to the internal components of the unit: DO NOT operate the concentrator without the filter installed or with a dirty filter. 1. Remove the filter and clean as needed. 1. Environmental conditions that may require more frequent inspection and cleaning of the filter include, but are not limited to: high dust, air pollutants, etc.1. Record review of the Electronic Health Record (EHR) revealed R58 was admitted on [DATE] with diagnoses including, but not limited to, chronic diastolic (congestive) heart failure, chronic respiratory failure with hypercapnia obstructive sleep apnea (adult) (pediatric), pulmonary hypertension, unspecified, personal history of covid-19, essential (primary) hypertension, and paranoid schizophrenia.Record review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented R58 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated little to no cognitive impairment. The MDS further revealed the resident was dependent on staff for activities of daily living and received oxygen therapy services.Record review of physician orders dated 04/01/2025 revealed an active order for oxygen at 2 liters per minute via nasal cannula continuously, with additional orders to change oxygen tubing and nasal cannula or mask as needed.Record review of the resident's care plan revealed an active problem for oxygen use related to a focus of congestive heart failure and a risk for complications with interventions to administer oxygen per physician order.Initial screening observation on 05/19/2026 at 12:10 PM revealed R58's oxygen concentrator built-in filter dirty with significant amount of brown, fuzzy particulate matter.Observation on 05/20/2026 at 10:15 AM revealed the built-in filter on R58's oxygen concentrator was dirty with a significant amount of brown, fuzzy particulate matter.Observation on 05/20/2026 at 1:13 PM revealed the built-in filter on R58's oxygen concentrator was dirty with a significant amount of brown, fuzzy particulate matter.2. Record review of the EHR revealed R67 was admitted on [DATE] with diagnoses including, but not limited to, chronic respiratory failure with hypoxia, type 2 diabetes mellitus with diabetic polyneuropathy, chronic obstructive pulmonary disease, unspecified, pulmonary hypertension, unspecified acute on chronic diastolic (congestive) heart failure, essential (primary) hypertension, chronic kidney disease, stage 3b.Record review of the Quarterly MDS dated [DATE] documented R67 had a BIMS score of 15, which indicated little to no cognitive impairment. The MDS further revealed the resident was dependent on staff for activities of daily living and received oxygen therapy services.Record review of physician orders dated 03/31/2025 revealed an active order for oxygen at 2 liters per minute via nasal cannula continuously, with additional orders to change oxygen tubing and nasal cannula or mask as needed.Record review of the resident's care plan documented an active problem for oxygen use related to a focus of congestive heart failure and a risk for complications with interventions to administer oxygen per physician order.Initial screening observation on 05/19/2026 at 10:46 AM revealed R67's oxygen concentrator's spongy foam intake filter was dirty with a significant amount of gray, fuzzy particulate matter.Observations on 05/20/2026 at 1:17 PM revealed R67's oxygen concentrator's spongy foam intake filter was dirty with a significant amount of gray, fuzzy particulate matter.Observation and interview on 05/20/2026 at 1:20 PM with Unit Manager/Licensed Practical Nurse (LPN)AA stated the nursing staff were responsible for changing out the oxygen tubing, nasal cannula, mask, and replacing equipment bags weekly. She stated they should check all (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other parts of the concentrator for cleaning purposes. She stated that all their residents should have a physician's orders stating to change oxygen tubing, nasal cannula, and mask every 30 days or as needed. She stated they kept a record of them completing the task on the residents' Medication Administration Record (MAR). She stated they clean the spongy style and/or built-in filters both with soap and water. LPN AA confirmed R58 and R67's oxygen concentrator filters were unclean with a thick gray, fuzzy particulate matter.Observation and interview on 05/20/2026 at 1:40 PM with Assistant Director of Nursing (ADON) confirmed R58 and R67's oxygen concentrator filters were unclean with a thick gray, fuzzy particulate matter. The ADON stated she was not for sure why LPN AA stated the nursing staff were responsible because she indicated the maintenance staff was responsible for cleaning the oxygen concentrators normally with a small portable vacuum cleaner. She stated the Maintenance Director (MD) could provide a routine cleaning schedule for the tasks that were recorded on their maintenance system called [name of electronic Work Order system.] Interview and observation on 05/20/2026 at 3:00 PM with MD mentioned there was a lot of patient care rounding being done at the same time as they are doing their routine cleaning. He stated the dirty equipment must have been an oversight that caused the residents' equipment routine cleaning to get missed.Interview 05/21/2026 at 12:52 PM with the Administrator revealed she was unaware that the oxygen concentrators' filters needed to be cleaned. She further provided an oxygen concentrator routine cleaning list from the electronic Work Order system, which indicated the task was completed by the MD on 05/15/2026.