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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115422	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roswell Nursing & Rehab Center	1109 Green Street Roswell, GA 30075

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 0578

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49687

Based on resident and staff interviews, and record review the facility failed to ensure the advanced directive was documented accurately throughout the Electronic Medical Record (EMR) for one of 43 residents (R) (R68) reviewed for advanced directives.

Findings included:

A review of the EMR revealed R68 was originally admitted to the facility on [DATE] with multiple diagnoses including hypertension, presence of a cardiac pacemaker, seizures, intraocular lens, polyneuropathy, depressive disorder, poly osteoarthritis, Alzheimer's disease, vascular dementia, alternating exotropia, cerebral infarction due to unspecified occlusion or stenosis of other cerebral arteries, dysphasia following cerebral infarction, chronic kidney disease, and encounter for palliative care. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R68 had a Brief Interview for Mental Status (BIMS) score of 12, indicating R68 had moderate cognitive impairment.

A review of the EMR dashboard revealed: Code Status: (Advance Directives) DNR (Do Not Resuscitate), FULL CODE. A review of R68's Physician Orders documented a Full Code status with a revision date of [DATE] and was documented as active. Further review of the Physician Orders revealed a DNR status with a revision date of [DATE] also documented as active.

A review of R68's Care Plan initiated on [DATE] documented, I am DNR status per me and my family wishes.

A review of the Physician Order for Life-sustaining Treatment (POLST) form dated [DATE] revealed R68's code status as Allow Natural Death - Do Not Attempt Resuscitation. The POLST code was signed by R68, the Medical Director, and an additional facility physician.

During an interview on [DATE] at 11:36 am, Licensed Practical Nurse (LPN) XX revealed that to find the code status of a resident; if it's during medication pass LPN XX stated the code status of that resident would appear right under the resident's picture under their dashboard of the resident's profile. Another place the staff could find the code status is under the resident's orders. LPN XX had never seen a resident coded for both DNR and Full code simultaneously. LPN XX revealed that she initially just noticed the full code status on R68's dashboard so she would have treated R68 as a Full Code. LPN XX will talk to her manager right away.

(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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NAME OF PROVIDER OR SUPPLIER: Roswell Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1109 Green Street Roswell, GA 30075	

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:09 pm, Unit Manager/LPN LLL revealed she updated the code status based on the residents most recent orders. During an interview on [DATE] at 12:38 pm the Director of Nursing (DON) revealed that they have new owners so the switchover may have caused a glitch in the system. Upon admission, all residents are coded as full code until the POLST form is completed. Residents' families are also notified about coding appropriately. The DON is unsure how both DNR and full code could have been reflected on the code status at the same time. During an interview on [DATE] at 2:46 pm, R68 revealed no one spoke to her today about her code status. R68 was asked if she knew what her code status was, and R68 stated no. When asked if something was to happen to her and CPR needed to be done would she want them to do that, R68 stated yes, she would.

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47794 49687 Based on interviews and record review, the facility failed to develop and implement a comprehensive care plan for one of 45 residents (R200) related to a diagnosis of dysphagia (difficulty swallowing) and supervision with meals, resulting in R200's death by choking on a sandwich. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on [DATE], at 10:25 am. The noncompliance related to the IJ was identified to have existed on [DATE]. An Acceptable Removal Plan was received on [DATE]. Based on observation, record review, a review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice were removed on [DATE]. The facility remained out of compliance while the facility continued management-level staff oversight as well as continuing to develop and implement a Plan of Correction (POC). This oversight process includes an analysis of the facility staff's conformance with the facility's policies and procedures governing providing Activities of Daily Living (ADL) care and supervision with meals. Finding included: A facility policy titled, Care Plans, Comprehensive Person-Centered updated [DATE] indicated, 9. Areas of concern that are identified during the resident assessment will be evaluated for interventions are added to the care plan. 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, or the endpoint of an interdisciplinary process . 13. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. An Admission Record revealed R200 was a [AGE] year-old male admitted to the facility on [DATE] with a medical history of gastroesophageal reflux disease without esophagitis, urinary tract infection, site not specified, cerebral palsy, congenital malformation syndromes predominantly involving limbs, functional quadriplegia, asthma, seizures, malaise, mood disorder. A Speech Therapy Transitional Evaluation and Plan of Treatment Record revealed that R200 had poor visual acuity (right eye retinal detachment) and was non-verbal. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An initial Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R200 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is severely impaired. The resident requires total dependence on all ADL care. Speech Therapy Transitional Evaluation and Plan of Treatment, dated [DATE] performed treatment for dysphagia, oropharyngeal phase by the facility Speech and Language Pathologist (SLP) revealed R200 prior level of function (PLOF) (before onset), Patient was previously consuming 75 - 100% of low residue diet (LRD) of regular texture solids with thin liquids, in a home environment with caregiver supervision, with history of one episode of choking on a chicken bone, per caregiver report. Baseline ([DATE]), Patient currently demonstrating oral/pharyngeal swallowing ability within functional limits for consumption of regular texture diet with thin liquids; however, patient demonstrates risk of choking/aspiration due to decreased visual acuity and per os (PO) (by mouth) efficiency. The assessment indicated Precautions/Contraindications are as follows: nonverbal, falls, left foot wound, communicate via vocalizations/gestures/facial expressions; poor visual acuity; follow aspiration/choking precautions - upright during PO intake, set up and orient resident to items on meal tray, supervision during meals. The most recent MDS dated [DATE] indicated in section GG the resident required Setup or clean-up assistance with eating. Section K Swallowing Disorder indicated in C. Coughing or choking during meals or when swallowing medications. No. Swallow Therapy (ST) notes outlined that R200 received Daily ST with a start date of [DATE] through [DATE]. A review of R200's 'ST Daily Treatment Note', dated [DATE] revealed R200 was unable to self-feed today's noon meal. Physical Therapy Review of Therapy notes dated [DATE] revealed: PT required one-to-one assistance with feeding today due to the nature of the breakfast meal. A review of the physician orders with the last review date of [DATE] revealed that R200 was full code, and had special instructions of up 90 degrees to eat sit up 30 minutes after eating alternate liquids and solids slowly . The Physician orders further included: Rehab ST orders: skilled therapy for 5 times a week x 12 weeks for dysphagia (start date [DATE] end date [DATE]. Aspiration Precautions Maintained: Up 90 degrees to eat sit up 30 minutes after eating alternate liquids and solids slowly every shift with the start date of [DATE]. Regular diet regular texture and regular consistency with a start date of [DATE]. On [DATE], R200's assigned feeding assistant Certified Nursing Assistant (CNA) EE received the late dinner trays for his assigned hall at approximately 6:40 pm, approximately 20 minutes before his shift ended. CNA EE notified the nurse that he would not have time to feed R200, but he could drop off R200's tray in his room before his time to clock out by 7:00 pm. Surveillance footage provided by PPP shows CNA EE entering R200's room with his food tray at 6:43 pm. The feeding assistants assignment was reassigned to CNA FF at 6:45 pm. Surveillance footage shows CNA FF initially entering R200's room at 7:15 pm and exiting at 7:21 pm with R200's food tray. CNA FF reported at approximately 7:15 pm that R200 was found to be unresponsive. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility provided R200 a sandwich to consume for 32 minutes without the required one-to-one supervision when eating or drinking on [DATE]. R200 had a banner alert in his electronic medical records (EMR) chart with orders/special instructions for the following, UP 90 DEGREES TO EAT SIT UP 30 MINUTES AFTER EATING ALTERNATE LIQUIDS AND SOLIDS SLOWLY. A record review of R200's Care Plan revealed the facility failed to customize R200's care plan to include one-to-one assistance while eating and drinking as an intervention for complication risks of dysphagia. A record review of the Medical Examiner's report and photos of the scene (a half-eaten slice of bread on R200's pillow and a half-eaten slice of bread on the floor next to the resident's bed) revealed the cause of death was R200 choked on a sandwich. In an interview and record review with the facility DON on [DATE] at 9:30 am she did not understand why the MDS nurse did not include the dysphagia diagnosis in the R200's chart and care plan. When asked about who is responsible for auditing the MDS and care plans for accuracy, the DON stated the facility has had many transfers of ownership and leadership in the last year and audit processes are not perfect right now, but they are working on it. In an interview and record review on [DATE] at 12:05 pm with the facility SLP, Director of Rehabilitation, she remembered prescribing R200 one-on-one assistance while he was eating to make sure that he was eating at a proper pace and not eating too fast or drinking. In an interview and record review on [DATE] at 12:19 pm with MDS Nurse, Registered Nurse (RN) NNN she stated that they do not always enter therapy diagnosis with the medical diagnosis. She stated that the doctor could have changed it. When shown the medical records list a diagnosis of oral pharyngeal impairment, which is dysphagia, and the resident required a specialized diet and close supervision to prevent an incident of aspiration. She replied, I don't remember it's been too long ago but if the doctor saw the person when they got here. He didn't include it. It may have been that he didn't feel they had dysphasia anymore. The RN NNN was reminded that the evaluation was concluded the day before the R200 admission to the facility. She stated, I don't know. I don't remember. I mean it's been so long ago, and we just do hundreds and hundreds of assessments. A review of the facility's dysphagia care plan audit compared with the residents currently assigned feeding assistance during meals revealed 30 of 45 residents diagnosed with dysphagia who require assistance with meals care plans had not been reviewed/customized/ or revised for this individualized intervention for complication risks of dysphagia. Record review revealed that the facility updated the 30 dysphagia residents' care plans on [DATE] and assigned caregivers and in-serviced all active nursing staff of their responsibilities and expectations of their duties when providing the various levels of feeding assistance. The facility implemented the following actions to remove the IJ: R200 expired at the center on [DATE]. On [DATE], the policy for comprehensive care plans was reviewed and/or revised by the Administrator and Regional Director of Clinical Operations without a recommendation for revisions. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the MDS Nurse reviewed care plans for 45 of 45 in-house residents identified with a diagnosis of dysphagia. Thirty care plans were updated to include a diagnosis of dysphagia current and active care plans for dysphagia and appropriate levels of meal supervision. On [DATE], the DON in-serviced the MDS team and licensed nurses on the Center's Comprehensive Care Plan policy and development/implementation and adherence of care plans. (RNs nine of nine equaling 100%; LPNs 42 of 43 equaling 97.7%; OVERALL 98%). Employees on leave of absence, vacation, agency staff, or new hires will be re-educated by the Staff Development Coordinator, DON, or Nursing Supervisor prior to returning to duty, and will not be given an assignment until they are given additional on-site education. On [DATE], the DON and Regional Director of Clinical Operations reviewed residents in the past thirty (30) days with a new diagnosis of dysphagia to ensure that care plans were updated as appropriate. Two (2) residents were identified with a new diagnosis of dysphagia for this review period. The Administrator reviewed the results of the audits and shared the findings with the Ad Hoc Quality Assurance Performance Improvement Committee on [DATE]. All corrective actions were completed on [DATE] and the IJ was removed on [DATE]. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: A review of the facility census list revealed that the facility stopped billing R200 on [DATE] with an action code of DE - deceased Date (Facility). A review of the Care Plans and Comprehensive Person-Centered policy statement updated in [DATE] and signed by the Administrator, DON, Regional Director of Clinical Operations, Regional Director of Operations, and Medical Director via phone on [DATE] without revisions. Review of the diagnosis report after the facility audited the residents diagnosed with dysphagia on [DATE] they discovered that 30 of 45 needed updates to their care plan interventions for feeding assistance. There were 23 residents assigned meal supervision on [DATE], the assignments were revised on [DATE] to 45 residents assigned meal supervision as an intervention for their individualized risk. On [DATE] at 9:08 pm, the facility provided via email a revised list of in-serviced staff due to recent terminations, suspensions, and agency staffing. This consisted of 43 LPNs and nine RNs. There were two new diagnoses of dysphagia identified in the last 30-day review of the diagnosis report after the facility audited the residents diagnosed with dysphagia on [DATE] and updates to their care plans were updated as appropriate. Dated ([DATE] and [DATE]) (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Ad hoc meeting was held on [DATE] to address the concerns described in the IJ called on [DATE] during the annual recertification survey that began on [DATE]. Topics reviewed F677 - ADL Care Provided for Dependent Residents, F656 - Develop/Implement Comprehensive Care Plan, and F835 - Administration. The POCs and related performance improvement plans were initiated for abatement. The root causes and contributing factors were discussed. A review of the sign-in sheet for QAPI revealed that the Medical Director attended via phone. All corrective actions were determined to be completed on [DATE] and the IJ was removed on [DATE].

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety 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** 47794 Based on interviews, record review, and the review of the facility policies titled Activities of Daily Living (ADL) and Assistance with Meals, the facility failed to provide supervision and assistance with Activities of Daily Living (ADL) care during meals for one of 45 residents (R) (R200) related to a diagnosis of dysphagia (difficulty swallowing). On [DATE], this failure resulted in R200's death by choking on a sandwich. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on [DATE], at 10:25 am. The noncompliance related to the IJ was identified to have existed on [DATE]. An Acceptable Removal Plan was received on [DATE]. Based on observation, record review, a review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice were removed on [DATE]. The facility remained out of compliance while the facility continued management-level staff oversight as well as continuing to develop and implement a Plan of Correction (POC). This oversight process includes an analysis of the facility staff's conformance with the facility's policies and procedures governing providing Activities of Daily Living (ADL) care and supervision with meals. Finding included: A facility policy titled, Activities of Daily Living (ADL) updated [DATE] indicated, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 4. Eating to include meals and snacks . A review of the facility policy titled Assistance with Meals issued in [DATE], revealed that Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. 3. Residents Requiring Full Assistance: Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity . Keeping interactions with other staff to a minimum while assisting residents with meals. A review of the Admission Record in the Electronic Medical Record (EMR) revealed R200 was a [AGE] year-old male admitted to the facility on [DATE] with a medical history of gastroesophageal reflux disease without esophagitis, urinary tract infection, cerebral palsy, congenital malformation syndromes predominantly involving limbs, functional quadriplegia, asthma, seizures, malaise, and mood disorder. A Speech Therapy Transitional Evaluation and Plan of Treatment Record revealed that R200 had poor visual acuity (right eye retinal detachment) and was non-verbal. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date of [DATE], revealed R200 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was severely impaired and required total dependence with ADL care. A review of the Speech Therapy Transitional Evaluation and Plan of Treatment dated [DATE] revealed that R200 received treatment for dysphagia and oropharyngeal phase by the facility Speech and Language Pathologist (SLP). It was revealed that R200's prior level of function (PLOF) (prior to onset), Patient was previously consuming 75 - 100% of low residue diet (LRD) of regular texture solids with thin liquids, in a home environment with caregiver supervision, with history of one episode of choking on a chicken bone, per caregiver report. Baseline ([DATE]), Patient currently demonstrating oral/pharyngeal swallowing ability within functional limits for consumption of regular texture diet with thin liquids; however, the patient demonstrates the risk of choking/aspiration due to decreased visual acuity and per os (PO) (by mouth) efficiency. The assessment indicated precautions/ contraindications are as follows: nonverbal, falls, left foot wound, communicate via vocalizations/gestures/facial expressions; poor visual acuity; follow aspiration/choking precautions - upright during PO intake, set up and orient resident to items on meal tray, supervision during meals. The most recent MDS assessment dated [DATE] indicated that the resident required Setup or clean-up assistance with eating. Section K Swallowing Disorder indicated in C. Coughing or choking during meals or when swallowing medications. No. Speech Therapy (ST) notes outlined that R200 received Daily ST with a start date of [DATE] through [DATE]. A review of R200's 'ST Daily Treatment Note', dated [DATE] revealed R200 was unable to self-feed today's noon meal. The Physical Therapy review notes dated [DATE] revealed: PT required one-on-one assistance with feeding today due to the nature of the breakfast meal. A review of the physician orders with the last review date of [DATE] revealed that R200 was full-code, and had special instructions of up 90 degrees to eat sit up 30 minutes after eating alternate liquids and solids slowly . The Physician orders further included: Rehab ST orders: skilled therapy for five times a week x 12 weeks for dysphagia (start date [DATE] end date [DATE]). Aspiration Precautions Maintained: Up 90 degrees to eat sit up 30 minutes after eating alternate liquids and solids slowly every shift with the start date of [DATE]. Regular diet regular texture and regular consistency with a start date of [DATE]. During an interview on [DATE] at 7:49 pm, Certified Nursing Assistant (CNA) EE stated he was assigned to feed R200 during the 7:00 am to 7:00 pm shift on [DATE]. CNA EE stated he fed R200 breakfast around 8:00 am. He stated that lunch arrived late, and he fed R200 after 1:00 pm. CNA EE stated the dinner service was running late as well that evening. The dinner trays came to his hall between 6:40 pm and 7:00 pm. He stated as an Agency CNA, they were not paid for working past the scheduled time. CNA EE stated, R200 can't feed himself because of his condition. It's like he cannot grip a spoon to feed himself with it, so he needed to be fed by staff. CNA EE stated a female CNA (Couldn't remember her name) would help him with positioning R200 to 90 degrees for feeding. CNA EE stated, You have to be patient feeding him and watch him . make sure he swallows before giving the resident the next bite. I would give R200 a bite and intermittently give him fluids to drink in between bites. CNA EE stated he notified the night nurse that he would not have time to feed R200 after distributing trays to other residents on the floor, but he could drop off R200's tray in his room before his clock-out time of 7:00 pm. CNA EE left the facility in the resident's room at 7:05 pm. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of posted dining times for meals delivered to R200's hall revealed that breakfast was served at 7:40 am, lunch was served at 11:40 am, and dinner was served at 4:40 pm. A review of the timesheet for [DATE] revealed that CNA HH clocked in at 6:45 pm for her 7:00 pm through 7:00 am shift. During an interview on [DATE] at 8:25 pm, CNA HH reported that she was assigned to care for R200 via assignment sheet and was assigned to feed R200 at the shift change meeting. A review of the video surveillance footage and documentation of the video footage the facility provided dated [DATE] revealed CNA EE entered R200's room with his food tray at 6:43 pm. The feeding assistance assignment was reassigned to CNA FF at 6:45 pm. Surveillance footage revealed that CNA FF entered R200's room at 7:15 pm and exited at 7:21 pm with R200's food tray. CNA FF reported that at approximately 7:15 pm, R200 was found to be unresponsive. A review of the EMR revealed that R200 had a banner alert in his chart with orders/special instructions for the following: UP 90 DEGREES TO EAT; SIT UP 30 MINUTES AFTER EATING; ALTERNATE LIQUIDS AND SOLIDS SLOWLY. It was revealed that R200 was provided with a meal, including a sandwich, to consume independently for 32 minutes without the required one-on-one supervision when eating or drinking on [DATE]. A review of R200's Care Plan revealed his care plan was not updated to include one-on-one assistance while eating and drinking as an intervention for complication risks of dysphagia. A review of the Medical Examiner's report and photos of the scene revealed a half-eaten slice of bread on R200's pillow and a half-eaten slice of bread on the floor next to the resident's bed. It was documented that the cause of death was R200 choked on a sandwich on [DATE]. During an interview on [DATE] at 9:30 am, the DON stated that she did not understand why the MDS nurse failed to include the dysphagia diagnosis on the care plan. The DON stated that the facility has had many transfers of ownership and leadership in the last year and that audit processes are not perfect right now in relation to the MDS assessments and care plans. During an interview on [DATE] at 12:05 p.m., the SLP, who is the Director of Rehabilitation, stated that s/he remembered prescribing R200 one-on-one assistance during meals to ensure that R200 was eating at a proper pace and not eating or drinking too fast. During an interview on [DATE] at 12:19 pm, the MDS Nurse, Registered Nurse (RN) NNN, stated that they do not always enter therapy diagnosis with the medical diagnosis. She confirmed that R200's medical record listed a diagnosis of oral pharyngeal impairment (dysphagia) and that R200 required a specialized diet and close supervision to prevent an incident of aspiration. She stated that she did not remember the specifics because it had been too long ago. She stated, If the doctor saw the person when they got here and he didn't include it in the diagnosis list, it may have been that he didn't feel they had dysphasia anymore. The facility implemented the following actions to remove the IJ: R200 expired at the center on ,d+[DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roswell Nursing & Rehab Center	1109 Green Street Roswell, GA 30075

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 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Regional Director of Operations (RDO) and the Administrator reviewed the dining assistance policies to ensure alliance with CMS/State regulation, on [DATE], without recommendation for changes/revisions. On [DATE], the Administrator, DON, and the Regional Director of Clinical Operation (RDCO) conducted mandatory retraining for nurses on supervision of ADL care including feeding/dining assistance assignments: nine of nine RNs; 42 of 43 LPNs; and 64 of 64 CNAs). Employees on leave of absence, vacation, agency staff, and/or new hires will be re-educated by the Staff Development Coordinator (SDC), DON, or Nursing Supervisor prior to returning to duty and will not be given an assignment until they are given additional on-site education. On [DATE], the DON and/or Administrator retrained nursing staff that ADL care/meal assistance must continue uninterrupted and cannot be halted or delayed due to a shift change. On ,d+[DATE], the Administrator and DON assessed staffing levels during meal service to ensure adequate assistance. On [DATE], an emergency Quality Assurance and Performance Improvement (QAPI) Ad Hoc meeting was conducted with the Administrator, DON, RDO, RDCO, and Medical Director to review the removal plan and root cause analysis. All corrective actions were alleged to be completed on [DATE] and the IJ was alleged to be removed on [DATE]. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: A review of the facility's census list revealed that R200 expired at the facility with an effective stop billing date of [DATE] at 8:00 pm. A review of the facility policy titled Assistance with Meals dated [DATE], revealed that the following individuals reviewed the policy for accuracy: The administrator signed on [DATE]; RDO signed on [DATE]; RDCO signed on [DATE]; the DON signed on [DATE]; and the Medical Director was documented as attending via the phone on [DATE]. A review of the facility's education/in-service record revealed the following: The presenters of in-service were the clinical leadership that was composed of the DON, Unit Manager (UM), and RDCO. The date of the education was [DATE]. The subject matter of the education was Nursing education-IJ POC and related policies. The overview of the education included a review of the comprehensive care plan policy (including development/implementation and adherence) and the ADL policy (including supervision of dependent residents during meal assistance, ADL care, and meal assistance). A review of the facility's active employee list below was the breakdown of direct care staff (CNAs) and Nurses (LPNs and RNs). (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:49 pm, the count for the active employees matched the number provided by the administrator. Per the RDCO, there were several employees who were crossed off the list, and they were terminated. Additionally, there was an in-service with staff names on the list with an R next to their name indicating they had refused in-service. On [DATE] at 3:19 pm, the Administrator was asked to provide an active list of employees and include an updated list of staff that received the in-serving. On [DATE] at 9:08 pm, the Director of Regulatory Compliance (DRC) provided an updated Active Employee list. During an interview on [DATE] at 7:55 am, the Administrator revealed the list that was provided by the DRC was on the active employee list and reflected on all the staff that were interviewed. This list included both active employees and staff that were reeducated/in-serviced. Some CNAs do work multiple shifts; UMs primarily work 7:00 am through 3:00 pm with one-weekend day shift per month. The following staff were interviewed on [DATE] to [DATE] to certify the education/in-services: [DATE] at 7:42 am (CNA JJ); [DATE] at 7:45 am (CNA KK); [DATE] at 10:53 am (CNA LL); [DATE] at 11:02 am (LPN MM); [DATE] at 11:15 am (LPN NN); [DATE] at 11:23 am (CNA OO); [DATE] at 11:23 am (CNA PP); [DATE] at 11:41 am (UM/LPN QQ); [DATE] at 11:51 am (CNA RR); [DATE] at 12:01 pm (CNA SS); [DATE] at 12:09 pm (UM/LPN TT); [DATE] at 12:18 pm (CNA UU); [DATE] at 12:23 pm (CNA VV); [DATE] at 12:34 pm (CNA WW); [DATE] at 5:45 am (RN YY); [DATE] at 5:58 am (CNA ZZ); [DATE] at 6:13 am (CNA AAA); [DATE] at 6:30 am (RN BBB); [DATE] at 6:50 am (LPN CCC); [DATE] at 7:07 am (LPN DDD); [DATE] at 7:15 am (CNA EEE); and [DATE] at 7:21 am (CNA FFF). A review of the facility's education/in-service record revealed the following: The presenters of the in-service were the Clinical leadership that was composed of the (DON, UM, and RDCO). The date of the education was [DATE]. The subject matter of the education was Nursing education-IJ POC and related policies. The overview of the education included: Comprehensive care plan policy (including development/implementation and adherence); ADL policy including supervision of dependent residents during meal assistance; reeducation related to meal assistance must continue uninterrupted until individual service is complete; assistance with meals policy; assignment of assisted diners (ensure orders match tray card and care plan/Kardex). Interviews were conducted on [DATE] from 7:42 am through [DATE] with no concerns. Several interviews were conducted with nursing staff (CNAs and nurses) to determine what happens when food is delivered late. Staff confirmed that they are to finish feeding/providing assistance to residents even if that means they will be staying past their scheduled time. During an interview on [DATE] at 11:23 am, CNA OO revealed they must stay and complete feeding a resident even if meals are served late due to kitchen staff shortage. During an interview on [DATE] at 12:09 pm, UM/LPN TT stated that staff must have the resident's meal tray when they leave the rooms. They enter the room with the tray and exit the room with the tray in hand. (continued on next page)

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F 0677 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:34 pm, CNA WW stated one of the re-educations was to ensure the proper meal tray delivery processes. The Administrator and the DON completed a review of staffing levels to ensure adequate assistance availability during mealtimes. They had no concerns identified. A daily assignment sheet will be used to identify residents who require assistance with ADL dining to ensure staff assistance is available. The Administrator and DON reviewed the assignments sheets daily to monitor compliance. Both the Administrator and DON signed off on the acknowledgment. A review of the facility's daily assignment sheets included the following: The staff who are scheduled, residents who are identified as 'need to feed' residents identified as NPO, and snack times. Residents were identified by room and bed numbers that needed to be fed. The monthly QAPI meeting was conducted on [DATE]. The presenter/facilitator was the facility Administrator. The duration of the meeting was 30 minutes. The team members included DON, Medical Director, UM, Assistant DON, Scheduler, RDO, VP of Clinical Services, Social Service Directors, MDS, Maintenance Director, Activities Director, Business Office Manager, and the RDCO. Per the attendance sign-in sheet, the following individuals were in attendance: The administrator, RDO, RDCO, Assistant DON, DON, Director of Regulatory Compliance (RDC), Staffing Coordinator, three Unit Managers, Infection Control Preventionist, Social Services, Dietary Manager, Registered Dietician, Director of Therapy, Central Supply, Medical Records, Maintenance Director, MDS, Business Office Manager/Human Resources, Director of Housekeeping, Staff Development Coordinator, and Assistant Administrator. The meeting overview was to review the IJ concerns. A brief narrative description of the QAPI meeting was documented. An updated get-up list for nursing was created. Each root cause had its corresponding corrective action, responsible individual(s) have been identified with a timeline determined to be ongoing, All corrective actions were completed on [DATE] and the IJ was removed on [DATE]. 49472

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on staff and resident interviews, record review, and review of the facility policy titled, Activities, the facility failed to ensure an ongoing program of activities based on preferences for one of one resident (R) (R59) reviewed for activities. The resident was not provided with person-centered activities that would meet their individual needs and preferences. Findings included: A review of the policy titled Activities revised January 2024, the policy revealed that each resident's interest and needs will be assessed on a routine basis. The assessment shall include but is not limited to: Activity assessment to include resident's interests, preferences, and needed adaptation. A review of the Electronic Medical Record (EMR) revealed that R59 was originally admitted to the facility on [DATE] with multiple diagnoses including, Peripheral Vascular Disease, Hypertension, Hypothyroidism, Cerebral Infarction, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Anorexia, Dysphagia and Gout. A review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed that R59 had a Brief Interview for Mental Status (BIMS) score of 10, indicating R59 had moderate cognitive impairment. During an interview on 1/13/2025 at 12:58 pm, R59 revealed she would like to be outside in the summer and winter, loves to read, and would like books to read. R59 went to her dresser behind her; however, there were no books. A review of R59's Activities Care Plan, dated 1/21/2025 revealed R59's goal was to attend/participate in activities of choice 3-5 times weekly by next review date. Additionally, R59's preferred activities included watching TV and reading books. During an interview on 2/13/2025 at 12:28 pm, the Interim Activities Director (IAD) revealed that R59 had shown an interest in religious services and had received a Bible. The IAD added that the facility has someone come every Friday to read to the residents. The IAD also offers the residents books, paper, and magazines. The IAD has a 1:1 list that she utilizes for residents who require or prefer 1:1 activity. A review of the list of residents that require 1:1 activity provided by the IAD revealed that R59 is on the list. During an interview on 2/18/2025 at 10:25 am, R59 stated she still hasn't received any books to read. She has a reader but no books. R59 also noted that the IAD will visit with her sometimes but maybe someone else must tell her to bring her some books. During an interview on 2/18/2025 at 11:39 am, the IAD and the surveyor went to the R59's room to ascertain the request for books. It was determined that the R59 owns a tablet, and she needed to have books downloaded to it. The IAD stated this was the first time she had heard about this from the R59. When asked what the IAD does during the 1:1 activity visit, IAD stated she just visits and talks to the residents on the list.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on resident and staff interviews, record review, and review of the facility's policy titled Incidents and Accidents, the facility failed to provide adequate supervision to prevent accidents for two of four sampled residents (R) (R46 and R206) reviewed for accidents hazards. Harm was identified to have occurred (1) on 9/25/2023 when R46 sustained a fall resulting in a right femur fracture with possible patella fracture, and (2) on 6/4/2023 when R206 sustained a second-degree burn to bilateral glutes from sitting in spilled hot coffee. Findings included: 1. A review of the Electronic Medical Record (EMR) revealed that R46 was admitted to the facility on [DATE] with multiple diagnoses including multiple sclerosis, insomnia, restless legs syndrome, dependence on a wheelchair, overactive bladder, other muscle spasms, major depressive disorder, bipolar disorder, hyperlipidemia, and urinary tract infection. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R46 had a Brief Interview for Mental Status (BIMS) score of 15, indicating R46 was cognitively intact. A review of the R46's quarterly MDS assessment dated [DATE] revealed that for transfers, R46 required extensive assistance with two persons' physical assistance. A review of R46's nursing progress note dated 9/25/2023 revealed that R46 was telling the officer that she had fallen earlier in the day and injured her knee. It was noted that the resident stated, I have complained of pain all day. The day shift nurse was passing along to (the writer) while doing room-to-room walking report that the resident had been lowered to the floor earlier on the day shift due to losing her balance with the Certified Nursing Assistant (CNA) and was lowered the resident to the floor. A review of R46's hospital record dated 9/25/2023 revealed R46's X-ray of the right knee with findings to include an acute intra-articular fracture of the distal femur with apparent extension to the patellofemoral joint. A review of the facility's policy titled Incidents and Accidents revised January 2024 revealed that an 'Accident' refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. During an interview on 1/15/2025 at 1:56 pm, R46 revealed that she was dropped by a CNA during a transfer and broke he right leg. R46 explained that she told the CNA there should be two staff transferring her however, the CNA didn't ask for assistance from another staff. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

During an interview on 2/19/2025 at 3:21 pm, the DON confirmed R46 required two-person assistance. The DON continued that the facility had included the intervention of a mechanical lift in the incident report to ensure that two people were required to transfer the resident and an in-service was also completed to ensure all staff understood that a mechanical lift required two staff to transfer a resident. The DON confirmed that the CNA does not work at the facility anymore and that she was a contract employee.

2. A review of the EMR revealed that R206 was admitted to the facility on [DATE] with multiple diagnoses including dementia, encephalopathy, hypertension, chronic kidney disease, unspecified abnormalities of gait and mobility, anemia, and acute kidney failure. A review of the Admission MDS assessment dated [DATE] revealed that R206 had a BIMS score of 13, indicating R206 was cognitively intact.

A review of R206's progress notes dated 6/4/2023 revealed that the CNA notified the nurse that R206 was complaining of pain in the buttocks area; the nurse assessed R206's buttocks and noticed skin breakdown; and a skin protectant was applied. Later, R206 came to the nurse asking for help with his leg where he had spilled coffee. It was noted that R206 specifically told the nurse he spilled coffee on the left side of his leg. The nurse assisted R206 to his room and assessed the resident's left side. The nurse observed burns and blisters on the left side of his leg.

A review of R206's progress notes dated 6/5/2023 revealed that the Unit Manager requested for the resident's buttock to be assessed related to coffee burn. The buttocks assessment noted the resident had three burn wounds. When the resident was asked how he burned himself he stated, I spilled the damn hot coffee . and it hurts. The wound measurements were documented as: Right buttock, 17.0 x 6.5 x 0.1 cm, 100% Dermis, no exudate; Left buttock, 16.5 x 26.5 x 0.1 cm, 90% Dermis & 10% Skin, no exudate; Left hip, 8.0 x 7.0 x 0.1 cm, 100% Dermis, no exudate.

A review of the EMR revealed that R206 was sent to the nearest hospital on 6/5/2023 to be treated for the coffee burn and did not return to the facility.

A review of the EMR revealed that R206 sustained second-degree burns to the bilateral buttock and the left hip and that R206 refused to return to the facility.

During an interview on 1/27/2025 at 11:35 am, the Dietary Manager stated that the hydration cart is provided during the meal service and confirmed that the temperature of the coffee is not monitored.

During an interview on 2/6/2025 at 3:10 pm, the Dietary Manager stated she heard about the resident who sustained the coffee burn. According to the Dietary Manager, two dietary aides were giving the resident coffee in his mug straight from the coffee machine. The Dietary Manager continued that the Director of Regulatory Compliance (DRC) notified the kitchen staff to start taking the temperature of the coffee on 2/5/2025.

During an observation on 2/6/2025 at 3:12 pm, the temperature of the coffee for breakfast and lunch on 2/6/2025 was not taken.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/12/2025 at 10:33 am, Former Administrator CC revealed that R206 had received coffee from an agency aide. R206 then complained to staff he had spilled the hot coffee on himself, and it was burning. The CNA reported the concerns to the nurse who was also an agency nurse. The Former Administrator CC stated that he found out about the incident approximately 24 hours later and that the staff was reeducated. The corrective action included that the dietary manager should monitor the temperature of the coffee and that it should be documented before serving the residents. The Former Administrator CC further added that the other corrective action was that the kitchen staff would pour the coffee in the facility's cups, not in residents' mugs.

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F 0694 Level of Harm - Actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47794

49472

Based on interviews, record review, and review of the facility policy titled Infusion Therapy, the facility failed to monitor one of 19 sampled residents (R) (R204) for complications related to intravenous (IV) therapy, resulting in infiltration of the IV. Harm was identified to have occurred on 8/27/2024 when this failure caused R204 to experience pain and swelling, resulting in R204 being sent to the emergency room (ER) for treatment and observation per family request.

Findings included:

A review of the undated facility policy titled, Infusion Therapy, revealed that the facility . will have qualified nursing staff present on all shifts to manage the care of patients receiving infusion therapy or maintain access devices. Additional training will be provided as needed for specific therapies.

A review of the Admission Record revealed R204 was an [AGE] year-old female admitted to the facility on [DATE] with a medical history of normal pressure hydrocephalus, essential hypertension, cerebrospinal fluid drainage device, adult failure to thrive, hyperlipidemia, hypomagnesemia, hypokalemia, anxiety disorder, paroxysmal atrial fibrillation, polyneuropathy, muscle weakness.

A review of the admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 8/29/2024, revealed R200 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was mildly impaired and that the resident requires substantial assistance with all Activities of Daily Living (ADL) care.

A review of the care plan dated 7/14/2024 revealed that R204 was at risk for dehydration or potential fluid deficit related to poor intake. Interventions included that directed staff was to encourage resident to drink fluids of choice, ensure access to cold water whenever possible, monitor vital signs as ordered and as needed (PRN), notify physician (MD) of significant abnormalities, observe/report PRN any signs/symptoms of dehydration, decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes (initiated 7/15/2024), obtain and monitor lab/diagnostic work as ordered, report results to MD and followup as indicated (initiated 7/15/2024).

A review of the physician orders dated 8/26/2024 revealed that R204 was ordered Dextrose 5 1/2 normal saline at 60 ml hour x 2-liter one time only for Nausea and Vomiting until 8/26/2024 at 11:59 pm.

A review of the Infection Note on 8/26/2024 at 6:16 pm by the Assistant Director of Nursing (DON)/Infection Prevention Coordinator (IPC) revealed that R204 had recently been readmitted with diagnoses of acute metabolic encephalopathy, altered mental status, recurrent urinary tract infection (UTI), failure to thrive, and was currently being treated for pneumonia, on antibiotics Cefpodoxime 10 milliliters (ml) every 12 hours x 5 days. A line is inserted for IV fluids.

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	115422	A. Building B. Wing	02/20/2025

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F 0694 Level of Harm - Actual harm Residents Affected - Few	A review of the nursing assignments revealed that Licensed Practical Nurse (LPN) DD was assigned to manage R204's IV therapy on the 7:00 pm through 7:00 am shift. Per the DON, LPN DD also attended an in-service for IV Management prior to her shift. A review of R204's vitals taken by LPN DD on 8/26/2024 at 9:30 pm revealed that her blood pressure was 140/73 mmHg; lying left arm. (Note: LPN DD took blood pressure on the same arm the IV was implanted. Potential complications: The application of a blood pressure cuff on an arm with an IV can cause blood to flow back into the IV line, potentially disrupting the infusion or creating clots). LPN DD documented a pain score for R204 as 0 out of 10. During an interview on 1/29/2025 at 9:50 am, the DON confirmed that her expectations were that nurses were supposed to be rounding at least every couple of hours when a resident has a continuous IV. A review of the 24-hour nurse logs and progress notes revealed no evidence that LPN DD monitored or documented R204's infusion rate amounts every two hours throughout the 7:00 pm through 7:00 am shift. A review of the police investigation report revealed that a family member called the emergency line on 8/27/2024 at 2:52 am with complaints that R204 was in pain and her nursing call light was being ignored at the facility. A review of the Health Status Note dated 8/27/2024 at 2:50 am and documented by LPN DD on the status of R204's IV revealed, (R204's) IV site to right (left) arm noted swollen, IV fluids stopped, arm elevated on pillow. Provider made aware. No orders to transfer to the hospital for further evaluation and treat. A review of the Physician's orders dated 8/26/2024 at 11:59 pm called for the IV to be discontinued. A review of Health Status Note dated 8/27/2024 at 3:30 am, revealed that LPN DD documented the status of the R204's IV revealed, R204 transported via stretcher x 2 EMT personnel to preferred hospital. No complaints, no distress noted. LPN DD did not respond to attempts to be interviewed via phone or while on-site at the facility about the incident. LPN DD later resigned from employment at the facility. A review of the police report dated 8/27/2024 revealed that Paramedic RRR and EMT SSS arrived and were shocked by how much the arm had swollen. Paramedic RRR stated that the IV gauge used was the smallest possible, normally used on infants and that caregivers should have noticed that it was blown immediately. Paramedic RRR stated that it was extremely out of the ordinary given that it would have taken several hours for the arm to swell to the level that it had. During an interview on 1/24/2025 at 10:42 am, LPN III, the night shift supervisor on 8/27/2024, stated that nurses are on two-hour rotations where they check on each patient in their care. LPN III stated, The Police Department was already walking through the building when I got up there, and they did call EMS. You know, I can't answer for what LPN DD did, you will have to ask her. (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	A review of emergency room records dated 8/27/2024 revealed that R204 arrived with weakness, IV infiltration, left arm pain, and left arm swelling. R204 was administered hydrocodone dash acetaminophen (Norco 10 milligrams - 325 milligrams oral tablet) for pain, Clonidine 0.1 milligrams, and ondansetron (Zofran) 4 milligrams. R204's ultrasound result of the left arm was negative for blot clots. R204 was later discharged from the hospital on 8/27/2024 and admitted back to the facility.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47794 Based on observations, interviews, record review, and a review of the facility policy titled, Menu Policy, the facility failed to offer one of 19 sampled residents (R) (R5) a diet that suits her pescatarian diet (a diet that includes plant-based foods and fish and other seafood) preferences. Findings included: A review of the facility's undated policy titled, Menu Policy revealed that menus are developed and prepared to meet resident choices including religious, cultural, and ethnic needs while following established national guidelines for nutritional adequacy. Menu items and available snacks reflect the religious, cultural, and ethnic preferences of the residents. A review of the Admission Record revealed R5 was an [AGE] year-old female that was admitted to the facility on [DATE] with diagnosis of parkinsonism, anemia, essential hypertension, type 2 diabetes, hyperlipidemia, dementia, anxiety disorder, major depressive disorder, coronary artery disease, acute kidney failure, bipolar disorder, obsessive-compulsive disorder, suicidal ideations, paraplegia, gastroesophageal reflux disease, rheumatoid arthritis, pruritus, and glaucoma. A review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed that R5 presented with a Brief Interview for Mental Status (BIMS) score of 12, indicating mild to moderate cognitive impairment and that R5 required supervision with eating. A review of the Care Plan for R5 dated 2/12/2025 revealed resident R5 was at nutritional risk related to having a fair appetite, history of weight fluctuations, history of poor appetite, history of wounds, edentulous, vegetarian preference (fish ok), and mechanically altered diet. Interventions to care include administering medications as ordered, observing/reporting any signs/symptoms of dysphagia, observing/reporting to the medical doctor (MD) signs/symptoms of malnutrition, emaciation (cachexia), muscle wasting, significant weight loss: 3 pounds in one week, >5% in one month, >7.5% in three months, >10% in six months, obtain lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Provide and serve supplements as ordered. Provide and serve diet as ordered. Registered Dietician (RD) to evaluate and make diet change recommendations as needed (PRN). Observation During an interview with R5 on 1/14/2025 at 10:46 am it was noted R5 had some hearing impairment. She stated that she was unhappy with her food choices. She does not eat meat, pork, beef, or chicken. She prefers fish, cottage cheese, peas, and potato salad. She would like fish to be a daily option. During an interview and observation on 2/12/2025 at 12:52 pm during lunch observation R5 expressed she did not like the food, she ate the mixed vegetables and pudding dessert. R5 stated, The vegetables were too hard, I could not eat them. She requested to speak with the dietitian about her food preferences. Observation of R5's plate had roasted zucchini and carrots (firm texture), mixed vegetables (yellow carrots, orange carrots, green beans, onions, green and red bell peppers) (mostly eaten), and uneaten rice. R5 is prescribed a mechanical soft diet with regular liquids. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Roswell Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 Green Street Roswell, GA 30075	

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 2/12/2025 at 1:30 pm, Kitchen Manager UUU assessed R5's lunch plate and meal ticket to confirm the accuracy of a vegetarian mechanical soft diet. She admitted that the zucchini and carrots were undercooked, and the rice had hard bits in it; too hard for the resident to consume. A review of the facility's October 2024 through February 2025 posted monthly menu revealed fish being offered only four times for four meals of the month. R5's pescatarian diet requires a fish option for all three meals of the day, daily. During an interview on 2/12/2025 at 5:37 pm, the Registered Dietician (RD) stated that she would observe food preparation in the kitchen and assess R5 at dinner service, as R5's quarterly assessment was due that day. She stated that R5 could have fish daily. A review of the updated care plan dated 2/12/2025 revealed no dietary interventions to provide R5 with fish daily. During an interview and observation on 2/13/2025 at 3:18 pm with UUU, the Kitchen Manager stated that the nurses are supposed to inform them of what the resident wanted to eat. She confirmed they do have alternates and that every nursing station had a menu, and the nurses were responsible for making sure the residents who were bedbound chose the meal. The only fish I have access to are tuna, flounder, breaded cod, and catfish nuggets. I won't buy the catfish nuggets that are trash fish covered in batter. Especially if you're not cutting the filets yourself. But I can't order regular catfish, it's not on my order guide. We have restricted order guides.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 49687 Based on observations, staff interviews, and a review of the facility's policy titled, Disposal of Garbage Refuse, the facility failed to ensure areas around the garbage dumpsters were kept free from dirt and debris. In addition, the facility failed to ensure the sliding door was kept closed when not in use. The facility census was 189 residents. Findings included: A review of the facility's policy titled Disposal of Garbage Refuse, revised April 2024, documented that Surrounding area should be kept clean so that accumulation of debris and insect/rodent attraction are minimized. During an initial tour of the kitchen accompanied by the facility's Dietary Manager (DM) on 1/13/2025 at 9:44 am, it was revealed that there was one garbage dumpster. The garbage dumpster had a lid that was left open while not in use and there was debris underneath the dumpster and an open blue trash can. During an Interview on 1/13/2025 at 9:44 am, the DM revealed that the garbage dumpster was used by the whole facility. She stated that she had brought concerns to the housekeeping manager about the cleanliness of the dumpster's surrounding areas was a concern. She confirmed that there was debris underneath the dumpster and an open blue trash can. She confirmed that she did not know where the debris and trashcan came from.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47794 Based on interviews and record review, the facility's Administration failed to provide protective oversight of the facility ensuring that staff followed appropriate policies and procedures to prevent accidents and hazards resulting in Immediate Jeopardy for resident (R) R200 and Harm for R46, R206, and R204. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on [DATE] at 10:25 am. The noncompliance related to the IJ was identified to have existed on [DATE]. An Acceptable Removal Plan was received on [DATE]. Based on observation, record review, a review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice were removed on [DATE]. The facility remained out of compliance while the facility continued management-level staff oversight as well as continuing to develop and implement a Plan of Correction (POC). This oversight process includes an analysis of the facility staff's conformance with the facility's policies and procedures governing providing Activities of Daily Living (ADL) care and supervision with meals. Findings included: 1. On [DATE], R200 was found unresponsive in his bed after a Certified Nursing Assistant (CNA) EE dropped off the resident's food tray, leaving R200 unsupervised with food for 30 minutes. R200 expired in the facility, with the cause of death documented as choking. Cross Refer F677 2. The facility failed to develop a comprehensive care plan for R200 related to a diagnosis of dysphagia and supervision with meals. Cross Refer F656 3. Harm was identified on [DATE] when R46 sustained a fall resulting in a right femur fracture with possible patella fracture; on [DATE], R206 sustained a second-degree burn to bilateral glutes from sitting in spilled hot coffee; and on [DATE], R204 experienced pain and swelling from an infiltrated intravenous site, resulting in R204 being sent to the emergency room (ER) for treatment and observation. Cross Refer F689 and F694 (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview and record review with the facility Director of Nursing (DON) on [DATE] at 9:30 am she did not understand why the Minimum Data Set (MDS) nurse did not include the dysphagia diagnosis in the R200's chart and care plan. When asked about who is responsible for auditing the MDS and care plans for accuracy, the DON stated the facility has had many transfers of ownership and leadership in the last year and audit processes are not perfect right now, but they are working on it. During an interview on [DATE] at 9:50 am, the DON confirmed that her expectations were that nurses were supposed to be rounding at least every couple of hours when a resident has a continuous IV. During an interview on [DATE] at 12:05 pm, the Director of Rehabilitation remembered prescribing R200 one-on-one assistance while he was eating to make sure that he was eating at a proper pace so he and not eat too fast or drink. During an interview on [DATE] at 12:19 pm, the MDS Nurse, Registered Nurse (RN) NNN, stated that they do not always enter therapy diagnosis with the medical diagnosis. She confirmed that R200's medical record listed a diagnosis of oral pharyngeal impairment (dysphagia) and that R200 required a specialized diet and close supervision to prevent an incident of aspiration. She stated that she did not remember the specifics because it had been too long ago. During an interview with the facility DON on [DATE] at 5:50 pm she stated she could not remember if R200's dysphagia or incidents related to dysphagia were discussed in Quality Assurance Performance Improvement (QAPI) meetings. The DON stated, I would have to review my QAPI notes. During an interview on [DATE] at 3:21 pm, the DON confirmed R46 required two-person assistance. The DON stated that that two people were required to transfer the resident and an in-service was also completed to ensure all staff understood that a mechanical lift required two staff to transfer a resident. The DON confirmed that the CNA does not work at the facility anymore and that she was a contract employee. The facility implemented the following actions to remove the IJ: On [DATE], a Root Cause Analysis (RCA) of the Care plans for residents with a diagnosis of dysphagia and ADL care for dependent residents who require assistance with dining system breakdown was completed by the Regional Director of Operation (RDC), Regional Director of Clinical Operations (RDCO), Administrator, and DON. Documentation of analysis was put on the RCA Tool and was included in the Ad Hoc meeting. The administrator hosted an Ad Hoc QAPI meeting on [DATE], with the Medical Director, DON, RDCO, and Director of Operations to review the center's ADL Care for Dependent Residents and Care Plan performance improvement measures outlined in this document. The Regional Director of Operations (RDO), RDCO, Medical Director, Administrator, and DON reviewed residents receiving swallow therapy in the past thirty (30) days to identify residents with a diagnosis of dysphagia to ensure that care plans were updated as appropriate, on [DATE]. Findings were shared at the next scheduled QAPI Meeting. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator identified Improvement Activities and Performance Improvement Projects (PIP) based on trends and identified potential opportunities upon completion of the care plan and swallowing therapy audit reviewed on [DATE]. PIP plans and RCA documents were maintained as part of the QAPI process. A review of the residents receiving swallow therapy audit was reviewed by the IDT members on [DATE], to validate care plans were updated appropriately to identify the level of dining assistance required. The MDS Nurse (s) reviewed and updated care plans on residents identified with a diagnosis of dysphagia as of [DATE]. Recommendations were reviewed at the next scheduled regular QAPI meeting. The RDCO provided re-education on [DATE] to the Administrator and DON on the policies and procedures related to ADL Care for Dependent Residents and Comprehensive Care Plans. The DON will assign Nurse Managers daily to each unit to provide supervision during meal service for those residents diagnosed with dysphagia, including those who are non-verbal or visually impaired. The Administrator reviewed the results of the audits and shared the findings with the Ad Hoc QAPI Committee in February 2025. All corrective actions were completed on [DATE] and the IJ was removed on [DATE]. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: A review of the diagnosis report after the facility audited the residents diagnosed with dysphagia on [DATE] discovered that 30 of 45 needed updates to their care plan interventions for feeding assistance. There were 23 residents assigned meal supervision on [DATE], the assignments were revised on [DATE] to 45 residents assigned meal supervision as an intervention for their individualized risk. A review of the IJ Removal Plan showed that there were QAPI Meeting Minutes that occurred on [DATE]. The signature includes the Administrator, DON, RDO, RDCO, Dietary, Social Services, and the Medical Director. The topic included an annual survey and IJ citations that were issued. Also, performance improvement plans were included. There were two new diagnoses of dysphagia identified in the last 30-day review of the diagnosis report after the facility audited the residents diagnosed with dysphagia on [DATE] and updates to their care plans were updated as appropriate. Dated ([DATE] and [DATE]) A review of the RCA PIP template that was started on [DATE] was completed. The Root Cause and Contributing Factors included staffing challenges in the kitchen and nursing staff to prepare and deliver meals on time; updating the get-up list for nursing staff to collaborate; poor coordination and communication between dietary staff and nursing staff related to meal readiness, delivery, and resident needs; inadequate coordination of get-ups times with meal delivery schedules; meal service workflow, review serving line efficiency in the kitchen. The plan further included the root cause, the corrective action, the responsible individual/group, and the completion deadline. (continued on next page)

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F 0835

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

A review of the diagnosis report after the facility audited the residents diagnosed with dysphagia on [DATE] discovered that 30 of 45 needed updates to their care plan interventions for feeding assistance. There were 23 residents assigned meal supervision on [DATE], the assignments were revised on [DATE] to 45 residents assigned meal supervision as an intervention for their individualized risk.

A review of the diagnosis report after the facility audited the residents diagnosed with dysphagia on [DATE] discovered that 30 of 45 needed updates to their care plan interventions for feeding assistance. There were 23 residents assigned meal supervision on [DATE], the assignments were revised on [DATE] to 45 residents assigned meal supervision as an intervention for their individualized risk.

A review of the diagnosis report after the facility audited the residents diagnosed with dysphagia on [DATE] discovered that 30 of 45 needed updates to their care plan interventions for feeding assistance. There were 23 residents assigned meal supervision on [DATE], the assignments were revised on [DATE] to 45 residents assigned meal supervision as an intervention for their individualized risk.

A review of the facility's education/in-service record revealed the following: The presenters of in-service were the Clinical leadership that was composed of the (DON, Unit Manager (UMs), and RDCO). The date of the education was [DATE].

The Administrator and the DON completed a review of staffing levels to ensure adequate assistance availability during mealtimes. They had no concerns identified. A daily assignment sheet will be used to identify residents who require assistance with ADLs, specifically dining to ensure availability of assistance, as appropriate.

The Administrator and DON will review assignment sheets daily to monitor compliance. Both the Administrator and DON signed off on the acknowledgment.

A review of the Facility's daily assignment sheets included the following: The staff that is scheduled, residents that are identified as 'need to feed; Residents that are NPO, Snack times; Pass Ice; residents with scheduled showers, residents who are on the get-up list and residents who have appointments/visit time his section identified the residents by room and bed number that need to be fed. NPO residents are identified.

Interviews were conducted with staff to ensure that staff were in-serviced and were knowledgeable of where to retrieve assignments on a daily basis, but to additionally ensure that staff understood requirements for supervision, one-on-one assistance and tray set-up for residents.

During an interview on [DATE] at 11:23 am, CNA OO revealed they must stay and complete feeding a resident even if meals are served late due to kitchen staff shortage.

During an interview on [DATE] at 12:09 pm UM/ Licensed Practical Nurse (LPN) TT stated that a staff is required to have the resident's meal tray when they leave the rooms. They enter the room with the tray and exit the room with the tray in hand.

During an interview on [DATE] at 12:34 pm, CNA WW stated one of the re-educations was to ensure the trays go in the resident room when they are ready to leave, and the tray goes out with the CNA when they leave the resident rooms

(continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A new Dining Time for Meal Delivered to Units was implemented during the week of [DATE]. New dining times for breakfast range from 7:30 am to 8:30 am; lunch from 11:30 am to 12:30 pm and dinner from 4:30 pm to 5:30 pm. Meal carts have been monitored since the new implementation and are ongoing and noted to have improvements. All corrective actions were completed on [DATE] and the IJ was removed on [DATE]. 49479

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49479 Based on observations, staff interviews, record reviews, and review of the facility's policies titled Handwashing/Hand Hygiene and Activities of Daily Living (ADLs), the facility failed to follow infection control protocols related to hand hygiene during ADL care for four of five residents (R) (R91, R9, R83, R16) reviewed for incontinent care. Findings included: A review of the facility's undated policy titled, Handwashing/Hand Hygiene, dated section Policy Interpretation and Implementation under number 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Number 7. Use an alcohol-based hand rub containing at least 62% alcohol; alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: H. Before moving from a contaminated body site to a clean body site during resident care. A review of the policy titled, Activities of Daily Living (ADLs), revised August 2023 revealed that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, groom, and personal and oral hygiene. 1. A review of the Electronic Medical Record (EMR) revealed that R91 was admitted into the facility on [DATE] with diagnoses of but not limited to cutaneous abscess of the chest wall, anoxic brain damage, and chronic obstructive pulmonary disease. A review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed that R91 presented with a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate impairment. The MDS also indicated R91 had impairment to bilateral lower extremities and required assistance with ADLs. During an interview on 2/10/2025 at 10:40 am, Licensed Practical Nurse (LPN) LPN III revealed two Certified Nursing Assistants (CNAs) CNA RR and CNA KKK would provide incontinent care for R91. During an observation on 2/10/2025 at 10:59 am, incontinence care for R91 revealed CNA RR provided incontinent care for R91 while CNA KKK positioned R91 in place. CNA RR completed the incontinent care without washing hands or using hand sanitizer between dirty and clean. CNA RR provided incontinent care, removed the soiled brief, and cleaned R91's peri area. CNA RR neglected to wash hands or use hand sanitizer before applying the barrier cream and clean brief to R91. During an interview on 2/10/2025 at 11:08 am, LPN III revealed the CNAs should have washed or sanitized their hands after cleansing R91 and before applying barrier cream and the clean brief. During an interview on 2/10/2025 at 11:10 am, CNA RR revealed the only time the hands should be washed was before and after incontinent care. CNA RR stated she did not wash or sanitize her hands after cleansing R91 and before applying barrier cream and a clean brief. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of R91's care plan revealed that R91 was at risk for skin breakdown related to decreased mobility and incontinence. The care plan interventions included but were not limited to providing residents with incontinence care after incontinence episodes, and applying moisture barrier as needed (PRN). R91's care plan also revealed that R91 was at risk for urinary tract infection (UTI) due to incontinence of the bladder and bowel. The interventions included but were not limited to increased fluid intake and observation of the color and characteristics of urine. 2. A review of the EMR revealed R9 was originally admitted to the facility on [DATE] with multiple diagnoses including cerebral infarction due to thrombosis of left anterior cerebral, hypertension, gastroesophageal reflux disease, cerebral infarction, hemiplegia, and hemiparesis following cerebral infarction affecting right dominant side and dementia. A review of the Quarterly MDS assessment dated [DATE] revealed that R68 had a BIMS score of 99, indicating R9 is severely cognitively impaired. During an observation on 2/17/2025 at 4:44 am, CNA MMM entered R9's room to provide incontinent care. CNA MMM completed the incontinent care without washing hands or using hand sanitizer between handling dirty and clean wipes and between handling dirty and clean briefs. Additionally, CNA MMM neglected to wash hands or use hand sanitizer before applying the barrier cream and clean brief to R9. 3. A review of the EMR revealed R83 was originally admitted to the facility on [DATE] with multiple diagnoses including end-stage renal disease, anemia, heart failure, hypertension, Gastro-Esophageal Reflux Disease, sleep apnea, muscle weakness, and bilateral primary osteoarthritis of the knee. A review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed that R83 had a Brief Interview for Mental Status (BIMS) score of 15, indicating R83 is cognitively intact. In an observation on 2/17/2025 from 5:04 am to 5:20 am, CNA MMM completed the incontinent for R83. R83 had a bowel movement, and the CNA MMM did not change the gloves after wiping the resident and putting on new clean briefs. 4. A review of the EMR revealed R16 was originally admitted to the facility on [DATE] with multiple diagnoses including, Type II diabetes with hyperglycemia, End stage renal disease, hypertension, insomnia, sleep apnea, chronic obstructive pulmonary disease, neuromuscular dysfunction of bladder, and left and right above knee amputee. A review of the Annual MDS assessment dated [DATE] revealed that R16 had a BIMS score of 15, indicating R16 is cognitively intact. An observation on 2/17/2025 at 6:25 am, CNA MMM enters R16's room to provide incontinent care. CNA MMM provided incontinent care and applied Vaseline to R16's peri area with the same contaminated gloves. During an Interview on 2/17/2025 at 7:05 am CNA MMM revealed she was not washing or sanitizing her hands in between taking off the dirty briefs and putting on the new one. CNA stated, I'm going to tell the truth and shame the devil. She didn't change gloves and sanitize between the dirty and clean briefs. During an Interview on 2/17/2025 at 8:25 am, the Director of Nursing (DON) revealed the staff should be changing gloves in between changing a resident's diaper. A new set of gloves should be worn after the resident is wiped down after having a bowel movement. The last In-service about incontinent care was done a week ago. The DON stated another Inservice will be done. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49687

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on observations, interviews, and a review of the facility's policy titled, Call Lights: Accessibility and Timely Response, the facility failed to ensure that the call light communication system was functioning adequately on one of five units (Jasmine Unit) to allow residents to call for staff assistance. Findings included: A review of the facility's policy titled, Call Lights: Accessibility and Timely Response, revised [DATE] Under Policy Explanation and Compliance number 1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring residents access to the call light. 8. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied . A review of the Electronic Medical Record (EMR) revealed R160 was originally admitted to the facility on [DATE] with multiple diagnoses including lymphedema, essential (primary) hypertension, poly osteoarthritis, hyperlipidemia, morbid obesity, and chronic sinusitis. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R160 had a Brief Interview for Mental Status (BIMS) score of 15, indicating R160 was cognitively intact. During an interview on [DATE] at 11:20 am, R160 revealed that none of the call lights work on the [NAME] Unit. R160 continued that the call light had been out of order since the weekend. R160 was asked how she would get help from staff since the call lights were not functioning, R160 revealed that she would wait till someone walks down the hall and then yell for help. R160 was asked to press the call light, but the call light did not light up. During observations on the [NAME] Unit, the following was observed: Observation on [DATE] at 11:45 am, room [ROOM NUMBER]A's call device was not working. Observation on [DATE] at 11:46 am, room [ROOM NUMBER]B's call light was not working. Observation on [DATE] at 12:50 pm, Licensed Practical Nurse (LPN) XX was observed passing out bells and placing them in various rooms on the [NAME] unit as the call light functionality testing ensued. Observation on [DATE] at 12:55 pm, room [ROOM NUMBER]A's call light was not functioning. Observation on [DATE] at 1:49 pm, room [ROOM NUMBER]A's call device was not working. Observation on [DATE] at 12:31 pm, room [ROOM NUMBER]A's call light was not working. During an interview on [DATE] at 12:31 pm, the Maintenance Assistant revealed, It needed a new battery. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER: Roswell Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1109 Green Street Roswell, GA 30075	

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 12:33 pm, room [ROOM NUMBER]B's Call light was not working. In an Interview on [DATE] at 12:33 pm, the Maintenance Assistant revealed, This may need a new light bulb. Observation on [DATE] at 12:37 pm, room [ROOM NUMBER]B's call light was not working Observation on Room [DATE] at 12:37 pm, room [ROOM NUMBER]C's call light was still not working In an Interview on [DATE] at 12:38 pm, the Maintenance Assistant revealed that these call lights may need a light bulb change. Observation on [DATE] at 3:05 pm, room [ROOM NUMBER]B's call light was not working. Observation on [DATE] at 3:28 pm, the Maintenance Assistant was outside room [ROOM NUMBER]B's, working on the call light. During an interview on [DATE] at 1:05 pm, LPN XX revealed she saw that the call lights were not working so she decided to go get the bells for the residents. When asked if LPN XX was aware the call devices were not working, LPN XX stated no. She confirmed that it wasn't until the surveyor was going to each room to check the lights that she noticed they were not working. On [DATE] at 12:29 PM, the Maintenance Assistant accompanied the surveyor to the [NAME] Unit to test the call devices' functionality. During an interview on [DATE] at 12:29 pm, the Maintenance Assistant revealed they check the call light functionality once to twice a week. The Maintenance Assistant continued that sometimes it just needs to be a new light bulb, or the call light needs to be reset. During an interview on [DATE] at 3:55 pm, the Maintenance Director (MD) stated since the new operating company, they don't test the call lights weekly they test them once a month.