

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Summerhill Elderliving Home & Care		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Stanley Street Perry, GA 31069	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>21213</p> <p>Based on interviews, record reviews, and a review of the policy titled Adverse Consequences and Medication Errors, the facility failed to ensure that the physician or nurse practitioner was notified of a significant medication error in a timely manner for one resident (R) (R2), from a total sample of 11 residents. Actual harm was identified to have occurred on 12/19/2024 when a Licensed Practical Nurse (LPN) CC administered the wrong resident's medications to R2. R2 was sent to the hospital and admitted for monitoring of potential side effects.</p> <p>Findings include:</p> <p>The facility also had an Adverse Consequences and Medication Errors policy, dated 3/22/2017. The policy documented in the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant was defined to include, but not limited to, requiring hospitalization. The policy also documented that the Attending Physician is notified promptly of any significant medication error or adverse consequence.</p> <p>Review of the 9/19/2024 Annual Minimum Data Set (MDS) assessment revealed that R2 was assessed as being cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15 out of 15.</p> <p>A review of facility investigation information including a 12/19/2024 Facility Incident Report Form, staff written statements, and a 12/23/24 conclusion summary revealed that R2 received oral medications that were ordered for R6 on 12/19/2024 around 9:03 am. LPN CC identified her error around 10:15 am and notified the Registered Nurse (RN) Supervisor EE around 11:00 am and the Nurse Practitioner (who was onsite).</p> <p>There was no evidence that LPN CC notified R2's physician or Nurse Practitioner of the medication error when she identified it at 10:15 am.</p> <p>Review of R2's physician ordered medications and review of R6's physician ordered medications, and December 2024 Medication Administration Record (MAR) revealed that on 12/19/2024, medications were signed out by LPN CC and administered in error to R2 at 9:02 am - 9:03 am to include a total of 14 medications.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/9/2025 at 4:05 pm, which included RN Supervisor EE and the Director of Nursing (DON), RN Supervisor EE stated that she would have expected LPN CC to report the medication error right away to nursing management, even if unable to locate RN Supervisor EE, the DON responded that LPN CC should have found the RN Supervisor and called the physician right away.</p> <p>During an interview on 1/16/2025 at 2:44 pm, the Medical Director confirmed that LPN CC should have notified him or the Nurse Practitioner of the medication error right away. When questioned if 45 minutes (from 10:15 am when the medication error was identified to 11:00 am when RN Supervisor EE was notified and subsequently the Nurse Practitioner) was considered prompt notification, the physician said no, he considered five to ten minutes prompt. He was in agreement with LPN CC to check on R2 and obtain vital signs, but she should have called him or the nurse practitioner.</p> <p>Cross reference to F760</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>21213</p> <p>Based on observation, staff and resident interviews, record reviews, and a review of the policy titled Abuse Prohibition Policy and Procedures, the facility failed to protect the resident's right to be free from physical abuse by Certified Nursing Assistant (CNA) FF for one of 11 residents (R) (R3), from a total sample. Actual harm was identified to have occurred on 12/17/2024, (CNA FF) grabbed R3's hand tight and took her call light out of her hand resulting in bruises and discoloration on the first three fingers on the right hand of R3.</p> <p>Findings include:</p> <p>The facility had an Abuse Prohibition Policy and Procedures, dated January 2017. The policy's statement documented that it was the intent of the facility to actively preserve each resident's right to be free from mistreatment, neglect, abuse or misappropriation of resident property. The policy included definitions of abuse and physical abuse. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. Physical abuse was defined as including hitting, slapping, pinching, and kicking. It also included controlling behavior through corporal punishment.</p> <p>Review of R3's clinical record revealed a diagnosis that included, but were not limited to, Parkinson's disease, polyneuropathy, adjustment disorder with mixed anxiety and depression, and dementia. Review of the 11/12/2024 Quarterly Minimum Data Set (MDS) assessment revealed that R3 was assessed as needing assistance from staff for Activities of Daily Living (ADL) care. Review of the 1/11/2025 Brief Interview for Mental Status (BIMS) form revealed that R3 was assessed as being cognitively intact with a score of 15 out of 15.</p> <p>A review of facility reported incidents revealed a Facility Incident Report Form, dated 12/18/2024, that documented an allegation of staff to resident abuse that had occurred on 12/17/2024 around 1:00 am. The form included that R3 reported to Registered Nurse (RN) LL on 12/18/2024 at 12:30 pm that she had bruises on her right hand because the CNA from the previous night (CNA FF) grabbed her hand tight and took her call light out of her hand. The form included that R3 had bruises on the first three fingers on the right hand. Further review of the form revealed that CNA FF had been removed from the schedule until an investigation was complete. The physician, responsible party, and ombudsman were notified.</p> <p>Review of the accompanying investigation information that included clinical record information, personnel file information, an assessment of the injury, and a follow-up summary revealed evidence that the allegation had occurred. The investigation revealed that CNA FF grabbed R3's hand on 12/17/2024 while in her room. CNA FF was terminated from employment.</p> <p>Review of CNA documentation on R3, dated 12/18/2024, revealed a new discoloration to the right hand was noted.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Review of an incident report for R3, dated 12/18/2024, revealed that bruises were noted to the right hand, three middle fingers, towards the base of each finger. The bruises were dark purple and blue in color.</p> <p>Review of the facility's follow-up summary revealed that R3 was interviewed by different staff members, three separate times, on 12/18/2024 by RN Supervisor LL, the Assistant Director of Nursing (ADON), and the Social Services Director and again on 12/19/2024 by the Social Services Director. R3's statements remained consistent. R3 reported during the interviews that CNA FF had come into her room to answer the call light, grabbed her right hand and squeezed it tight, and took her call light, telling her she did not need the call light. R3 was asking for water, which she did not receive.</p> <p>Review of CNA FF's written statement, dated 12/18/2024, revealed she did not recall seeing any bruising and denied squeezing R3's hand.</p> <p>During an observation and interview on 1/13/2024 at 2:48 pm, when R3 was asked about bruising to her hand, she responded by pointing (with her left hand) to the base of the first three fingers on her right hand (to indicate where the bruises had been).</p> <p>During an interview on 1/14/2025 at 2:00 pm, the Director of Nursing (DON) confirmed that CNA FF was taken off the schedule during the investigation and then terminated.</p> <p>Review of the Employee Consultation form, dated 12/23/2024, and the Payroll Change Form, dated 12/23/2024, revealed that CNA FF was terminated on 12/23/2024. The Employee Consultation form included the nature of the incident as mistreating/abuse/neglect of a resident. The Payroll Change form included CNA FF, which was terminated for resident neglect.</p> <p>Following the incident, in-service education on abuse was provided to facility staff on 12/20/2024.</p>		

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<p>F 0609</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213</p> <p>Based on observation, staff and resident interviews, record reviews, and review of the policy titled Abuse Prohibition Policy and Procedures, the facility failed to ensure that an allegation of abuse was reported to law enforcement for one of 11 residents (R) (R3), from a total sampled.</p> <p>Findings include:</p> <p>The facility had an Abuse Prohibition Policy and Procedures, dated January 2017. The policy included a section titled Reporting. The reporting section included that regarding reasonable suspicion of a crime, it would be reported to the State Agency and one or more law enforcement entities for the location in which the facility is located.</p> <p>Review of R3's clinical record revealed that she was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, Parkinson's disease, polyneuropathy, adjustment disorder with mixed anxiety and depression, and dementia.</p> <p>A review of facility reported incidents revealed a Facility Incident Report Form, dated 12/18/2024, that documented an allegation of staff to resident abuse that had occurred on 12/17/2024 around 1:00 am. The physician, responsible party, and ombudsman were notified.</p> <p>Review of an incident report for R3, dated 12/18/2024, revealed that bruises were noted to the right hand, three middle fingers, towards the base of each finger. The bruises were dark purple and blue in color.</p> <p>Although the facility's investigation information revealed that the physician, responsible party, and ombudsman were notified, there was no evidence that law enforcement was notified of the allegation of abuse with bruising.</p> <p>During an interview on 1/14/2025 at 2:40 pm, the Director of Nursing (DON) confirmed that law enforcement was not notified.</p> <p>During an interview on 1/24/2025 at 3:35 pm with the Administrator, when questioned why law enforcement was not notified, the Administrator responded that the situation was, and the police were not notified because the resident R3 did not sustain serious bodily injury. The Administrator also stated that the facility had reported allegations in the past but did not feel this incident warranted notifying the police. R3 said the CNA grabbed her hand, and the CNA denied it, and the resident did not sustain serious bodily injury.</p> <p>After surveyor inquiry, the facility contacted law enforcement. A review of the local police department's Incident/Investigation Report, dated 1/14/2025, revealed that the allegation of abuse of R3 by CNA FF was reported. The crime incident was listed as Abuse of Elderly.</p> <p>Cross reference to F600</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213</p> <p>Based on interviews and record reviews, the facility failed to ensure that Activities of Daily Living (ADL) care was provided by the appropriate number of staff as care planned for one resident (R1), and medications were administered as care planned and ordered for one resident (R2), from a total sample of 11 residents. Actual harm was identified to have occurred on 12/21/2024, when Certified Nursing Assistant (CNA) AA provided ADL care to R1 by herself, instead of with the required two-person assistance. R1 fell from the bed and sustained a laceration to the right side of the forehead. Actual harm was also identified to have occurred on 12/19/2024 when Licensed Practical Nurse (LPN) CC administered the wrong resident's medications to R2. R2 was sent to the hospital and admitted for monitoring for potential side effects.</p> <p>Findings include:</p> <p>1. Review of the care plan revealed that R1 had impaired cognition, a self-care deficit, was at risk for falls, and received hospice services. The fall risk care plan problem included an intervention, dated 1/22/2024, for padded bolsters to bilateral sides of the bed to define the bed parameters and bring a sense of security related to fear of falling from the bed. The ADL self-care performance deficit care plan problem included an intervention, dated 1/25/2022, that documented R1 required total assistance from two staff persons to turn and reposition in bed. There was also an intervention, dated 1/25/2022, that indicated R1 was not toileted. She was incontinent of bowel and bladder, wore adult briefs, and was checked and changed.</p> <p>Review of progress notes revealed a 12/21/2024 6:28 am nurse's note entry that documented Licensed Practical Nurse (LPN) HH was notified by staff that R1 was observed on the floor. R1 was observed to be on the floor beside the bed with blood on the floor. R1 was responding normally to verbal and physical stimuli. The nurse's note documented that R1 had a cut above the right eyebrow and a scrape to the right knee with noticeable bleeding in both areas. Hospice services, R1's family, and the physician were notified, and R1 was sent to the hospital emergency room for evaluation.</p> <p>A review of the 12/21/2024 hospital emergency department physician documentation revealed that R1 sustained a 3-centimeter (cm) laceration to the right forehead and received three sutures to close the wound. A 12/21/2024 nurse's note at 2:47 pm documented that R1 had returned to the facility. The resident had three sutures to the right side of the forehead and a dressing wrapped around her head.</p> <p>A review of facility investigation information including a 12/21/2024 Facility Incident Report Form, staff written statements from 12/21/2024, and a 12/23/2024 conclusion summary revealed that R1 fell out of bed during the provision of ADL care by one staff person, CNA AA.</p> <p>During an interview on 1/6/2025 at 2:00 pm, the Director of Nursing (DON) confirmed that CNA AA did not follow R1's care plan. During the interview, a detailed view of R1's ADL self-care performance deficit care plan problem was reviewed. The care plan problem specified the interventions that were included on the Kardex, which was for the CNAs to reference for resident care needs. The interventions included that R1 required total assistance from two staff persons to turn and reposition in bed. The DON stated that the information on the Kardex was generated directly from the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/7/2025 at 2:16 pm, CNA AA stated that on 12/21/2024, she was in R1's room providing care by herself. When questioned how she knows what to do for a resident and how to care for them, CNA AA stated she gets a report from the previous shift CNA and goes on the (electronic) chart system and clicks on the Kardex to see what they need. She did not recall how many people were required to provide bed mobility for R1.</p> <p>Cross reference to F689</p> <p>2. Review of clinical record for R2 revealed that he was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction, aphasia, dysphagia, cerebral atherosclerosis, atherosclerotic heart disease, hypertension, hyperlipidemia, major depressive disorder, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, and vitamin D deficiency.</p> <p>A review of the care plan dated 10/30/2020 revealed that R2 had a communication problem related to aphasia following cerebral infarction. Further review of the care plan dated 1/16/2020 revealed interventions in place for licensed nursing staff to administer medications as ordered for cardiac prophylaxis, altered cardiovascular status, gastro-esophageal reflux disease, hyperlipidemia, depression, history of cerebral vascular accident and vitamin D deficiency.</p> <p>However, on 12/19/2024, Licensed Practical Nurse (LPN) CC failed to administer the correct medications to R2 as care planned and ordered.</p> <p>A review of facility investigation information including a 12/19/2024 Facility Incident Report Form, staff written statements, and a 12/23/2024 conclusion summary, revealed that R2 received oral medications that were ordered for R6 on 12/19/2024 around 9:03 am. R2 was subsequently admitted for observation due to polypharmacy and a syncopal episode.</p> <p>LPN CC documented in a written statement that on 12/19/2024, R2 was pushed (in his wheelchair) to the medication cart. LPN CC asked R2 if his name was R2 or R6's last name. R2 incorrectly stated R6's last name. LPN CC looked at the picture on the Medication Administration Record (MAR) (for R6), which she documented resembled R2. Her statement included that she administered R6's oral medications (to R2).</p> <p>During an interview on 1/9/2025 at 4:05 pm, which included RN Supervisor EE and the Director of Nursing (DON), RN Supervisor EE stated that she was coming out of a meeting (on 12/19/2024) when LPN CC told her about the medication error. RN EE went to put her paperwork down on her desk and said she was going to call the Nurse Practitioner and check on R2. As RN EE rounded the corner to go that way, the CNA called out about R2 being on the floor. When questioned why LPN CC asked R2 if his name was the last name of R2 or R6 (instead of just asking him what his name was), the DON stated that she did not know why LPN CC asked the question that way. The DON stated that R2 jokes and can be silly. RN Supervisor EE stated that R2 was probably joking when he told LPN CC his name was R6.</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the 12/19/2024 hospital Emergency Department (ED) Physician Documentation revealed that it was determined that R2 had a vasovagal syncope (fainting) episode while having a bowel movement. Additional differential diagnoses included medication error, polypharmacy, and chronic obstructive pulmonary disease exacerbation. Poison control was contacted about the medication error and recommended baseline laboratory tests, an electrocardiogram (EKG), monitoring vital signs and 24-hour observation. R2 was subsequently admitted to the hospital. Cross reference to F760		

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<p>F 0657</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>21213</p> <p>Based on observation, interviews, record reviews, and a review of the policy titled Care Plans - Comprehensive, the facility failed to revise the care plan to include actual skin impairment (bruising) for one resident (R) (R3), from a total sample of 11 residents.</p> <p>Findings include:</p> <p>The facility had a policy titled Care Plans - Comprehensive. The policy documented that assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change.</p> <p>Review of the care plan revealed that R3 was at risk for impairment to skin integrity. However, further review of the care plan revealed no evidence that the care plan had been revised to include actual skin impairment of bruising to the right hand, which was identified on 12/18/2024.</p> <p>A review of facility reported incidents revealed a Facility Incident Report Form, dated 12/18/2024, that documented an allegation of staff to resident abuse that had occurred on 12/17/2024 around 1:00 am. The form included that R3 had bruises to the first three fingers on the right hand.</p> <p>During an observation and interview on 1/13/2024 at 2:48 pm, when R3 was asked about bruising to her hand, she responded by pointing (with her left hand) to the base of the first three fingers on her right hand (to indicate where the bruises had been).</p> <p>During an interview on 1/9/2025 at 4:05 pm, when the MDS Coordinator was questioned if the bruising to R3 hand that was identified on 12/18/2024 would be information included on the care plan, she responded yes. The MDS Coordinator stated that the treatment nurse or RN supervisor would be responsible for adding the bruising information to the care plan.</p> <p>Cross reference to F600</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>21213</p> <p>Based on interviews, record review, review of the facility's policy titled Documentation of Medication Administration, and review of the Licensed Practical Nurse (LPN) job description, the facility failed to ensure that services being provided by a licensed nurse met professional standards of quality including inaccurate documentation of medication administration for one resident (R2), from a total sample of 11 residents. Actual harm was identified to have occurred on 12/19/2024 when a Licensed Practical Nurse (LPN) CC administered the wrong resident's medications to R2. R2 was sent to the hospital and admitted for monitoring of potential side effects.</p> <p>Findings include:</p> <p>The facility had a Documentation of Medication Administration policy, dated 3/22/2017. The policy documented that the nurse shall document all medications administered to each resident on the resident's electronic Medication Administration Record (eMAR). The policy included that administration of medication must be documented immediately as medications administration is being done per individual resident.</p> <p>Review of LPN CC's personnel file revealed a Licensed Practical Nurse Job Description. The job description documented a position summary of an LPN which included that the LPN provides direct patient care under the supervision of a registered nurse. The LPN contributes to patient care, provides a therapeutic environment, and is expected to abide by the standards, the job description, policies and procedures of the nursing department and hospital. The job description also documented that one of the principle duties and responsibilities included administering medications and treatments utilizing the five Rights of Medication Administration and two patient identifiers.</p> <p>Further review of LPN CC's personnel file revealed a Clinical Competency Testing evaluation. The evaluation included that LPN CC had between mid-level and advanced-level experience with medication administration and advanced-level experience in a nursing home setting.</p> <p>On 12/19/2024, a significant medication error occurred when LPN CC incorrectly administered another resident's medications to R2. Further review revealed R2 was sent to the hospital emergency room for evaluation and admitted for observation due to polypharmacy and syncopal episode.</p> <p>LPN CC documented in a written statement that on 12/19/2024, that she asked R2 if his name was R2 or R6's last name. R2 incorrectly stated R6's last name. LPN CC looked at the picture on the Medication Administration Record (MAR) (for R6), which she documented resembled R2. Her statement included that she administered R6's oral medications (to R2). When she arrived at R6's room to administer medication to his roommate, she realized her error when R6 was lying in his bed and was wearing different clothing.</p> <p>Further review of the facility's conclusion summary revealed that following the medication error on 12/19/2024, LPN CC was relieved of her medication cart at 11:50 am and subsequently sent home.</p> <p>However, after being relieved of her medication cart on 12/19/2024 at 11:50 am, LPN CC then documented administering medications to R2, who was no longer in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R2's MAR revealed that LPN CC signed off administering 10 medications at 12:44 pm- 12:45 pm, that were scheduled for 9:00 am. The medications signed off as administered included docusate sodium 100 milligrams (mg), GlycoLax powder, Linzess 72 micrograms (mcg), probiotic oral capsule, Zetia 10 mg, Klor-Con 20 milliequivalents (mEq), Lasix 40 mg, metoprolol succinate extended release 25 mg, amlodipine besylate 2.5 mg, and a chewable aspirin 81 mg.</p> <p>However, review of the hospital Emergency Department (ED) Physician Documentation revealed that R2 was seen by the physician at the hospital on 12/19/2024 at 12:15 pm.</p> <p>During an interview on 1/9/2025 at 4:05 pm, that included RN Supervisor EE and the Director of Nursing (DON), RN Supervisor EE stated that the Education Nurse took the keys to the medication cart before 11:30 am (on 12/19/2024) and LPN CC was off of the hall but could still document. The DON stated that when she spoke with LPN CC (over the phone, after the medication error), LPN CC did not indicate she gave R2 his own medications. The DON stated that she thought LPN CC signed items off on the MAR before she left the facility because the items were signed off after 12:00 pm. During an interview on 1/13/2025 at 11:05 am, the Education Nurse confirmed she took over the medication cart for LPN CC on 12/19/2024.</p> <p>Cross reference to F760</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Summerhill Elderliving Home & Care		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Stanley Street Perry, GA 31069	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213</p> <p>Based on interviews and record reviews, the facility failed to ensure that bed bolsters were secured, and that Activities of Daily Living (ADL) care was provided by the appropriate number of staff, to prevent accidents for one of 11 residents (R) (R1) sampled for ADL care. Actual harm was identified to have occurred on 12/21/2024, when a Certified Nursing Assistant (CNA) AA provided ADL care to R1 by herself, instead of with the required two-person assistance. R1 fell from the bed and sustained a laceration to the right side of the forehead.</p> <p>Findings include:</p> <p>Review of the clinical record for R1 revealed that she was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, Alzheimer's disease, fibromyalgia, dementia, and adult failure to thrive.</p> <p>Review of the 10/11/2024 Quarterly Minimum Data Set (MDS) assessment revealed that R1 was cognitively impaired and dependent on staff for ADL, including bed mobility.</p> <p>Review of physician's orders revealed a corresponding physician's order, dated 1/22/2024, for padded bolsters to bilateral sides of the bed to define the bed parameters and bring a sense of security related to fear of falling from the bed.</p> <p>The ADL self-care performance deficit care plan problem included an intervention, dated 1/25/2022, that documented R1 required total assistance from two staff to turn and reposition in bed. There was also an intervention, dated 1/25/2022, that indicated R1 was not toileted. She was incontinent of bowel and bladder, wore adult briefs, and was checked and changed.</p> <p>Review of the Fall Risk Evaluation form, dated 10/9/2024, revealed that R1 was assessed as being at moderate risk for falls.</p> <p>Review of progress notes revealed a 12/21/2024 6:28 am nurse's note entry that documented Licensed Practical Nurse (LPN) HH was notified by staff that R1 was observed on the floor. R1 was observed to be on the floor beside the bed with blood on the floor. R1 was responding normally to verbal and physical stimuli. The nurse's note documented that R1 had a cut above the right eyebrow and a scrape to the right knee with noticeable bleeding in both areas. Hospice services, R1's family, and the physician were notified, and R1 was sent to the hospital emergency room for evaluation.</p> <p>Review of the 12/21/2024 hospital emergency department physician documentation revealed that R1 sustained a 3-centimeter (cm) laceration to the right forehead and received three sutures to close the wound. A 12/21/2024 nurse's note at 2:47 pm documented that R1 had returned to the facility. The resident had three sutures to the right side of the forehead and a dressing wrapped around her head.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of facility investigation information, including a 12/21/2024 Facility Incident Report Form, staff written statements from 12/21/2024, and a 12/23/2024 conclusion summary, revealed that R1 fell out of bed during the provision of ADL care by one staff person, CNA AA. CNA AA documented in a 12/21/2024 statement that she went to R1's room on her rounds to perform care. As she had the resident turned on her right side (in bed) to get changed, the sheet and the bolster started sliding off, causing the resident to fall off the bed.</p> <p>During an interview on 1/6/2025 at 2:00 pm, the Director of Nursing (DON) stated that from what she determined, the bolsters were not secured to the bed, and R1 rolled off onto the floor. The DON also confirmed that CNA AA did not follow R1's care plan.</p> <p>During an interview on 1/7/2025 at 2:16 pm, CNA AA stated that on 12/21/2024, she had positioned R1 on her side (in the bed) to change her because she had a bowel movement. CNA AA stated that the bolster slid off really fast, and R1 fell (on the floor) and hurt herself. CNA AA confirmed that she was alone in R1's room providing care.</p> <p>After R1's fall out of bed with head injury sustained on 12/21/2024, in-service education was provided to nursing staff on following the care plan and Kardex and checking bolsters on the bed on 12/21/2024. CNA AA was also removed from the schedule and then terminated on 12/23/2024. Review of the Payroll Change Form, dated 12/23/2024, revealed that CNA AA was terminated. In addition, a 30 Day Resolution plan was developed on 12/23/2024 to address the CNA's failure to follow the care plan.</p>

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213</p> <p>Based on interviews, record reviews, and review of the facility policies titled Administering Medications and Adverse Consequences and Medication Errors, the facility failed to ensure that one resident (R2) was free from significant medication errors, from a total sample of 11 residents. Actual harm was identified to have occurred on 12/19/2024 when a Licensed Practical Nurse (LPN) CC administered the wrong resident's medications to R2. R2 was sent to the hospital and admitted for monitoring of potential side effects.</p> <p>Findings include:</p> <p>The facility had an Administering Medications policy, dated 4/7/2023. The policy statement documented that medications shall be administered in a safe and timely manner, and as prescribed. The policy interpretation and implementation section included that the individual administering medications must verify the resident's identity before giving the resident his/her medications. Methods of identifying the resident included verbally asking the resident their name, checking the photograph attached to the medical record, and if necessary, verifying resident identification with other facility personnel.</p> <p>The facility also had an Adverse Consequences and Medication Errors policy, dated 3/22/2017. The policy included a definition of medication error. A medication error was defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional providing services. Examples of medication errors included omission, unauthorized drug, wrong dose, wrong route, wrong dosage form, wrong drug and wrong time and/or failure to follow manufacturer instructions or accepted professional standards.</p> <p>However, LPN CC failed to accurately verify the correct resident prior to administering medications to R2 on 12/19/2024.</p> <p>Review of clinical record for R2 revealed that he was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction, aphasia, dysphagia, cerebral atherosclerosis, atherosclerotic heart disease, hypertension, hyperlipidemia, major depressive disorder, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, and vitamin D deficiency.</p> <p>A review of facility investigation information, including a 12/19/2024 Facility Incident Report Form, staff written statements, and a 12/23/2024 conclusion summary, revealed that R2 received oral medications that were ordered for R6 on 12/19/2024 around 9:03 am. At 11:00 am Registered Nurse (RN) Supervisor EE was notified by Certified Nursing Assistant (CNA) KK that R2 had fallen in the bathroom. R2 was assisted back to bed and assessed. The Nurse Practitioner (NP) (who was onsite) at the same time was notified and evaluated R2, and he was sent to the hospital emergency room for further evaluation. R2 was subsequently admitted for observation due to polypharmacy and a syncopal episode.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>LPN CC documented in a written statement that on 12/19/2024, R2 was pushed (in his wheelchair) to the medication cart. LPN CC asked R2 if his name was R2 or R6's last name. R2 incorrectly stated R6's last name. LPN CC looked at the picture on the Medication Administration Record (MAR) (for R6), which she documented resembled R2. Her statement included that she administered R6's oral medications (to R2). LPN CC continued to administer medications to other residents. When she arrived at R6's room to administer medication to his roommate, she realized her error when R6 was lying in his bed and was wearing clothing different from the resident who had identified himself as R6 earlier at the medication cart. She documented that she immediately located R2 and took his vital signs, which were within normal limits. LPN CC included in her statement that she proceeded to look for the Nurse Manager, but was unable to locate her, so she continued to check on R2 until she was able to speak to the Nurse Manager. Minutes later, a CNA reported that R2 fell . LPN CC documented that she, several CNA's, the Nurse Manager, and the NP went to R2's room.</p> <p>During an interview on 1/9/2025 at 4:05 pm, which included RN Supervisor EE and the Director of Nursing (DON), RN Supervisor EE stated that she was coming out of a meeting (on 12/19/2024) when LPN CC told her about the medication error. RN EE went to put her paperwork down on her desk and said she was going to call the Nurse Practitioner and check on R2. As RN EE rounded the corner to go that way, the CNA called out about R2 being on the floor. When questioned why LPN CC asked R2 if his name was the last name of R2 or R6 (instead of just asking him what his name was), the DON stated that she did not know why LPN CC asked the question that way. The DON stated that R2 jokes and can be silly. RN Supervisor EE stated that R2 was probably joking when he told LPN CC his name was R6.</p> <p>Review of R2's physician ordered medications and review of R6's physician ordered medications and December 2024 Medication Administration Record (MAR) revealed that on 12/19/2024 the medications signed out by LPN CC and administered in error to R2 at 9:02 am - 9:03 am included allopurinol 300 milligrams (mg), amiodarone 200 mg, aspirin 325 mg, escitalopram 20 mg, Flomax 0.4 mg, Integra supplement, Linzess 145 micrograms (mcg), Potassium Chloride extended release 10 milliequivalents (mEq), carvedilol 3.125 mg, Eliquis 2.5 mg, hydralazine 50 mg, Magox 400 mg, dicyclomine 10 mg, and gabapentin 300 mg.</p> <p>Review of the 12/19/2024 hospital Emergency Department (ED) Physician Documentation revealed that it was determined that R2 had a vasovagal syncope (fainting) episode while having a bowel movement. Additional differential diagnoses included medication error, polypharmacy, and chronic obstructive pulmonary disease exacerbation. Poison control was contacted about the medication error and recommended baseline laboratory tests, an electrocardiogram (EKG), monitoring vital signs and 24-hour observation. R2 was subsequently admitted to the hospital. Review of additional hospital documentation including the History and Physical and Discharge Instructions and Summary revealed that while hospitalized , R2 tested positive for influenza and remained hospitalized until 12/24/2024, at which time he was discharged back to the facility.</p> <p>During an interview on 1/16/2025 at 2:44 pm, the Medical Director confirmed that the medication error was significant, and could be for someone else, but not harmful or life threatening for R2. When questioned if the vasovagal syncope episode was caused by the medication error, the physician responded no, that they were separate issues. The Medical Director stated that R2 had a remote history of having a vasovagal episode.</p>		