STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115427	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thomasville Care Center LLC	120 Skyline Drive Thomasville, GA 31757

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. 34318 Based on record review and staff interview the facility failed to ensure that one of 10 sampled residents (R1) was free from chemical restraints, related to not using other interventions to manage behaviors prior to using Haloperidol. Findings include Review of the medical record revealed R1 was admitted to the facility with the following diagnoses that include but not limited to chronic obstructive pulmonary disease, hypertension, gastro-esophageal reflux disease, deaf nonspeaking, mood disorder, post-traumatic stress disorder, type 2 diabetes mellitus, and anxiety disorder. Review of the Electronic Medication Administration Record (MAR) for February 2024 R1 was administered a one-time dose of Haldol injection solution 5 MG/ML on 2/8/2024 and a one-time dose of Haloperidol Lactate Injection Solution 1 mg intramuscularly one time only on 2/13/2024. Haloperidol Lactate Injection Solution inject 5 mg intramuscularly every 6 hours as needed for agitation on 2/20/2024 and Haloperidol Lactate Injection Solution inject 5 mg intramuscularly every 6 hours as needed on 6/28/2024. Review of the medical record revealed that on 2/13/2024 R1 was agitated and threw his trash can, slammed door, and was yelling out. Haldol 1 milligram (mg) was administrated in right arm deltoid. There was no evidence of any other interventions attempted prior to the administration of the Haldol. Review of Progress Notes dated 2/20/2024, revealed Haldol 5 mg was administered for yelling at intervals during the shift. The Haldol effectiveness was noted as being ineffective R1 threw a cup into the hallway. There was no evidence of any other interventions prior to the administration of the Haldol. Review of Progress Notes (Patients at Risk - PAR) dated 2/29/2024 revealed the Director of Nursing (DON) noted that R1 was seen by a behavioral consultant. The Nurse Practitioner (NP) made recommendation for Ativan 0.5 mg twice a day as needed for agitation and the Haldol as needed intramuscular for increased agitation. It was noted that the physician and family were made aware of the recommendations. Review of the MAR for March 2024 revealed R1 was not administered any Haloperidol Lactate Injection Solution inject 5 mg intramuscularly every 6 hours as needed. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Note titled Behavior Note entry dated 3/7/2024 revealed resident was combative and beating on a staff door. Resident was given prn medication (Haldol) and transported to the hospital for a mental assessment. The hospital sent the resident back to the facility. It is noted that there were no interventions documented as used prior to the Haldol shot. An interview was conducted on 3/14/2024 at 10:42 am with R1 through use of an interpreter. Interpreter EE revealed that R1 was angry, and he revealed that the nurses were acting crazy and, on an occasion, there were three nurses that came into his room and was holding him down. R1 reported that he kept saying no, but they did not stop until they gave him a shot. R1 further reported that the shot made him feel funny. R1 went on to report that he feels that they (facility staff) are giving him too much medicine. An interview on 3/18/2024 at 1:40 pm, LPN MM revealed that when R1 admitted to the facility he came in on a stretcher and was being combative and aggressive. R1 was reported to be swinging and kicking at the two female EMTs and he would not allow them to get him off the stretcher. One of the female EMTs came up to the nursing station and asked for help. In the resident's room were the two female EMTs, Staff ZZ, LPN CC, and the former maintenance assistant came because the two female EMTs said that they needed manpower. It was further reported that on 2/29/2024 the DON was observed as holding R1 down, with R1's legs between her legs and her hands were on R1's thighs as she held his hands down on his thighs. The resident was calm and not yelling. It was reported that R1 wanted to talk to the Administrator and DON because the DON had taken his vape pen. An interview on 3/18/2024 at 4:22 pm with Certified Nursing Assistant (CNA) PP revealed that R1 uses body language. It was reported that the DON, Licensed Practical Nurse (LPN) CC and herself were in the room of R1 a couple of days after R1 was admitted to the facility (2/13/2024) and it was explained that LPN CC and LPN DD held down R1's arms as he received a shot of Haldol. CNA PP stated that she was standing nearby and wondered why R1 was being held down when he was not acting out. An interview on 3/26/2024 at 1:31 pm, NP HH revealed that he had discussed Ativan recommendation with the DON and advised her that she would need to get the order for the medication from the physician. However, there is no evidence to show that the order was ever initiated as an alternative to the Haldol.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34318 Based on record review, staff interviews and the facility policy Abuse, Mistreatment, Neglect, Exploitation, Misappropriation of Resident Property Policy, the facility failed to ensure that staff reported an allegation of restraining one resident (R1) of 10 sampled residents. Finding include Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation, Misappropriation of Resident Property Policy, dated 9/2012, revised 11/2022. D. Protect the Resident. 1. Assess the Involved Resident (s). a. Staff should report all incidents/allegations immediately to the Administrator or designee. Review of the medical record revealed R1 was admitted to the facility with the following diagnoses that include but not limited to chronic obstructive pulmonary disease, hypertension, gastro-esophageal reflux disease, deaf, nonspeaking, mood disorder, post-traumatic stress disorder, type 2 diabetes mellitus, and anxiety disorder. Review of the progress notes (nursing) revealed on 2/13/2024 that R1 appears agitated at this time. Resident threw the trash can, slammed door, and yelled out. Licensed Practical Nurse (LPN) CC notified the physician to obtain a new order. She received an order for Haldol 1 milligram (mg) and administered in R1 right deltoid and will continue to monitor. An interview on 3/18/2024 at 4:22 pm, Certified Nurse Aide (CNA) PP revealed the Director of Nursing (DON), LPN CC, and herself was in the room a couple of days after R1 was admitted to the facility (referring to 2/13/2024). CNA PP stated that she was standing nearby, and she wondered why he needed to be held down when he was not acting out. The DON is reported to have asked LPN UU to give the Haldol and LPN UU refused, stating that resident didn't need it. LPN CC was initially going to give him the shot, but she was too jittery, so the DON took the syringe, and LPN CC and LPN DD held R1 down while receiving the shot from the DON. When the DON stuck him with the needle, R1 started kicking with his legs. An interview on 4/8/2024 at 12:53 pm, LPN MM revealed that on 2/29/2024, she observed LPN DD take the needle and syringe of Haldol from LPN TT. The DON was observed holding R1 down. She had his legs between her legs and her hands were on his thighs and she held his hands down on his thighs. The resident was calm and not yelling. He had wanted to talk to the Administrator and DON because DON had taken his vape pen. LPN TT reported that she did not call the State Agency because she was not familiar with how to call the State Agency. She stated that she did try to call an advocate for the resident but did not get an answer and she did not leave a voice message. Approximately 10 minutes later it is reported that the DON was in the R1's face saying that she had taken his vape pen. It is reported that R1 gave DON the sign that he was angry, and the DON thought he wanted to fight. The resident made the sign that the vape pen cost him money. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/9/2024 at 11:18 am and at 2:49 pm, the Administrator revealed that she was not initially aware of R1 being held down by staff on 2/13/2024 when administered Haldol. However, she reported that she has since spoken with DON and DON denied restraining the resident when administering the Haldol.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34318 Based on record review and interviews the facility failed to ensure antipsychotic medications were not ordered as needed (PRN) beyond 14 days, failed to document the rationale in the resident's medical record and indicate the duration for the PRN order for one of ten sampled residents (R) R1. Findings include: The policy related to antipsychotic drug usage was requested but the facility was unable to provide the policy prior to exit. Review of the medical records revealed that R1 was sent to the emergency room (ER) on 2/14/2025 and returned on 2/16/2024. He return from the hospital to the facility with medications orders that included the prn Haldol. The prn Haldol was entered into the electronic medical record on 2/16/2024 as indefinitely. This order would have an end date of 3/2/2024. However, on 2/26/2024, Licensed Practical Nurse (LPN) DD entered a new order for the prn Haldol with an end date of 3/10/2024. Thus, a face-to-face re-evaluation and rationale for use was required by the physician in order to continue the prn Haldol till 3/10/2024. The medical records revealed that R1 received a prn Haldol dose on 3/7/2024 which exceed the 14-day evaluation. Review of Progress Notes dated 2/29/2024 (PAR) revealed R1 was seen by a behavioral consultant. The Nurse Practitioner (NP) made recommendation for Ativan 0.5 mg twice a day as needed for agitation. And the Haldol as needed intramuscular for increased agitation. It was noted that the physician and family were made aware of the recommendations. However, the medical record did not reflect any documentation from the Physician indicating that R1 had been seen and a continued need for the PRN medication identified. An interview on 3/19/2024 at 2:00 pm with the Physician revealed that he did not do a progress note for the Haldol prn renewal.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 34318 Based on record review, and staff interviews, the facility failed to provide restorative services for one Resident (R1) of 10 sampled residents. Findings include: Policy related to restorative services were requested but not received by the time of exit. Review of the medical record revealed R1 was admitted to the facility with the following diagnoses that include but not limited to chronic obstructive pulmonary disease, hypertension, gastro-esophageal reflux disease, deaf nonspeaking, mood disorder, post-traumatic stress disorder, type 2 diabetes mellitus, and anxiety disorder. Review of Physical Therapy PT Discharge Summary dated 2/19/2024 through 3/15/2024 revealed R1 was discharged from skilled physical therapy with recommendation for Restorative Program. R1 had restorative for ambulation on the parallel bar; range of motion (ROM) seated bilateral lower extremity times two; transfer to wheelchair; and bed mobility up in chair in the morning. R1 was discharged from skilled physical therapy with recommendation for restorative service. The facility census is 38 residents. Review of the medical records revealed no evidence of the restorative recommendations being implemented prior to 4/1/2024. Review of Restorative Nursing Communication Tool dated 3/15/2024 revealed the goal was to increase ambulation, ROM, and transfer six days per week; minutes per day 15. Ambulation in parallel bars with emphasis on balance. The form was received by the restorative nurse on 3/27/2024. Review of Task form dated April 2024 revealed restorative for ambulation started 4/1/2024. An interview on 3/26/2024 at 12:01 pm, the Physical Therapy Assistant (PTA) revealed that he communicated with R1 by hand gestures and being close to his faces so that he can read his lips. Continued to state that resident was discharged from skill therapy about two weeks ago and he had not given the form for the order to be written for restorative services. An interview on 4/8/2024 at 12:53 pm, Licensed Practical Nurse (LPN) MM revealed that she did not receive any communication from therapy department that R1 was on restorative for ambulation until 3/27/2024. She stated that the PTA was new to the management position, and he was responsible for providing the communication form for the restorative services. the. An interview on 4/8/2024 at 4:11 pm, the Director of Nursing (DON) revealed that she did not know why R1 did not receive restorative services and it sounded like therapy dropped the ball by not communicating with the restorative nurse. An interview on 4/9/2024 at 11:18 am, the Administrator revealed that she will audit other residents record and will do a correction plan.