STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115412	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Tifton	1451 Newton Drive Tifton, GA 31794

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 - 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. 34318 Based on observations, medical records, and staff interviews, the facility failed to implement the care plan related to wound treatment for two of three sampled residents (R1 and R3) who had stage IV wounds. Harm was determined to have occurred on 3/5/2025 when R1 and R3 experienced pain that was not addressed during wound care treatment. Findings included: 1. A review of the electronic medical record (EMR) revealed R1 was admitted to the facility with the following diagnoses including but not limited to type 2 diabetes mellitus, chronic gout, metabolic encephalopathy, pressure ulcer, hypertensive heart disease, dementia, pain, and glaucoma. A review of the care plan dated 1/21/2025 revealed that R1 had a stage 4 pressure wound to her coccyx with the following interventions/tasks: conduct weekly skin inspections and treatments as ordered. Further, R1 had a pain care plan dated 1/21/2025 which revealed that R1 has chronic pain related to her disease process. The interventions included monitoring and documenting the probable cause of each pain episode, removing and limiting causes of pain where possible, and administering medications per orders. During an observation on 3/5/2025 at 10:39 pm, Licensed Practical Nurse (LPN) CC and LPN DD were observed providing wound care for R1. During this observation, R1 was moving her body away from the nurses' hands that were touching the wound. The resident was moaning and verbalizing, Oh, oh. However, during wound care, LPN CC and LPN DD did not acknowledge R1's pain and LPN CC continued to complete the dressing change. During an interview on 3/11/2025 at 2:11 pm, LPN DD revealed that when a resident has pain, the staff are supposed to stop and administer pain medication. During an interview on 3/11/2025 at 2:17 pm, LPN CC confirmed that she was a wound care nurse. She revealed that she should have stopped the treatment when R1 expressed pain and asked R1 if she had anything for the 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 0656 Level of Harm - Actual harm Residents Affected - Few	2. A review of the admission record revealed R3 was admitted to the facility with diagnoses including but not limited to chronic obstructive pulmonary disease, type 2 diabetes mellitus, cirrhosis of the liver, emphysema, atherosclerotic heart disease of native coronary, hypertensive heart disease, and fibromyalgia. A review of the care plan dated 11/27/2024 revealed that R3 had acute/chronic pain related to depression, postoperative discomfort, and wounds. The intervention/task was to administer analgesia as per orders; to give half an hour before treatment or care; anticipate her need for pain relief; and respond immediately to any complaint of pain. A review of the EMR revealed that R3 did not have an order for pain medication until she was enrolled in hospice services on 3/5/2025 after her wound treatment. During an observation on 3/5/2025 at 11:04 am, LPN CC removed the dressing from the coccyx area of R3. As the dressing was being removed, R3 was moaning and grimacing, and LPN DD continued to peel the dressing from the resident's lower buttock. The resident was swarming in bed, trying to move away from the removal of the dressings. The resident started complaining about her face on the bed rail and LPN DD told the resident that they (LPN CC and LPN DD) were just about done. During an interview on 3/12/2025 at 3:24 pm, the MDS Registered Nurse (RN) FF revealed that staff are supposed to follow the pain management care plan and that she did not know why it was not being followed. Cross Reference F697

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34318 Based on observations, record review, staff interviews, and a review of the facility policy titled Administering Pain Management, the facility failed to ensure that two of three sampled residents (R) (R1 and R3) were free from pain during wound care treatment. Harm was determined to have occurred on 3/5/2025 when R1 and R3 experienced pain that was not addressed during wound care treatment. Findings included: A review of the undated policy titled Administering Pain Management, it was documented that the pain management program was based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. It was noted that Pain Management was defined as the process of alleviating the resident's pain based on his/her clinical condition and established treatment goals and that Pain Management was a multidisciplinary care process that included the following: assessing the potential for pain; recognizing the presence of pain; identifying the characteristics of pain; and addressing the underlying causes of the pain. 1. A review of the electronic medical record (EMR) revealed that R1 was admitted to the facility with diagnoses of type 2 diabetes mellitus, chronic gout, metabolic encephalopathy, pressure ulcer, hypertensive heart disease, dementia, pain, and glaucoma. During an observation on 3/5/2025 at 10:39 am, R1 was lying in bed on an airflow mattress with bilateral assistive rails in the upper position and had a wedge and a pillow for positioning. Wound Nurse/Licensed Practical Nurse (LPN) CC was being assisted by LPN DD and Certified Nurse Certified (CNA) SS to provide the resident with wound care treatment. LPN CC washed her hands, and CNA SS removed the resident brief and provided perineal care. The wound bed was 80% yellowish slough and 20% reddish granulation. LPN CC cleaned the wound with wound cleanser, and while cleaning the wound, R1 was observed voicing, Ouch, ouch, ouch. That hurts. LPN CC continued to obtain wound measurements of 8.5L x 3.1W x 4.7D. LPN CC began checking for undermining using her finger and again the resident began saying, Oh, oh and tried moving away from LPN CC's hand. LPN DD told R1 to take a deep breath and that it was almost over. LPN CC continued applying the Dakin solution on a kerlix and packing the Dakin-moistened kerlix into the wound bed. LPN CC then placed an adhesive border dressing over the moistened kerlix. R1 continued squirming on the bed throughout the dressing change (moving away from the nurse's hands). Further observation revealed a sign on R1's door documenting that enhanced barrier precautions were in place. LPN CC, LPN DD, and CNA SS were not wearing a gown as they performed wound care and/or perineal care. A review of the Order Summary Report dated 3/5/2025 revealed R1 had an order for Tylenol 325 milligrams (mg) tablet, to administer two tablets orally every six hours as needed for pain related to pressure ulcer of the sacral region with an order and start date of 3/4/2025. A review of the Medication Administration Record (MAR) dated 3/1/2025 through 3/31/2025 revealed no evidence that Tylenol was administered. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	2. A review of the EMR revealed that R3 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, cirrhosis of the liver, emphysema, atherosclerotic heart disease of native coronary, hypertensive heart disease, and fibromyalgia. During an observation on 3/5/2025 at 11:04 am, an enhanced barrier precaution sign was posted on R3's door. The resident was observed lying on an airflow mattress with bilateral quarter-side rails in the up position. R1's designated Power of Attorney (POA) was also in the room. LPN CC and LPN DD entered the room and neither nurse was wearing a protective gown. The nurses repositioned the resident turning her to face the door and R3's face was pressing against the quarter side rail. LPN CC removed the dressing from R3's coccyx area and as the dressing was being removed the resident was moaning and grimacing in pain. The resident wound bed was observed with red granulation. The nurse cleaned the wound bed with wound cleaner; obtained measurements 4.0L x 31W; and LPN DD began peeling an adhesive dressing from the right lower buttock. As she was peeling the dressing from the resident skin, the resident began squirming in bed, trying to move away from the removal of the dressing. LPN DD stated that the wound was not open yesterday and that she would call hospice to inform them of the opening of the lower right buttock wound. LPN CC measured the lower right buttock wound and obtained measurements (7.3L x 2.1). The upper part of the wound was red, and the lower half of the wound was dark red. The resident started complaining about her face being pressed against the bed rail, and LPN DD told the resident that they were just about done. The POA, who was standing at the head of the bed, put her hand between the rail and the resident's face. LPN CC began to skin-prep the outer skin surrounding the wound bed, placed calcium alginate on the wound bed, placed a 4x4 gauze over the wound, and covered the area with an adhesive dressing. A review of the order summary report dated 3/5/2025 revealed a wound order to clean R3's coccyx with normal saline, skin prep, alginate calcium, and dressing with border gauze once a day (every Tuesday, Thursday, and Saturday.) There was an order for pain medication of hydrocodone-acetaminophen tablet 10-300 mg that was discontinued on 11/6/2024; Tramadol 50 mg that was discontinued on 9/21/2023, and hydromorphone HCL tablet 4 mg that was discontinued on 10/21/02021. There was no active order for pain medication until R3 was admitted to hospice care on 3/5/2025 later in the afternoon after the wound care treatment. During an interview on 3/5/2025 at 11:33 am, R3 confirmed that she was uncomfortable and that the wound treatment hurt. During an interview on 3/11/2025 at 12:55 pm, the Nurse Practitioner (NP) revealed that staff should be educated on pre-medication and the stages of wounds and that she will follow up on residents with wounds for pain management. During an interview on 3/11/2025 at 2:11 pm, LPN DD revealed that when a resident has pain during wound care treatment, the staff are supposed to stop the treatment and administer pain medication; call the NP for an order for pain medication and send the order to the pharmacy; or if the physician sends a prescription in, the pharmacy will allow nurses to get the pain medication from the pixel as soon as the doctor signs the prescription. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/11/2025 at 2:17 pm, LPN CC revealed that she should have stopped and asked R1 if she needed anything for pain. LPN CC confirmed that she had not assessed R1 or R3 for pain. LPN CC stated that she was focused on the wound care treatment and that is why she did not administer pain medication to R1 or get an order for pain medication for R3. During an interview on 3/12/2025 at 1:26 pm, the Director of Nursing (DON) revealed that the staff should have assessed the residents for pain and determined the cause of the pain. Cross Reference F 656

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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. 34318 Based on observations, record review, staff interviews, and a review of the facility policy titled Infection Prevention and Control Program, the facility failed to ensure that the staff wore the appropriate personal protective equipment (PPE) while providing care for three of three sampled residents (R) (R1, R2, and R3) during wound care and perineal care. Findings included: A review of the Infection Prevention and Control Program dated 5/23/23 and last revised on 3/1/2024, revealed that it is standard precaution that all staff shall use PPE according to established facility policy governing the use of PPE. A review of the Enhanced Barrier Precautions (EBP)sign noted that doctors and staff must wear gloves and a gown for high-contact resident care activities such as dressing, bathing/showering, transferring, changing lines, providing hygiene, changing briefs, assisting with toileting, device care or use of a central line, urinary catheter, feeding tube, tracheostomy, wound care, and any skin opening requiring a dressing. It was further noted that staff are not to wear the same gown and gloves for the care of more than one person. 1. A review of the electronic medical record (EMR) revealed that R1 was admitted to the facility with diagnoses of type 2 diabetes mellitus, chronic gout, metabolic encephalopathy, pressure ulcer, hypertensive heart disease, dementia, pain, and glaucoma. During an observation on 3/5/2025 at 10:39 am, there was a sign on the outside of R1's door that read, Enhanced Barrier Precautions. R1 had a bowel movement and Certified Nurse Aide (CNA) SS performed perineal care. R1 had a stage IV coccyx pressure ulcer. Licensed Practical Nurse (LPN) CC and LPN DD provided wound care. CNA SS, LPN CC, and LPN DD did not wear a protective gown during the observations. During an observation on 3/11/2025 at 11:24 am, CNA GG was assisting CNA HH in providing perineal care to R1. During the observation, CNA HH and CNA GG were not wearing protective gowns. While CNA HH and CNA GG were providing perineal care, LPN CC came into the room and replaced the soiled dressing. LPN CC was not wearing a protective gown. During an interview on 3/11/2025 at 3:21 pm, CNA HH revealed she didn't have a gown because she didn't read the sign on the door and had not seen any PPE by the door. During an interview on 3/11/2025 at 12:47 pm, CNA GG revealed that she should have put on the protective gown but that she didn't think about it. 2. A review of the ERM revealed that R2 was admitted to the facility with diagnoses of type 2 diabetes mellitus, hypertension, pressure ulcer of sacral stage 4, and pleural effusion. It was revealed in the EMR that R2 was on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/5/2025 at 2:01 pm, LPN CC was providing wound care to R2 and was not wearing a protective gown. During an interview on 3/11/2025 at 2:17 pm, LPN CC revealed that she did not know why she didn't put on a gown. 3. A review of the EMR revealed that R3 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, cirrhosis of the liver, emphysema, atherosclerotic heart disease of native coronary, hypertensive heart disease, and fibromyalgia. During an observation on 3/5/2025 at 11:04 am, there was an EBP sign on the door. The Wound Care Nurse/LPN CC was being assisted by LPN DD. They were providing wound care treatment to R3. Neither LPN CC nor LPN DD were wearing protective gowns during the observation of the wound care treatment. A review of the Order Summary Report dated 3/5/2025 revealed an order date and start date for Enhanced Barrier Precautions: Resident is placed on this precaution due to having a colostomy and a wound. The use of PPE when providing care in high-contact resident care activities where gowns and gloves are appropriate, two times a day. During an interview on 3/11/2025 at 2:11 pm, LPN DD revealed that she had no answer for why she didn't put on the protective gown and stated that she just forgot. During an interview on 3/11/2025 at 2:17 pm, LPN CC revealed she didn't know why she didn't put on a protective gown. During an observation on 3/3/2025 at 11:29 am, observed a staff (identified as AA) with a cart loaded with boxes of gloves. She went into the residents' room and brought out partially empty glove boxes to her cart took an open box of gloves on the cart took gloves out with her bare hand and stuffed gloves into the box brought from the residents. If the resident had an empty box, she would replace it with a full box. She continued to go into each resident's room either stuffing gloves with her bare hand into partially empty boxes or placing a box of gloves in the room in the absence of a box of gloves in the room. AA was observed going into each resident's room in the halls and annexes. During an interview on 3/12/2025 at 1:55 pm, Infection Control Preventionist/Registered Nurse (RN) QQ stated that they had one box containing 50 gowns in the outside shed. During an observation on 3/12/2025 at 1:58 pm, two boxes of 50 protective gowns were observed in the medication room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/11/2025 at 3:38 pm, Central Supply/Medical Record AA revealed that if the glove boxes have four or five gloves, she will replace the entire box with a new box of gloves. If the box was half full and two boxes were the same size, she would take one box out and put the half-full box in another room. If the gloves box is less than half full, she would put the gloves from the box on the cart and put the gloves in the box that came from the room. She stated that she was not wearing gloves when transferring gloves into another glove box. She confirmed that the resident rooms had hand sanitizer, but she didn't use it. She continued to state that she normally does the glove boxes twice a week unless they (the staff) use a lot of gloves. She stated that she would order some, keep a few supplies in the medication room, and keep some in the shed. She had two or three cases of gown and had recently ordered two more cases. During an interview on 3/12/2025 at 2:47 pm, the Administrator revealed that the staff will be retrained on the use of PPE and keeping a clean cart.