STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115431	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haralson Nsg & Rehab Center	315 Field Street Bremen, GA 30110

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled, Transfer or Discharge, Preparing a Resident for, the facility failed to provide a 30-day notice to one of three residents (R) (R14). This deficient practice had the potential to place the resident and resident representative at risk of being uninformed about their rights related to being transferred to another facility. Findings include:Review of the facility policy titled, Transfer or Discharge, preparing a Resident For with a revised date of April 2024, revealed, Residents will be prepared in advance for discharge. The facility shall develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Under Policy Interpretation and Implementation: 1. The facility shall support each resident and/or representative in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge. 4. A notice of transfer or discharge and /or Bed-hold shall be provided to the resident/representative prior to or at or discharge or as soon as practicable. 5. The nursing services shall assist with: a. Obtaining orders for discharge or transfe4, as well as the recommended discharge services and equipment.Review of R14's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R14 was admitted to the facility on [DATE] with diagnoses that included, but not limited to, dysarthria following cerebral infarction, paraplegia, unspecified cerebral infarction, unspecified, adult failure to thrive, poly osteoarthritis, unspecified, insomnia, unspecified, major depressive disorder, recurrent, unspecified, constipation, unspecified, gastro-esophageal reflux disease without esophagitis, nicotine dependence, unspecified, uncomplicatedReview of R14's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/07/2025 Discharge Return Not Anticipated revealed R14 had a Brief Interview for Mental Status (BIMS) score of 14, indicating little to no cognitive impairment.Record review revealed a progress note dated 11/07/2025 initiated by the Social Worker (SW) revealed, Due to repeated behaviors, facility initiated a Discharge/transfer to another SNF {skilled nursing facility.} Resident was informed of this intention and agreed to the transfer. Resident was accepted at {name of other facility} Healthcare. DC {discharge} will be today. Facility will transport.Review of R14's progress notes revealed no prior conversation of transfer documented between the SW and the resident. Review of R14's medical record revealed no evidence that a 30-day notice was provided to R14. An interview on 05/06/2026 at 10:10 AM, the Administrator stated that the discharge notice process was initiated after the resident was discussed during the facility's morning meeting. The Administrator further stated that she began the discharge paperwork and, in her absence, the social worker completed the process. The Administrator also stated that the ombudsman was notified regarding the discharge.During a telephone interview conducted on 05/06/2026 at 10:17 AM, the Ombudsman stated that the facility did not inform her of R14's discharge. The Ombudsman stated that she reviewed her records and confirmed there was no notification regarding R14. She further stated that, had the facility informed her of the discharge, she would have opened a case regarding the matter. The (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ombudsman stated that she did not receive any communication from the facility regarding R14.An interview on 05/07/2026 at 10:08 AM with the Social Worker confirmed no 30-day discharge notice was issued for R14. She stated that she had a conversation with R14 regarding the discharge; however, she could not recall when R14 requested the discharge. The Social Worker acknowledged that the discharge was a facility-initiated transfer and confirmed that the Ombudsman was not notified.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled, Administering Medications and the Standing Orders-Medication Protocols, the facility failed to ensure systems were in place to accurately document medication administration in the Medication Administration Record (MAR) for two of five residents (R) (R16 and R2) reviewed during medication administration. These deficient practices resulted in incomplete clinical records with the potential to negatively impact safety for R16 and R2. Findings include:Review of the facility policy titled Administering Medications, dated February 2020, revealed: The individual administering the medication should document the administration on the eMAR.Review of the facility's Standing Orders-Medication Protocols revealed an order for Acetaminophen 325 mg, two tablets every six hours as needed for pain for seven days; however, the standing order did not include instructions regarding transcription of the medication into the electronic medication administration record (MAR) prior to administration.Review of the Electronic Medical Record (EMR) revealed R16 was admitted to the facility on [DATE] with diagnoses including, but not limited to, tubulo-interstitial nephritis, congestive heart failure, Parkinson's disease, type 2 diabetes mellitus, aphasia, polyneuropathy, atrial fibrillation, spinal stenosis, failure to thrive, obesity, and history of myocardial infarction and lung cancer.Review of R16's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact.Review of R16's care plan, reviewed 03/23/2026, indicated problems related to use of muscle relaxant medication for muscle spasms and pain management, anticonvulsant medication used for neuropathic pain, and pain associated with spinal stenosis and mobility deficits requiring ongoing pain management. Goals included but were not limited to the resident having little to no unaddressed adverse reactions and verbalizing adequate pain relief or ability to cope with incompletely relieved pain through the review date. Interventions included administering medications as ordered and monitoring for potential side effects including abdominal pain, abnormal gait, blurred vision, dizziness, drowsiness, fatigue, tremors, weakness, and decreased memory.Review of R16's physician orders included, but was not limited to: Order dated 04/07/2026 and discontinued 05/05/2026 for Tramadol HCL (hydrochloride) 50 mg (milligram,) one tablet every six hours as needed (PRN) for chronic shoulder pain. Order dated 05/05/2026 for Tramadol HCL 50 mg, one tablet by mouth every four hours as needed for pain. Order dated 04/07/2026 for Gabapentin 300 mg, one capsule at bedtime for polyneuropathy. Order dated 12/05/2025 for Baclofen 10 mg, 0.5 tablet three times daily for muscle spasms; hold for sedation. Order dated 01/13/2026 for Lidocaine External Patch 4% (percent,) apply to left shoulder topically one time daily for chronic left shoulder pain, patch on for 12 hours and off for 12 hours.Review of R16's EMR conducted on 05/05/2026 through 05/07/2026 revealed no progress note documenting the administration of acetaminophen and no corresponding MAR documentation indicating Acetaminophen had been administered. Further review revealed the only medication order change during that time frame was the discontinuation of Tramadol HCL 50 mg on 5/5/2026 and replacement with a new order changing the indication from chronic right shoulder pain to pain.Interview and observation on 05/05/2026 at 12:50 PM with R16 revealed she had been given a pain medication, Tylenol, around 11:30 AM; however, she stated it was not helping and she continued to experience pain.Interview on 05/05/2026 at 12:59 PM with Licensed Practical Nurse (LPN) CC on Wing 1-A during narcotic count and medication cart review, revealed she administered Tylenol 325 mg, two tablets every six hours as needed, to R16 from the facility's standing orders list. LPN CC stated she followed up with the resident after administration and the resident later reported improvement in pain. When asked why the medication administration was not documented in the MAR, LPN CC stated she documents these medications in the progress notes because they were PRN medications. When further questioned regarding MAR documentation requirements, LPN CC stated she was unsure and would need to check with the Unit Manager.Review (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the EMR revealed R2 was admitted to the facility on [DATE] with diagnoses including, but not limited to, nonrheumatic aortic valve stenosis, pericardial effusion, chronic respiratory failure with hypoxia, acute on chronic diastolic heart failure, Parkinson's disease, and presence of cardiac pacemaker.Review of R2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment.Review of R2's care plan indicated a problem of risk for pain related to osteoarthritis (OA) and age-related factors. Goals included but were not limited to the resident verbalizing adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Interventions included administering analgesia as ordered, anticipating pain relief needs and responding immediately to complaints of pain, notifying the physician if interventions were unsuccessful or if pain significantly changed from baseline, monitoring and documenting side effects of pain medication including constipation, agitation, confusion, hallucinations, nausea, vomiting, dizziness, and falls, and observing for non-verbal signs and symptoms of pain including changes in breathing, vocalizations, mood and behavior, facial expressions, and body movements.Review of R2's physician orders included, but was not limited to: Order dated 04/22/2026 for acetaminophen 325 mg, two tablets every six hours as needed for pain. Order dated 04/22/2026 for Clonazepam 0.5 mg, one tablet three times daily for irritability.Review of R2's EMR revealed Acetaminophen 325 mg, two tablets, was administered on 04/30/2026; however, administration was not documented in the MAR. Review of the MAR revealed the administration entry for that date was left blank with no documentation indicating the medication had been administered.Interview on 05/05/2026 at 1:17 PM with the Director of Nursing (DON) regarding medication administration processes and standing orders revealed that any medication listed on the facility's standing orders list must be entered into the MAR prior to administration. The DON stated that medications administered for pain management required nursing staff to assess and follow up on the resident's pain response to ensure appropriate evaluation and intervention. The DON further stated accurate MAR documentation was necessary to maintain medication tracking and reduce the risk of duplicate administration or medication errors. The DON stated the expectation was that medication orders were transcribed into the MAR prior to administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, staff interviews, record review, and review of the facility's policies titled Administering Medications, Medication and Treatment Orders, Insulin Administration, and package insert titled, Lantus (insulin glargine injection), the facility failed to ensure medications were administered accurately for four of 25 medication administration opportunities observed, resulting in a medication error rate of 16 percent. This deficient practice had the potential to adversely affect residents' clinical conditions.Findings include:Observation on 05/05/2026 at 9:58 AM on Wing 2-B with Registered Nurse (RN) AA revealed R17 had a physician order for Lantus SoloStar (insulin glargine) 50 units subcutaneously every 12 hours for diabetes mellitus type II (DMII). During medication administration, RN AA dialed the prescribed dose but failed to prime the insulin pen prior to injection. RN AA administered the medication to the abdomen and removed the pen after approximately three seconds. Medication leakage was observed at the injection site, and RN AA stated, let me wipe what is coming out. During interview, RN AA stated she did not know the meaning of priming in relation to insulin pens.During the same observation, R17 had a physician order for Metformin HCl ER 500 mg, give two tablets by mouth twice daily for DMII. The medication was not available in the medication cart at the scheduled administration time and was not administered. RN AA notified the Unit Manager FF, who stated that the pharmacy reported that this medication was on backorder and the Nurse Practitioner (NP) was notified. The NP discontinued the existing order effective 05/05/2026 and initiated a new order for Metformin HCl 500 mg, give 2 tablets by mouth twice daily for DM2. Review of the Medication Administration Record (MAR) on 05/06/2026 for 05/05/2026 revealed Metformin HCl ER was not administered during the scheduled morning and evening medication passes, resulting in two missed doses.Review of MARs on 05/06/2026 revealed the pharmacy subsequently supplied Metformin HCl ER (hydrochloride extended release) 500 mg (milligram); however, the MAR reflected Metformin HCl 500 mg (non-extended release), indicating a discrepancy between the physician order, MAR documentation, and dispensed medication. R17 received Metformin ER 500 mg, two tablets twice daily on 05/06/2026, despite the revised physician order for Metformin (non-ER formulation).Interview on 05/05/2026 at 3:35 PM with the pharmacist at outside contracted pharmacy revealed no refill requests had been received for R17 prior to 05/05/2026. The pharmacist stated that the only refill request received was the morning of 05/05/2026 for Metformin and Metformin ER had been discontinued. The pharmacist further stated Metformin ER was not on backorder.Observation on 05/05/2026 at 10:17 AM on Wing 2-B with RN AA revealed R18 had a physician order for Biotin 1 mg oral capsule, give 1 mg by mouth once daily for supplement. During medication administration, RN AA administered Biotin 5,000 mcg (micrograms) (5 mg), a dose five times greater than the ordered dose.Additionally, R18 had a physician order for Psyllium 3.4-gram oral packet, give one packet by mouth once daily mixed with 8 oz (ounces) of water or juice of choice, hold for loose stool. The medication was not available in the medication cart at the time of administration and was not administered. Review of the MAR revealed repeated instances of coded unavailability of Psyllium including 04/28/2026, 04/29/2026, 05/01/2026, 05/03/2026, 05/04/2026, and 05/05/2026 indicating multiple missed or interrupted administrations.Interview on 05/05/2026 at 1:17 PM with the Director of Nursing (DON) regarding medication supply and reordering, the DON stated that routine pharmacy turnaround time was approximately 72 hours. The DON stated nursing staff were expected to monitor medication supply levels and reorder medications prior to reaching a low or critical stock level. The facility utilizes a backup pharmacy when medications were not available through the primary pharmacy.The DON stated that all disciplines share responsibility for ensuring timely medication reordering. The DON further stated when medications were unavailable, nursing staff were expected to notify the Nurse Practitioner for further direction. Based on clinical need and provider orders, medications may be rerouted or expedited through the pharmacy, or, in urgent circumstances, requested as STAT (right away) delivery from the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy. The DON stated that nursing staff communicated medication availability concerns to Unit Managers, and if the issue was not resolved at that level, it was escalated to the DON. The DON confirmed ongoing communication with the pharmacy to address supply issues and ensure residents received medications.Follow-up interview on 05/05/2026 at 2:06 PM with DON revealed that insulin pens needed to be set to the amount of dosage, check BG prior. Prime the pen with at least 1 unit to ensure pushing out any air bubbles, hold pen in place for at least 10 seconds after administration. This was all important to ensure the correct administration was given. Observation and interview on 05/07/2026 at 8:35 AM with Licensed Practical Nurse (LPN) DD revealed Metformin ER remained in the medication cart and had been administered to R17 during both the morning and evening medication passes on 05/06/2026. The DON was informed that the resident had received Metformin ER twice daily on 05/06/2026 despite the new order for Metformin (non-ER formulation). LPN DD removed the Metformin ER medication card from the medication cart and provided it to the DON who stated she would be completing an investigation.Interview on 05/06/26 at 2:47 PM with RN EE confirmed that R18 received Biotin 5,000 mcg and not 1 gm as this is the only bottle available in the medication cart. RN EE stated she would contact the NP for further guidance.Interview and observation on 05/06/2026 at 2:48 PM with RN EE confirmed that R18 Psyllium was not in the medication cart, however, RN EE marked this medication as given this morning, but when questioned about it, she changed it to not available, and stated, I did not mean to mark it as given. Then walked to the Nurse's station and was informed by RN Unit Manager FF that Psyllium was at the nurse's station.Interview on 05/07/2026 at 1:46 PM with DON regarding medication reconciliation revealed nursing staff compare the medication received from the pharmacy with the physician order, pharmacy manifest, and MAR to ensure accuracy. The DON stated any nurse receiving the medication served as the first line of review to ensure medications matched the active physician orders. The DON further stated she had investigated the medication issue involving R17 and completed staff competency training with involved nurses and provided immediate education after identifying concerns with the medication reconciliation process.The DON further stated agency nurses were expected to follow the six rights of medication administration and the facility expectation was for the medication error rate was zero.Review of facility policy titled, Administering Medications dated February 2020 revealed item 3. Medications must be administered in accordance with the orders, including any required time frame. Further review of item 1. The individual administering the medication should check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.Review of facility policy titled, Medication and Treatment Orders revised July 2016 revealed item 10. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy prior to that last dosage being administered to ensure that refills are readily available.Review of facility policy titled, Insulin Administration revised September 2014 revealed under section Nursing Competency item 3. Checking the flow of the delivery device (Air shot) and item 4. Giving the injection: PRIME the pen before injection; Hold needle in place for 5-10 seconds.Review of package insert titled, Lantus (insulin glargine injection) revised May 2019 revealed under section Important information for use of SoloStar: step 3. Perform a Safety test. Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen and needle work properly; removing air bubbles. Item A. Select a dose of 2 units by turning the dosage selector. Tap the insulin reservoir so that any air bubbles rise up towards the needle. Press the injection button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. Further review revealed step 5. Inject the dose item D. Keep the injection button pressed all the way in. Slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose will be delivered.