

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/30/2024
NAME OF PROVIDER OR SUPPLIER  Haralson Nsg & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49394</b></p> <p>Based on observations, staff interviews, and review of the facility policy titled, Water Temperatures, Safety of, the facility failed to maintain a safe, clean, comfortable, homelike environment related to water temperatures above 110 degrees Fahrenheit (F) on one of two wings in the facility affecting 27 resident rooms and the shower room, and failed to change bed linen for one resident (R) (R103). The deficient practice had the potential for water over 110 degrees F to cause skin burns.</p> <p>Findings include:</p> <p>1. Review of the undated facility policy titled Water Temperatures, Safety of, under policy Interpretation and Implementation revealed, 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 110 degrees F, or the maximum allowable temperature per state regulation. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log. 3. Maintenance staff shall conduct periodic tap water temperature checks and record temperatures in a safety log. 4. If at any time water temperatures feel excessive to the touch (i.e. hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor.</p> <p>Review of undated facility document titled Job Description and Performance Evaluation-Maintenance Director revealed, 4. Ensure that the plant and equipment are properly maintained for patient/resident comfort and convenience. 8. Inspect the facility, on a regular basis, to ensure that the grounds, facility, and equipment are maintained in accordance with established policies and procedures and all hazardous areas properly identified.</p> <p>Review of the facility's Weekly Water Temperature logs from October 2023 to May 2024 revealed several temperatures that were above the stated 110 degree F facility policy.</p> <p>Review of the facility's Weekly Water Temperature logs for Wing 100 revealed within range temperatures.</p> <p>Observations on 5/28/2024 between 11:06 am and 11:56 am during the initial tour of the facility and screening of the residents revealed water temperatures over 110 degrees F in resident rooms on the 200 wing as follows:</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER] hot water temperature from the sink was 119.3 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 119.1 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 119.7 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.3 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 119.5 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 121.5 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 115.0 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.4 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.0 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.4 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.1 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.4 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.1 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 119.5 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.0 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 119.5 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.2 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 119.6 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 119.7 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 116.5 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 119.0 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.1 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.5 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 121.0 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER] hot water temperature from the sink was 121.1 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 121.1 degrees F.</p> <p>room [ROOM NUMBER] hot water temperature from the sink was 120.1 degrees F.</p> <p>Observation on 5/28/2024 at 12:01 pm revealed the shower room sink temperature was 121.4 degrees F, shower one had a water temperature of 120.3 degrees F, and shower two had a water temperature of 119.8 degrees F.</p> <p>Interview on 5/28/2024 at 11:50 am with R412 in room [ROOM NUMBER], the resident stated, the water is too hot sometimes. He denied any burns or injuries from the water temperature.</p> <p>Interview during walking rounds on 5/28/2024 at 10:59 am with the Maintenance Director (MD), he was notified of the water feeling hot. Water temperatures were taken in all rooms on Wing 200. The MD verified that the water temperatures were high and out of compliance with the facility policy. The MD admitted that the mixing valve had been giving him issues for a couple of months and that he had been trying to regulate the water temperatures by the valves. He also revealed that he had checked temperatures last week, in the early am, and temperatures were fine. He was then asked for the temperature logs to show these temperatures. He stated that he was going to turn off the hot water immediately.</p> <p>Interview on 5/28/2024 at 5:48 pm with the Administrator, she was notified of the water temperature concerns and revealed that she was just made aware of the findings by the MD. She stated that the hot water to Wing 200 was currently turned off and will not be in used until the part was ordered to fix the water temperature issue. When asked what her plan was for resident care and the availability of hot/warm water, she revealed that the staff had been made aware that hot water would not be available on Wing 200 and that staff would have to get hot/warm water from Wing 100, which was not affected by the malfunctioning part. She also stated that residents would be taken to Wing 100 for showers and baths. She also revealed that she was not aware of any water temperature issues prior to the survey. She stated that the part had been ordered and was expected to arrive this week.</p> <p>47947</p> <p>2. Interview on 05/28/2024 at 12:11 pm with R103 revealed that they received a shower on 5/27/2024, but staff did not change bed linens.</p> <p>Review of the Minimum Data Set (MDS) Annual assessment dated [DATE] for R103, documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating that the resident is cognitively intact.</p> <p>Interview on 5/30/2024 at 1:15 pm R103 stated that staff had not changed her bed linens.</p> <p>Review of the Task section of electronic medical records (EMR) revealed that R103 received showers on 5/28/2024 at 9:30 pm, and on 5/29/2024 at 2:59 pm.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 5/30/2024 at 1:20 pm with Certified Nursing Assistant (CNA) BB, she stated that bed sheets must be changed each time a resident received a shower. R103 was scheduled for evening showers and staff from the evening shift were responsible for changing bed linens.</p> <p>Interview on 5/30/2024 at 2:25 pm with DON revealed that the bed sheets should be changed on shower days. If a resident complained that sheets did not get changed after two previous showers, then this was grounds for in-service education and an employee write up. If CNAs note the need for deep bed cleaning, they would notify the Environmental Department and coordinate scheduling of the cleaning.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49394</p> <p>Based on observations, record review, staff interviews, and review of the facility policy titled, Oxygen (O2) Administration, the facility failed to administer O2 therapy as ordered for one of 20 residents (R) (R21) receiving O2 therapy. The deficient practice had the potential to place R21 at risk for medical complications, unmet needs, and a diminished quality of life.</p> <p>Findings include:</p> <p>Review of the undated facility policy titled Oxygen Administration revealed under the section titled Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Section titled Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Under section titled Steps in the Procedure . 6. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Review of this policy also revealed that it did not include policies and procedures for maintaining O2 concentrators (machine that produces O2), proper storage of O2 devices (i.e. mask, nasal cannula (NC) and/or nasal catheter), and nursing staff responsibilities for assuring that the flow of O2 is at the level ordered.</p> <p>Review of the electronic medical record (EMR) revealed R21 was admitted to the facility with diagnoses including, but not limited to heart failure, morbid (severe) obesity due to excess calories, hypertension, transient cerebral ischemic attack, and sleep apnea.</p> <p>Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating R21 was cognitively intact. Section O-Special Treatments and Programs revealed resident receives O2 therapy while a resident.</p> <p>Review of R21's Physician's order dated 1/9/2024 for oxygen (O2) at 2 (liters) L per (nasal canula) NC to keep O2 above 92% [percent].</p> <p>Observation on 5/28/2024 at 10:00 am of R21, the resident had an O2 concentrator at bedside, turned on at 3 liters per minute (LPM).</p> <p>Observation on 5/29/2024 at 8:19 am, R21 was resting in a recliner chair in her room with O2 via NC in place at 3 LPM.</p> <p>Observation on 5/29/2024 at 2:00 pm, R21 was reclined back in a recliner chair in her room, dozing off to sleep with O2 in place via NC at 3 LPM.</p> <p>Staff Interview/Walking Rounds on 5/29/2024 at 2:02 pm with LPN AA confirmed that R21's O2 was at 3 LPM and immediately turned the O2 down to 2 LPM. She stated that the resident sometimes adjusts the machine herself when she feels it's not pushing out enough. She also revealed that residents that were receiving O2 were to have pulse oximetry (O2 saturation test) checks as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 5/30/2024 at 10:35 am with the Assistant Director of Nursing/Infection Preventionist (ADON/IP) revealed that she and the Unit Managers do daily rounds and check O2 concentrators and settings of residents that are receiving O2. She stated that the nurses were primarily responsible for checking the settings of the O2.</p> <p>Interview on 5/30/2024 at 2:13 pm with the Director of Nursing (DON), she stated that her expectation was for nurses to follow the Physician's orders. She also revealed that the nurses were to monitor O2 levels every shift, especially when doing assessments and passing medications. She also stated that when residents were self-adjusting O2, they should be care planned for such actions.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>47947</p> <p>Based on staff and family interviews, and review of the PBJ (payroll-based journal) Staffing Data Report Quarter 1 2024 (October 1, 2023, through December 31, 2023), the facility failed to ensure that the facility had adequate nursing staff. The deficient practice had the potential to affect the care provided to the 104 residents that resided in the facility.</p> <p>Findings include:</p> <p>Review of the PBJ Staffing Data Report Quarter 1 2024 (October 1, 2023, through December 31, 2023) revealed based on the data submitted, the facility triggered for a One-Star Staffing Rating (Failure to submit PBJ data by the deadline, more than 4 days in the quarter without RN (Registered Nurse) Staffing hours, failure to respond to, submit documentation for, or failure to pass a CMS (Centers for Medicare and Medicaid Services) audit designed to discover discrepancies in PBJ data).</p> <p>Interview on 5/30/2024 at 2:30 pm with the Human Resources (HR) Director revealed she assumed scheduling responsibility due to the Scheduler being on maternity leave. She went on to reveal that the facility had about 75 percent (%) full-time staff and 25% agency nurses and CNAs. She stated that normally she scheduled five to six CNAs per hall during the day shift (7:00 am to 3:00 pm), four to five CNAs during evening shift (3:00 pm to 11:00 pm), and two to three CNAs during the night shift (11:00 pm to 7:00 am). She stated in case someone called out, the Charge Nurse was notified first, then the Charge Nurse let the Scheduler know. The Scheduler would reach out to full-time staff first and offer the extra shift, if no one was available, she would contact the staffing agency and offer the additional shift. She revealed that most of the agency nurses and CNAs had been working in this facility for one or two years.</p> <p>Interview on 5/30/2024 at 4:45 pm with the Administrator revealed that the facility had a high turnover during the first quarter of 2024 when several Licensed Practical Nurses (LPNs), Unit Managers, and CNAs resigned. Currently, full-time positions were offered to agency staff. Company recruiters are seeking ways to connect with potential candidates in local communities.</p>		