

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Oaks - Athens Skilled Nursing, The		STREET ADDRESS, CITY, STATE, ZIP CODE  490 Kathwood Dr Athens, GA 30607	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44757</b></p> <p>Based on observations, staff interviews, and review of the facility policy's titled, Oxygen Safety and Storage , Respiratory Equipment Changeouts, and the Procedure: Transferring a Resident Using a Mechanical Lift, the facility failed to ensure an environment free of accident hazards related to the handling and storage of Oxygen cannisters. In addition, the facility failed to use a mechanical lift device according to facility procedure and the manufacturer recommendation when transferring R100 via mechanical lift. The facility census 112.</p> <p>Findings include:</p> <p>1. Review of the facility policy titled, Oxygen Safety and Storage revised 5/9/2023, documented the policy statement as the facility will ensure that Oxygen is administered and stored safely within the healthcare centers or outside storage areas. Procedure: Safety: Number 3. Do not fasten an oxygen tank to a patients/resident's bed. Tanks in use must either be installed on a stable, wheeled dolly or on an oxygen tank stand.Storage .Number 3. Oxygen tanks that are considered in use (regulator attached) should be stored in a rack or carrier in an upright position with the regulator off. Oxygen tanks should never be stored lying down. Number 6. Oxygen tanks shall be protected from tampering by unauthorized individuals. Number 8. Empty oxygen tanks shall be adequately separated from full tanks. Empty and Full tanks shall be marked to avoid confusion and delay if a full tank is needed quickly.</p> <p>A review of the facility policy titled, Respiratory Equipment Changeouts revised 1/25/2022 revealed Procedure: The Respiratory Therapist will change circuits and O2 therapy equipment per the following guidelines: .Oxygen Therapy Equipment: (Can be changed out by Charge Nurse or designee).</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 1/28/2025 from 3:02 pm to 3:12 pm, Certified Nursing Assistant (CNA) KK entered room [ROOM NUMBER] in response to the call light button being pressed. She donned appropriate personal protective equipment (PPE). She stuck her head outside of R20's room to ask surveyor to bring her an oxygen tank from the storage closet. Surveyor respectfully declined stating surveyor does not work for the facility. At that time CNA KK doffed her PPE, and exited the room. Certified Nursing Assistant KK proceeded to the oxygen storage closet and retrieved an oxygen tank from the storage closet. Upon leaving the storage closet halfway back to R20's room, CNA KK inspected the oxygen tank whispering, that it [the oxygen tank] was not full. She walked back to the oxygen storage closet and sat the oxygen tank down on the floor at the door and then retrieved a full oxygen tank. She left the half-empty tank outside the storage closet sitting on the floor, while she carried the full oxygen tank to R20's room door sitting it on the floor in order to put on PPE. CNA KK then dragged the tank across the floor into R20's room. At 3:12 pm CNA KK dragged the oxygen tank that had been in front of the oxygen storage closet down the hall, then came back to the storage door with the oxygen tank in her hand, putting the half empty oxygen tank back in the oxygen storage closet.</p> <p>Interview on 1/28/2025 at 3:15 pm, CNA KK revealed she switched out the oxygen tanks because the first oxygen tank was halfway empty and she was trying to make sure the resident got her oxygen on time which is why she did not put the half full oxygen tank back immediately. She further revealed she left the hall with the half full oxygen tank to ask the nurse if it should be put where the empty tanks should be. She revealed the nurse advised her no because someone else could use what is left in there which is why she put it back in the closet.</p> <p>Interview on 1/30/2025 at 3:13 pm, with Licensed Practical Nurse (LPN) JJ revealed LPN's and Registered Nurses (RN's) are able to administer the oxygen. LPN JJ stated the oxygen tanks have to be put in a canister and at that point, they will go to the resident and hook the tubing up. She revealed that if a tank is not completely empty she does not know where to put it and has never been given the answer as to what to do. She further revealed the nurses can be very bad about checking the room and not returning the canisters to where they should be.</p> <p>Interview on 1/30/2025 at 3:36 pm with Charge Nurse, LPN FF revealed only licensed nurses (LPNs or RNs) can give the tanks to the residents. She further revealed that CNA's are not allowed to carry the tanks to the room or touch the tanks. The nurses will get the tank and make sure that it is filled and turn it on, they will pick it up and carry it to the resident's room. During further interview, she stated when the oxygen therapy is completed the tank is moved out of the room and put in the empty oxygen tank room. She stated that the CNA's can move the empty tanks to the empty tank storage room. LPN FF stated in order for the resident to be safe it is better for the nurse to get the tank and make sure it is turned on properly.</p> <p>Interview on 1/30/2025 at 4:39 pm with the Director of Nursing (DON) revealed when the staff realized she was not going to use the tank she should have put it back in the oxygen storage closet at that time. The DON revealed normally the CNA's are not able to handle the oxygen tanks. In addition, the DON added, this could have been devastating, causing an explosion or fire or could injure anyone if the oxygen tank would have fallen.</p> <p>50878</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the procedure titled Transferring a Resident Using a Mechanical Lift dated 2019, revealed 28 steps to transferring a resident using a mechanical lift. Considerations: The mechanical lift is a two-person device. One caregiver should never use it alone. After opening the spreader bar, lock the legs in position. Push one side inward with your foot to ensure the legs will not close. If the legs move under pressure, do not move the lift.</p> <p>Review of the electronic medical record (EMR) revealed R100 was admitted to the facility on [DATE] with diagnoses of but not limited to respiratory distress, cerebral vascular accident (CVA), dysphagia, gait abnormality, chronic obstructive pulmonary disease (COPD), diabetes, encephalopathy, and hyperlipidemia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score was coded as 15, which indicated no cognitive impairment. Section GG-Functional Abilities and Goals Status revealed resident requires two-person mechanical lift for most activities and is dependent on staff for all activities of daily living (ADL).</p> <p>Review of incident reports revealed that the fall occurred on 11/6/2024 at 4:52 pm and was described as resident was lowered to the floor by CNA BB and included but is not limited to CNA CC holding chair, braced fall and lowered resident to the ground. Hoyer then tipped and knocked CNA BB to the floor.</p> <p>Review of x-ray of the spine dated 11/6/2024 revealed images are not conclusive for damage from fall due to other issues with spine making viewing difficult.</p> <p>During interview with R100 on 1/28/2025 at 1:28 pm revealed she is totally dependent on the care staff for all ADLs. She stated that approximately three months ago she fell from a mechanical lift while being taken out of shower chair. She revealed Certified Nursing Assistant (CNA) BB operated mechanical lift while CNA CC held onto the shower chair. R100 stated the mechanical lift tipped over and she fell to the floor with strap bar hitting her in the face. She stated that CNA BB fell as well. During further interview, R100 stated the Floor Manager came into the room immediately following the fall and asked why CNA CC had not locked the shower chair wheels and been assisting with mechanical lift operation.</p> <p>During an interview on 1/28/2025 at 11:25 am, with CNA BB, she stated she had not been properly trained on the mechanical lift. She stated that following the accident she was told that the legs should have been spread for balance and that this was not included in the training she had.</p> <p>During an interview on 1/28/2025 at 5:15 pm with Unit Manager DD confirmed resident had experienced a fall but was found uninjured after x-ray of her spine following the accident.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49140</p> <p>Based on observations, record review, resident and staff interviews, the facility failed to provide sufficient nursing staff to provide for the needs of 3 out of 122 residents (R251, R114 and R718) in a timely manner. This failure had the potential to cause resident care needs to be delayed.</p> <p>Findings:</p> <p>1. R251 was admitted to the facility on [DATE] and discharged on [DATE]. Her diagnoses were unspecified fracture of right femur and multiple fractures of pelvis without disruption of pelvic ring.</p> <p>Review of R251's discharge Minimum Data Set (MDS) assessment dated [DATE] indicated a BIMS of 15. Mood severity score of two. No behaviors and independent for most activities of daily living (ADLs) and always incontinent of bowel and bladder with presence of surgical wound.</p> <p>Review of care plan for R251 dated 1/2/2025 included risk for complication related to recent orthopedic surgery, requires assistance for all activities of daily living related to weakness, injury, and debility. She was care planned for urinary and bowel incontinence, and she was identified as having the potential for skin breakdown related decreased mobility, incontinence, and obesity.</p> <p>Interview with family of R251 on 1/29/2025 revealed concerns related to R251's untimely response to incontinence as it relates to the recent surgical wound. Specifically, the family stated that on 1/3/2025, During the day she was given a laxative and was sitting in a chair next to her bed. When she felt her feces begin to come out, she called the nursing staff for help. No one came. As more feces came out, she again called for help and I went into the hallway and notified the staff that she needed urgent help. She remained sitting in the chair surrounded by large amounts of loose feces for approximately one half an hour. Finally, two nursing staff came and used a mechanical lift to move her back to her bed. The staff then began to clean her up. After she was somewhat clean, a nurse arrived, and I told the nurse about her surgical incisions from her hip to her knee and asked her to check to see that they were clean and not infected. The nurse gave a very cursory inspection. I was not satisfied that her surgical wounds had been adequately cleaned. I feared severe infection that could compromise the healing of her leg, especially because of R251's lowered immunity as a result of her cancer treatment. I called for emergency transport back to a local hospital to have medical staff examine her surgical wounds. The resident did not return to the facility.</p> <p>2. R114 was admitted to the facility on [DATE] with diagnoses of cellulitis of groin, acute infections, urinary tract infection, infection and inflammatory reaction due to indwelling urethral catheter, colostomy status, and panic disorder.</p> <p>Review of the Quarterly MDS assessment dated [DATE], documented a BIMS score of 15, which indicated no cognitive impairment. R114 has limited mobility and requires some set-up and supervision.</p> <p>Review of care plan dated 10/28/2024 revealed R114's need for catheter and ostomy care in addition to need for wound vac care of for groin wound.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 1/28/2025 at 1:12 pm, R114 stated I think the facility has staffing problems. I put my call light on one morning, I learned right quick not to do that. It was almost three hours, from 10:00 am to 1:00 pm before they came. All I wanted was a cup of coffee. When the aide answered the call light, I explained, sarcastically that I was dead. I tell the nurse, I tell everybody, and nothing gets done. It takes at least an hour for them to answer a call light. It is because they are severely short staffed. They just don't have enough people to take care of the residents. During further interview, R114 stated that nobody outside the Certified Nursing Assistant (CNAs) answer call lights. The administration nurses are nice, but they really don't show it by helping.</p> <p>Observation on 1/29/2025 at 7:58 am, breakfast meal service on 200 hall where R114's tray came out of the dining room at 7:58 am, and she was served at 8:30 am. R114 was the very last person on that hall to be served.</p> <p>Observation on 1/30/2025 at 12:49 pm, lunch meal service on 200 hall. R114 was the very last resident to be served.</p> <p>3. R718 was admitted to the facility on [DATE] with diagnoses of fracture of upper end of right humerus, fall on same level, anxiety disorder, cognitive communication deficit and pain.</p> <p>Review of R718's Quarterly MDS dated [DATE] revealed a BIMS score of 10, indicating moderate cognitive impairment. R718 requires partial to moderate assistance with ADL's and is occasionally incontinent of bowel and bladder.</p> <p>Review of care plans for R718 dated 1/21/2025 documented approaches to his cognitive communication deficit and psychotropic drug usage.</p> <p>Interview on 1/28/2025 2:07 pm, R718 stated he wasn't exactly happy with his care. He was eating his lunch, so I said I would come back. Follow-up interview on 1/28/2025 3:40 pm speaking with R718 and his family member, revealed It just takes so long for nurses to respond to his bowel and bladder urges. The staff are very pushy. They told me I had to eat on a bedside table by the bed. I wanted them to bring it to my lounge chair. The nurse made me walk over and sit on the edge of my bed to eat. They refused to provide me incontinent service during mealtime. The nurse told me I had to wait until lunch was over. I wanted to go to the bathroom with diarrhea, and they said no. Eventually I went in my pants and was sitting in [NAME] all while looking at my lunch. The nurse just dropped the tray and left. I told her I had to go. Some nurses are very nice, and others treat you like dirt. They said we'll get to you in a mean and threatening way. I've been here only a week, and all this has happened. I don't know anybody here.</p> <p>Observation on 1/28/25 at 10:43 am Resident Council meeting was held and the residents indicated that untimely call light answering continues to be a problem.</p> <p>Review of Patient/Resident Council Minutes/Report Form dated 1/30/2024 under New Business item 1) 3. [name] took notes regarding call light response: 800 hall reported a long wait time during 2nd shift and that CNA will come in turn off the call light, say they will be back, and never return. 800 hall reports that 2nd shift showers are not being completed. 800 hall residents reported they feel they are not getting the assistance they need all the time, because staff assume they can do more.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Patient/Resident Council Minutes/Report Form dated 3/28/2024 under New Business item 5. 800 hall residents reported the CNA's can be pushy when asking the residents to come eat breakfast in the dining room. 800 hall residents reported second shift call lights are not being answered in a timely manner.</p> <p>Review of Patient/Resident Council Minutes/Report form dated 4/30/2024 under Old Business/Resolution item 2. Continue need for improvement regarding showers on 700 &amp; 800, lift batteries not working, and poor call light time.</p> <p>Review of Patient/Resident Council minutes/Report form dated 12/12/2024 under New Business. Nursing - 2) All residents reported CNA's are not rounding before breakfast, 3) All residents reported they wait a long time for assistance during lunch and believe a CNA should be assigned to the call lights while others pass trays. 4) Residents stated CNAs are taking long lunches, not at assigned times, leading to long wait times.</p> <p>Review of Grievance/Complaint Log Form: Healthcare Centers and Grievances: Healthcare Centers from 1/1/2024 to 1/16/2025. There were 13 resident grievances documented in this time-period related to untimely call light response. The dates were: 2/14/2024, 3/7/2024, 3/27/2024, 3/26/2024, 3/29/2024, 5/15/2024, 5/9/2024, 5/8/2024, 9/16/2024, 9/19/2024, 9/14/2024, 9/21/2024, and 1/16/2025.</p> <p>Interview on 1/29/2025 at 12:50 pm, CNA BB stated sometimes the mechanical lifts don't work so we can't shower or get folks up. She stated there are one - two aides hall on the low census halls, which makes it a problem using the bathroom or taking a break. During further interview, CNA BB stated during the snowstorm, they were told they would be written up if they couldn't come to work because of the weather. There definitely could be more staff to get things done.</p> <p>Interviewed on 1/29/2025 at 1:46 pm, Licensed Practical Nurse LPN) AA stated staffing is a major issue here. We can pick up on our days off because we are so short staffed. Especially when we work the post-acute care, as the residents are extremely demanding. More Licensed Nurses and Certified Nursing Assistants are needed here. The staff come in angry and stressed all the time. I honestly don't know how it could be any worse here. It's awful.</p> <p>Interview on 1/30/2025 at 11:41 am, Director of Nursing (DON) stated she's only the Interim DON. She stated staff are supposed to make rounds prior to meals. If someone has to go to the restroom we're supposed to stop and help them. During further interview, it was revealed the employees use being short staffed as an excuse not to take care of residents. The DON stated, I am not aware of the resident council staffing issues that were brought up on Tuesday of this week.</p> <p>Interview on 1/30/2025 at 12:05 pm, the Administrator stated, my expectation is that we meet at least a 2.5 PPD and the residents are taken care of. I review the resident council meeting minutes. They did have concerns about some of the staff .that there wasn't enough. I can't pinpoint any staffing concerns since I been here since July. She stated the staff need have more teamwork. During further interview, she stated that some of the CNA's won't help each other. By looking at our numbers, the staffing numbers look good to me. I was told about the nursing complaints from Tuesday's meeting, but I don't recall the exact nature of the issues. I'm not aware of the last 12 month's resident council meeting minutes; only the ones since I've been here.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579</b></p> <p>Based on observations, record review, staff interviews, and review of the facility policy's titled Transmission -Based Isolation Precautions, Enhanced Barrier Precautions, and the Procedure: Catheter Care, the facility failed to maintain an effective infection prevention and control program to prevent possible cross contamination. Specifically, facility failed to decrease the risk of transmission of infection related to one staff member not properly changing N-95 mask when exiting Transmission Based Precautions (TBP) room; one nurse not performing hand hygiene during catheter care, not using personal protective equipment during catheter care in an Enhanced Barrier Precaution (EBP) room, and not properly cleaning the tip of the catheter tubing after emptying the bedside drainage bag for one resident R52 of ten residents with a catheter. The deficient practice had the potential to spread infection throughout the facility. The facility census was 112.</p> <p>Findings:</p> <p>1. Review of the facility policy titled Transmission - Based Isolation Precautions revised 12/11/2023, revealed that the use of droplet precautions for residents with known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a resident who is coughing, sneezing, or talking. Review of the subtitle of Personal Protective Equipment' revealed that staff 1. don a disposable mask, covering mask, covering the nose and mouth, prior to entering the resident's room and 2. Discard the mask and perform hand hygiene when leaving the resident room and do not reuse masks.</p> <p>Observation on 1/28/2025 at 11:25 am, the Maintenance Director (MD) was in room [ROOM NUMBER]. He was talking with the resident in the room. Signage on the door of room [ROOM NUMBER] revealed that the resident was on contact and droplet precautions. At 11:27 am, the MD left room [ROOM NUMBER], a TBP room, without PPE on, except for an N-95 mask. He then was observed walking down the hall. Outside the room, there was an area set up that contained PPE for staff and visitors.</p> <p>Interview on 1/28/2025 at 11:31 am, the MD was asked if he was in-serviced on Transmission Based Precaution rooms and if he was that he was supposed to change his mask when exiting those rooms. He stated that he knew about it, but he was in a hurry to get out of the room.</p> <p>Interview on 1/29/2025 at 2:00 pm, the Infection Preventionist (IP) stated that she has been in the position since April of 2024. She provided the surveyor with the education that was provided to staff on 1/8/2025 on COVID expectations and donning and doffing of personal protective equipment (PPE). The maintenance director was not on the sign-in sheet. She then provided education and the sign in sheet for education that was provided to staff on 1/29/2025. The review of the education revealed that she had in-serviced staff present on 1/29/2025 on sequence of donning and doffing of PPE.</p> <p>2. Review of the facility policy titled Enhanced Barrier Precaution (EBP), revised 4/30/2024 revealed that it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug -resistant organisms. EBP refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gown and gloves use during high contact resident care activities.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled Transmission -Based Isolation Precautions, revised 12/11/2023, documented that under PPE subtitle, staff should perform hand hygiene prior to donning gloves.</p> <p>Review of the undated Procedure: Catheter Care, revealed that step 4. Perform hand hygiene according to facility policy/protocol, and 5. DON personal protective equipment as appropriate for procedure.</p> <p>Review of the electronic medical record for resident R52 revealed that she was admitted to the facility on [DATE] with diagnoses that included but were not limited to sepsis due to Escherichia Coli, urinary tract infection (UTI), and pressure ulcer of sacral region, Stage 4.</p> <p>Review of the physician orders for R52 revealed that catheter care to be provided every shift, catheter: diagnosis-bladder outlet obstruction, resident placed on Enhanced Barrier Precautions.</p> <p>Observation on 1/30/2025 at 11:41 am, Licensed Practical Nurse (LPN) FF performed catheter care on R52, who is on EBP. She entered the residents room without donning PPE. She went to the sink and washed her hands and then applied gloves. LPN FF repositioned the resident and removed her brief. She cleaned the catheter, going from the meatus towards the catheter bag. She used a different wipe with each stroke. She then performed perineal care in the front going from front to back. She then turned the resident to the side and then cleaned the resident from front to back, cleaning the stool. She then doffed gloves and donned a clean pair of gloves and then applied a clean brief. She then went to the bathroom and retrieved the urinal and went back to the resident to empty the catheter bag. She opened the clamp and drained the urine out of the bag and then clamped the tube and placed it back into its slot. She then emptied the urinal and placed the urinal in the bag in the bathroom. She then repositioned the resident, doffed gloves and then washed hands at the sink before exiting.</p> <p>Interview on 1/30/2025 at 11:57 am, outside R52 room LPN FF was questioned about what EBP means and why a resident would be on it. She stated that R52 would be on EBP but stated that she did not see that she was on it, and then stated yes, she was on it, and yes she was supposed to don PPE to give her care. She was asked about performing hand hygiene when gloves are used, and she stated before starting and after then procedure. She was asked if hand hygiene should be performed in between glove use and she stated yes but she did not do it. She was asked if there was something special that needed to be done when emptying a catheter bag, and she stated that she is supposed to clean it with alcohol before returning it to the sleeve and she confirmed that she did not do that.</p> <p>Interviewed on 1/30/2025 at 12:13 pm, Director of Health Services (DHS) was asked when PPE should be used in an EBP room and stated that PPE should be used when doing any kind of hands-on care in the room and then stated that the nurse should have donned and doffed PPE during catheter and perineal care. She was then asked about hand hygiene during glove use. She stated that hand hygiene should be performed before and after care. She then stated that hand hygiene should be performed between glove use/change. Shen was then asked about what the nurse should have done before returning the catheter tube back into the sleeve, and she stated that it should have been returned after it was clamped and cleaned.</p> <p>Interview on 1/30/2025 at 12:41 pm, Infection Preventionist (IP) stated that any resident that was on EBP, staff needed to don PPE when high contact care will be performed. She stated that catheter care is a high contact care task. She stated that hand hygiene should be performed before donning and after doffing gloves.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  Oaks - Athens Skilled Nursing, The		STREET ADDRESS, CITY, STATE, ZIP CODE  490 Kathwood Dr Athens, GA 30607	

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