STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115421	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodstock Nursing & Rehab Ctr	105 Arnold Mill Road Woodstock, GA 30188

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47947 Based on observations, staff interviews, record review, and review of the facility policy titled, Prevention of Components of Facility Abuse Prevention Program, the facility failed to protect the resident's right to be free from sexual abuse by another resident for four of 50 sampled residents (R52, R51, R8, and R270). Specifically, R52 was groped by R51 and R270 placed their hand down R8's shirt. Findings include: Review of the facility policy titled Prevention of Components of Facility Abuse Prevention Program dated 5/18/2023 revealed under Policy: It is the policy of this facility that each resident has the right to be free from verbal, sexual, physical, and mental abuse; corporal punishment; involuntary seclusion; mistreatment of any kind, and misappropriation of property. Each resident will be always treated with respect and dignity. The facility shall foster an environment that recognizes the worth and uniqueness of all individuals, to promote respect and set standards of care. Residents will not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, volunteer staff, family members, friends, or others. Review of the electronic medical record (EMR) for R52 revealed diagnoses including but not limited to peripheral vascular disease (PVD) or peripheral artery disease (PAD), renal insufficiency, or end stage renal disease (ESRD), and dementia. Review of the quarterly Minimum Data Set (MDS) assessment for R52 dated 3/12/2024 revealed a Brief Interview for Mental Status (BIMS) score as unscored, indicating resident could not answer interview questions. Section GG-Functional Abilities and Goals indicated R52 was dependent on staff for most activities of daily living (ADLs). Review of the EMR for R51 revealed diagnoses including but not limited to renal insufficiency, renal failure, or ESRD, diabetes mellitus, Alzheimer's disease, cerebral vascular accident (CVA), and depression. Review of the quarterly MDS assessment for R51 dated 3/19/2024 revealed a BIMS score of 6, indicating severe cognitive impairment. Section GG-Functional Abilities and Goals indicated R51 required substantial to total assistance with ADLs. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Facility Incident Report Form dated 2/9/2024 documented resident to resident sexual abuse in which R51was observed groping R52's breast in common area. The physician and responsible parties were notified. Residents were separated. Police were not notified due to both residents residing in a memory unit without decision making capabilities. 15-minute checks initiated for R51. R52 was not able to be interviewed due to her cognition and non-sensible dialogue. R51 placed on continuous monitoring for 72 hours to evaluate for any additional behaviors on 2/9/2024 to 2/12/2024. No additional incidents were noted by staff. Random observations throughout the survey from 5/13/2024 through 5/16/2024 revealed R51 and R52 in activities and in the dining room for meals where they were positioned at separate tables with close supervision from staff members. Review of the EMR for R8 revealed diagnoses including but not limited to renal insufficiency, renal failure, or ESRD, diabetes mellitus, and dementia. Review of the quarterly MDS assessment for R8 dated 3/6/2024 revealed a BIMS score of 8, indicating moderate cognitive impairment. Section GG-Functional Abilities and Goals indicated R8 required partial assistance for most ADLs. Review of the EMR for R270 revealed diagnoses including but not limited to anxiety disorder and diabetes mellitus. Review of the annual MDS assessment for R270 dated 3/4/2024 revealed a BIMS score of 15, indicating little or no cognitive impairment. Section GG-Functional Abilities and Goals indicated R270 was dependent on staff for ADLs. Facility Incident Report dated 2/7/2024 documented resident to resident sexual abuse in which R270's hand was inside R8's shirt in dining room. The physician and responsible parties were notified. Police were notified. Residents were separated and returned to their rooms on separate hallways. R8 denied the incident. R8 was interviewed by police department name police officers on 2/7/2024 at 2:00 pm. She did not remember the incident. The above sexual abuse allegations were reported to the state and investigated per facility policy. Interview on 5/15/2024 at 3:52 pm with CNA CC confirmed receiving weekly in-services on Abuse and Dementia care online and in person sessions. She was educated in case of any abuse to report to the Abuse Coordinator - facility Administrator. She stated that abuse must be reported to the state within two hours and investigated within 5 days. CNA CC stated that any change of condition and/or behavior should be reported to the nurse. Interview on 5/15/2024 at 3:00 pm with RN BB confirmed quarterly staff education on Abuse. She stated that any type of abuse must be reported immediately to the Administrator. Abuse must be reported to the state within two hours of occurrence. Any change of condition and/or unusual behavior when caring for Dementia care residents must be reported and to notify the Medical Director, Resident Representative, Unit Manager, and DON.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579 Based on record review and resident and staff interviews, the facility failed to provide activities of daily living (ADL) for one of 50 sampled residents (R) (R35) related to showers/baths. Review of the EMR revealed that R35 was admitted with diagnoses that included, but were not limited to spina bifida (a birth defect that occurs when the spine and the spinal cord do not develop completely), neurogenic bowel (the loss of normal bowel function due to a nerve problem), neuromuscular dysfunction of bladder, and Fournier gangrene (a rare, life-threatening bacterial infection of the scrotum, penis or perineum). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that R35 had a Basic Interview of Mental Status (BIMS) score of 15, indicating little or no cognitive impairment. Section E-Behavior revealed that he had no behaviors. Section GG-Functional Abilities revealed that he had impairment to both lower extremities, and was dependent on staff for toileting, shower and bathing, and personal hygiene. Review of the care plan dated 4/2/2024 for R35 revealed that he was having trouble in performing the tasks of daily living. Interventions added for this difficulty included but were not limited to checking for incontinence on rounds, extensive assist with bed mobility as needed, including turning and repositioning on rounds, and dependent with bathing as needed. Review of the Physician Orders for R35 dated 4/29/2024 revealed that he was to be straight catheterized if he had no urine output for 8 hours or more, to monitor for urine output because the resident no longer had a catheter, and to reposition resident every two (2) hours. Review of task documentation for showers revealed that between the dates of 4/15/2024 and 5/14/2024, staff documented that showers were not applicable on all days except for total dependence on 4/29/2024. Review of the shower sheets for March 2024 and April revealed that R35 was offered and given a shower on the following days: 3/7/2024, 3/20/2024, 3/24/2024, 4/10/2024, and 4/29/2024. Interview on 5/13/2024 at 12:50 pm with R35, he stated that it had been two weeks since he had a shower. Interview on 5/15/2024 at 10:05 am with RR35, he stated that he still had not had a shower. He then stated that they had taken one of his roommates to the shower but not him or his other roommate. Interview on 5/16/2024 at 2:40 pm with the Director of Nursing (DON) revealed that there was no actual shower team. However, they do have someone assigned to give showers daily. She continued by stating that there were not any routine showers scheduled for the 11:00 pm to 7:00 am shift, but staff would do them if they were requested. She then stated that if a resident refused a shower, staff would ask again at a different time, document the refusal, give the resident other opportunities, and give them encouragement and education of the benefits of the shower. The residents that require supervision for showers, staff would escort them to the showers and allow them to take their shower, and then the resident would usually finish up in their own bathrooms.

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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. 38154 Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Oxygen (O2) Administration, the facility failed to follow physician orders related to O2 liter flow for one of four sampled residents (R) (R61) with physician orders for O2 as needed (PRN). Findings include: Review of the undated facility policy titled Oxygen Administration revealed the following: Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review of the electronic medical record (EMR) revealed R61 admitted with diagnoses to include but not limited to unspecified respiratory failure and personal history of COVID-19. Review of the PPS (prospective payment system) 5-Day Minimum Data Set (MDS) assessment for R61 dated 4/11/2024 documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment; a Mood score of 0; and no behaviors. Review of the care plan for R61 revealed a focus concern for O2 therapy related to respiratory failure. O2 1 LPM (liters per minute) via nasal cannula (NC) to keep SpO2 (O2 saturation) above 92% (percent). A second focus concern, altered respiratory status/difficulty breathing related to respiratory failure, documented interventions to include observe/document/report abnormal breathing patterns to MD. Review of the Physician Orders revealed an order dated 3/27/2024 for Respiratory: O2 1 LPM [liters per minute] via nasal cannula to keep SpO2 above 92% as needed related to respiratory failure. Observation/interview on 05/13/2024 at 2:34 pm with R61 revealed she was alert, oriented, and pleasant. She had no concerns regarding the care she received. She was wearing O2 via NC at 3.5 LPM. Observation/interview on 5/15/2024 at 4:40 pm with Licensed Practical Nurse (LPN) AA revealed R61 was alert, oriented, and pleasant with no care/service concerns at this time. LPN AA confirmed O2 was set at 3.5 LPM with a physician's order for O2 via NC at 1 LPM. Observation/interview on 5/16/2024 at 4:30 pm with Registered Nurse (RN)/Unit Manager (UM) BB verified R61 was wearing O2 at 3.5 LPM. She confirmed R61 had an order for O2 via NC at 1 LPM PRN to keep O2 saturation above 92%. She stated if a resident was in need of more O2, depending on the situation, the nurse might try titrating (adjusting) the O2 if the resident was in visible distress. The UM also stated when a resident was in need of more O2, the provider was notified and would put in an order.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46579 Based on observations, staff interviews, record review, and review of the facility policy titled, Administering Medications Through a Small Volume (Handheld) Nebulizer, the facility failed to ensure that the medication administration error rate was less than 5 percent (%) as evidence by an error rate of 6.45 % from two of three nurses observed during medication administration. Findings include: Review of the undated facility policy titled Administering Medications Through a Small Volume (Handheld) Nebulizer, revealed steps in the administering of the treatment included but was not limited to: . 6. Obtain baseline pulse respiratory rate and lung sounds 17. Remain with the resident for the treatment. 26. Obtain post-treatment pulse, respiratory rate, and lung sounds. The following information should be recorded in the resident's medical record includes but is not limited to: . 5. Pulse, respiratory rate and lungs sound before and after the treatment and . 8. The resident's toleration of the treatment. Medication administration observations on 5/15/2024 at 9:11 am of Licensed Practical Nurse (LPN) PP during medication administration revealed she prepared medications for R24. Review of the physician orders for R24 revealed that he was to receive carvedilol, furosemide, gabapentin liquid, and iron. She prepared the medications and had a total of two pills and 2.5 milliliters (ml) of liquid for a total of three medications, because there was no furosemide available for the resident. LPN PP stated that she reordered the furosemide and that it could be pulled from the automated medication dispensing system. She entered the room of R24 and administered the two tables and the liquid medication. She then exited the room, performed hand hygiene, and then charted that carvedilol, iron, and gabapentin was administered and that the furosemide was not administered. Interview on 5/16/2024 at 2:46 pm with the Director of Nursing (DON), she stated that furosemide was in the automated medication dispensing system. She then revealed that the resident should not have gone without that medication. On 5/15/2024 at 9:24 am, LPN PP prepared the medication for R100. Review of the Physician Orders revealed that R100 was to receive fexofenadine, calcium with Vitamin D, Flonase nasal spray, divalproex, metoprolol, sertraline, colesevelam, gabapentin, lisinopril, duloxetine, haloperidol, diclofenac 3% gel, Tylenol, and a nebulizer (breathing) treatment. She picked up the Flonase, checked the box, and it was labeled with a pharmacy label, but it was not labeled with a resident's name. It was labeled on the box with the name of ____ and room [ROOM NUMBER]A. R100 was in room [ROOM NUMBER]. She prepared all the other medications as ordered and then entered the room with the prepared medications and a container of Ensure. LPN PP administered R100's medications and then administered the nebulizer treatment, after leaving the open carton of Ensure on the over bed table of the resident. She left the room while the nebulizer treatment was being administered. At the medication cart, LPN PP was asked if she should have assessed the resident's respiratory status before starting the nebulizer treatment. She stated that she checked O2 levels with the rest of the vital signs, and there was no other assessment linked to the nebulizer treatment. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/16/2024 at 2:46 pm with the DON revealed that for a resident to receive Ensure routinely, there needed to be an order for it. She continued by stating that when a resident received a nebulizer treatment, the respiratory status should be assessed before and after administering the treatment and documented.

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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. 46579 Based on observations, staff interviews, and review of the facility policy titled, Storge of Medications, the facility failed to safely secure resident medications as evidenced by the observation of two of six medication carts left unlocked when left unattended. The deficient practice had the potential for residents, staff, and visitors to have unauthorized access to resident's medications. Findings include: Review of the undated facility policy titled Storage of Medications revealed that compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. Observation during the initial tour of the facility on 5/16/2024 at 5:35 am revealed that the C-Hall (300 hall) medication cart was left unlocked and was left unattended in the hallway. Upon her return to the medication cart on 5/16/2024 at 5:37 am, Registered Nurse (RN) QQ was asked if the medication cart was able to be left unlocked, and she stated, no, it was not, but I left it unlocked because the cart is split between two different charge nurses. The key to the cart was observed to be left in the narcotic count book so that each nurse had access to the key to the medication cart. Observation on 5/16/2024 at 5:49 am revealed that the B-Hall (200 hall) medication cart was left unlocked and was left unattended in the hallway. Upon return to the medication cart on 5/16/2024 at 5:51 am, Licensed Practical Nurse (LPN) NN was asked if the medication cart was supposed to be left unlocked and unattended, and she stated that it was not supposed to be left unlocked. On 5/16/2024 at 5:54 am, the IV (intravenous) cart was noted to be unlocked, and it was verified by the Unit Manager. Interview on 5/16/2024 at 2:46 pm with the Director of Nursing (DON), she was asked about the medication carts during the night shift, and she stated that medication carts should always be locked when not attended.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46579 Based on observations and staff interviews, the facility failed to properly perform infection control practices to prevent the possible spread of infections during medication administration for one of three nurses observed. Specifically, the facility failed to properly disinfect an electonic blood pressure cuff in between uses and by handling medication with ungloved hands. Findings include: Observation during medication administration on 5/15/2024 at 8:57 am of Licensed Practical Nurse FF revealed that LPN FF stated that she needed to check vital signs for R79 before administering his medications. She performed hand hygiene and then grabbed the portable, reusable electronic blood pressure cuff. She collected the data that she needed and then placed the electronic blood pressure cuff on the medication cart. She prepared the medications, documented vital signs, and then administered the medications to R79. On 5/15/2024 at 9:25 am, LPN FF began to prepare medication for another resident. She then picked up the electronic blood pressure cuff and obtained the blood pressure of the next resident. After obtaining the blood pressure from the next resident, she went to the medication cart to begin prepping of the medications. She was asked if she was supposed to clean the electronic blood pressure cuff. She stated that she did not clean it, but she was supposed to clean it before using it on the next resident. She stated, I totally forgot. On 5/15/2024 at 10:03 am, LPN PP was observed during medication administration for R100. She performed hand hygiene and then went to prepare the medications. She then began to prepare the Tylenol and poured Tylenol out of the bottle into the lid of the Tylenol bottle, which had three that came out. She then used her hand to hold the extra pill, poured the two Tylenol into the medication cup, and then put the extra one back in the Tylenol bottle. After preparing all the medications, she was then asked how many pills she was about to administer. She placed a tissue on the cart and then poured the pills onto the tissue and then counted them. She then picked up all the pills with her bare hand and placed them back into the medication cup. Interview on 5/15/2024 at 10:12 am with LPN PP, she was asked if it was acceptable to touch medications with her bare hands. She stated that she thought it was okay to touch the pills with bare hands if she had used hand sanitizer prior to preparing the medication. Interview on 5/16/2024 at 2:46 pm with the Director of Nursing (DON) revealed that staff were supposed to clean the electronic blood pressure cuff after each use, before using it on another resident. She also revealed that she expected nurses to perform hand hygiene before prepping medications, and even though hand hygiene was performed, nurses still should not be handling pills with bare hands.