

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2025
NAME OF PROVIDER OR SUPPLIER  Hart Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  261 Fairview Avenue Hartwell, GA 30643	

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 0811</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 12273</p> <p>Based on observation, interview, record review, and policy review, the facility failed to ensure the staff trained through the Paid Feeding Assistants (PFA) program did not provide assistance to residents with swallowing disorders or were at risk for aspiration for one of three sample residents (Resident (R) 115) reviewed for swallowing disorders out of a total sample of 23 residents . Failure to ensure the Interdisciplinary Team (IDT) identified residents who could be assisted with meals by the PFA, increased the risk R115 could experience aspiration pneumonia and/or choking.</p> <p>Findings include:</p> <p>The policy Paid Feeding Assistants dated ,d+[DATE], included the following directives: 1. Paid feeding assistants provide assistance only for resident [sic] with no complicated feeding problems include difficulty swallowing, recurrent lung aspirations and tube or parenteral IV feedings. 2. Resident are assessed for the appropriateness for the feeding assistant program by the interdisciplinary team, taking into account the most recent assessment and plan of care. 3. Only residents who have been selected by the interdisciplinary team are eligible for feeding assistance by a paid feeding assistant.</p> <p>R115's Admission Record tab in the Electronic Medical Record (EMR) identified an admitted d of [DATE], with hospice services in place. The admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of [DATE], revealed the full assessment had not yet been completed.</p> <p>Review of the EMR Orders tab revealed physician orders for a pureed no added salt diet with nectar think liquids. The MDS assessment indicated R115 was dependent on staff for eating.</p> <p>Review of a Nursing Note dated [DATE], documented by an Licensed Practical Nurse (LPN) under the tab for nursing notes, , identified concerns about the resident swallowing abilities. The entry stated, After lunch today the resident continued to cough and spit out clear frothy mucus the entry went on to note lungs clear . puree diet and ordered palliative set up suction at bedside if needed The entry went on to explain that a crushed medication was administered with thicken liquids to help manage the oral secretions observed.</p> <p>On [DATE], at 12:30 PM, the residents in the dining room were seated at three tables. Each table had staff seated next to them assisting with feeding. Each table had one and/or two staff members seated next to residents who were assisting with feeding.</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 0811</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:30 PM, R115 was seated in the dining room, next to her was the Activities Director (AD) who was assisting by feeding her a pureed diet and nectar thick liquids. Two other residents sitting at the table were eating with verbal prompts and encouragement.</p> <p>On [DATE], at 12:45 PM, LPN 2 who was supervising the dining session was interviewed. LPN 2 explained the second seating in the dining room was for residents who were dependent on the staff for eating. When asked about the staff observed assisting the residents, she identified four of the five staff observed were Certified Nursing Assistants (CNA's), except the AD who was assisting R115. When asked about the AD specifically, she explained the AD was also a CNA.</p> <p>On [DATE] at 2:00 PM, the Minimum Data Set Coordinator (MDSC) 2, was interviewed and identified she coordinated the PFA program. She provided the training curriculum. MDSC2 then provided the names of the staff who had completed the program, which included AD. When asked which residents were eligible to receive assistance from the PFA, she stated the IDT had not reviewed or identified residents who were eligible to receive services from staff who completed the PFA training.</p> <p>On [DATE] at 12:00 PM the AD was interviewed, when asked if she was a CNA, she stated her CNA license expired. The AD explained she had last worked as a CNA in 2023 and had recently returned to work at the facility taking the position as the AD and added she had completed the PFA training. On [DATE] at 2:15 PM, during a follow up interview when asked who directed her to assist R115 with the meal, the AD stated, she could not recall.</p>		