STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115461	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Townsend Park Health and Rehabilitation	196 North Dixie Avenue Cartersville, GA 30120

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39411 Based on record review, staff interviews, and facility policy review, the facility failed to immediately report an injury of unknown origin for one of 28 sampled residents (Resident (R) 97). This failure decreased the facility's potential to protect R97 from a possible allegation of abuse and ensure a safe environment during the investigation of the cause of injury. Findings include: A review of the facility's policy titled Abuse Prohibition reviewed 12/27/24 indicated, Injuries of unknown origin should be thoroughly investigated to determine the cause. Discussion should be held with the Governing Body or Division Nurse if the cause cannot be identified prior to reporting. Once an injury or event is identified as suspicious and may constitute abuse, the center will follow the investigation procedures. Review of R97's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses which included Alzheimer's, severe dementia with psychotic features, depression, and agitation. Review of R97's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/17/25 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was unable to complete the cognitive interview. The staff assessment indicated R97 was severely cognitively impaired. Review of R97's Care Plan, dated 03/21/24 and located in the Care Plan tab of the EMR, revealed R97 had a focus area of pain related to a left (lf) wrist fracture. A review of Nursing Notes, found under Notes tab of EMR, dated 02/26/25, revealed an acute radial fracture noted. There were no documented falls. A review of the Patient at Risk (PAR) review, provided by the facility, dated 02/27/25, revealed a full investigation into the etiology of the fracture. The investigation could not determine the cause of the fracture. There were no witnesses to the cause of the injury. A review of the X-Ray Report, provided by the facility, dated 02/26/25 revealed a subtle hairline fracture of the distal radius. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 04/09/25 at 2:02 PM the Administrator stated she was the abuse coordinator. The Administrator stated that the incident was not witnessed, and she was notified when they received the report of the fracture. The Administrator stated that the incident should have been reported as an injury of unknown origin within the mandated timeframe. The Administrator stated that no report was made to the stated agency. During an interview conducted on 04/09/25 at 2:37 PM Licensed Practical Nurse (LPN) 2 stated that she was notified by staff about R97 swollen wrist. LPN2 stated that R97 is ambulatory and will often sit on the ground and get up by herself. LPN2 stated R97 did not show any signs of pain, and no accident or fall was witnessed by staff. LPN2 stated she did not remember the timeframe of the incident but reported the incident to the Director of Nursing (DON) as soon as she received the report of the fracture. LPN2 stated they are in-serviced monthly on abuse and immediately report all injuries or allegations of abuse to management, and they do the investigations and reporting.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 35690 Based on record review and interviews, the facility failed to ensure five Certified Nurse Aides (CNA) of five CNAs reviewed received their annual performance evaluation. Failing to ensure CNAs received their annual performance evaluations potentially could cause CNAs to not meet the requirements of their job description and potentially lead to poor resident care. Findings Include: Review of the facility's policy titled, dated 2019, .3.1 HR (Human Resources) Conditions of Employment: Standard of Conduct: Performance Evaluations, revealed, It is the intent of this organization to evaluate its [sic] associates on the performance of essential job functions .The goal of ongoing performance management is to support the associate in understanding the essential functions and responsibilities of the position .Managers are accountable for failure to providing [sic] ongoing performance management for their direct reports in their personal evaluation. Review of CNA 3's personnel file revealed there had not been an annual performance evaluation completed since their date of hire. Review of CNA 4's personnel file revealed there had not been an annual performance evaluation completed since their date of hire. Review of CNA 5's personnel file revealed there had not been an annual performance evaluation completed since their date of hire. Review of CNA 6's personnel file revealed there had not been an annual performance evaluation completed since their date of hire. Review of CNA 7's personnel file revealed there had not been an annual performance evaluation completed since their date of hire. During an interview on 04/10/25 at 1:40 PM, the Assistant Director of Nursing (ADON) stated she was not aware that staff needed an annual performance review. During an interview on 04/10/25 at 1:44 PM, the Human Resources Director stated she prints the list of all employees every month that are scheduled to receive their annual performance review and provides the list to the department managers. She stated she rarely gets reviews returned. She stated for the CNAs; she will give the list to the ADON. She confirmed she did not have any performance evaluations for the five CNAs that had been reviewed. During an interview on 04/10/25 at 2:48 PM, the Director of Nursing (DON) stated the regulation should be followed and CNAs should have annual performance evaluations. During an interview on 04/10/25 at 2:59 PM, the Administrator stated that the regulation should be followed, and CNAs should receive their annual performance evaluations.

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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. 35426 Based on observations, staff interview, and reviews of the facility's policy and procedures, the facility failed to ensure that the medication error rate was not five percent or greater, the medication error rate was 7.69 percent. Findings include: Review of the facility's policy titled, Pharmacy Services Medication Administration-General dated 2024, indicated, The joint responsibility of the center and the pharmacy is to facilitate accurate medication administration. Prior to medication administration the Nurse or Certified Medication Aide: . Reads the administration directions on the MAR [Medication Administration Record] and verifies correct medication, dose and direction for use. On 04/09/25, three Licensed Practical Nurses and two Certified Medication Aides (CMA) were observed administering medications on three of three halls. A total of 25 medication opportunities were observed. Two medications errors were observed. On 04/09/25 at 8:40 AM, CMA2 was observed administering the following medication to resident (R) 80: 1. Aspirin 81 mg po (by mouth) daily 2. Vitamin D3 1 capsule po daily 3. Culturelle 15 billion cell sprinkle capsule 1 capsule sprinkle po bid (CMA handled capsule in hand without gloves) 4. Diltiazem 120 milligram (mg) 1 tab po daily 5. Iron 65 mg 1 tab po daily 6. Furosemide 20mg 1 tab po daily 7. Polyethylene Glycol 3350 (administered 1/2 cap with 8oz water) [MD order 1 cap full by mouth 1 time a day mix with 4-8 ounces of liquid] 8. Senna Plus 8.6 mg-50mg 1 every 12 hours [MD order Senna Plus 8.6mg-50mg tab 2 tablets po every 12 hours] 9. Xarelto 10 mg 1 tab po daily Two (2) medication errors were observed by CMA2 while administering the medications to R80. CMA2 administered 1/2 cap Polyethylene Glycol 3350 with 8oz water and administered one tablet of the Senna Plus 8.6 mg -50mg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R80's physician orders, dated 06/07/24, indicated, Polyethylene Glycol 3350 one capful by mouth one time per day. Mix with four to eight ounces of liquid. Diagnosis (DX): Constipation, unspecified and Senna Plus 8.6 mg -50mg 2 tabs by mouth every 12 hours, take with plenty of water. DX; constipation. Interview with CMA2 on 04/10/25 at 9:10 AM confirmed that the medication errors occurred.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observations, interviews, record review, and review of facility policy, the facility failed to ensure staff adhered to the guidelines for Enhanced Barrier Precautions for two of sixteen residents (Resident (R)44 and R81). Additionally, the staff member failed to sanitize a stand to lift equipment after using it on R44. This failure has the potential cross-contamination. Findings include: Review of facility's policy titled, Transmission Based Precautions (Contact, Enhanced Barrier Precautions, Droplet, Airborne) with a review date of 12/27/24, indicated, .Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from patient to patient during high contact activities. Nursing home patients with wounds and indwelling medical devices are especially at high risk of both acquisition and colonization of MDROs. The use of a gown and gloves for high-contact patient care activities is indicated when Contact Precautions do not apply, for nursing home patients with wounds and/or indwelling medical devices, regardless of MDRO colonization as well as for patients with MDRO infection or colonization. Examples of high contact patient care activities requiring gown and glove use for Enhanced Barrier Precautions include: . Dressing. Bathing/showering. Transferring. Providing hygiene. Changing linens. Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, and tracheostomy/ventilator . 1. R44's Face Sheet located in the resident's electronic medical record section (EMR) tab labeled Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that include cerebral vascular accident with hemiplegia, atrial fibrillation, diabetes mellitus, COPD, gastrostomy tube placement Review of R44's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/07/24 located in the resident's EMR section titled MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact. The resident was assessed to have a gastrostomy tube. Observation on 04/08/25 at 9:30 AM revealed Certified Nursing Assistant (CNA)10 entering R44's room without donning a gown, carrying wash cloths and towels. At 9:55 AM, CNA 10 exited the resident's room carrying a bag with dirty items. The CNA was observed entering the resident's room again without donning a gown with a sit-to-stand lift. Ten minutes later, the CNA exited the room with the sit-to-stand lift and returned the lift to the storage area without sanitizing the equipment On 04/08/25 at 10:15 AM, an interview with CNA10 revealed that it was no longer required to wear a gown while providing care for the resident. CNA acknowledged that she did not sanitize the lift only when used on residents in contact isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/08/25 at 10:21 AM with Certified Medication Aide (CMT) 3 revealed R44 had a gastrostomy tube, but she no longer received nutrition through the tube. CMT3 also stated the resident on Enhanced Barrier Precautions (EBP), only providing care of the gastrostomy tube. The CNAs did not need to don a gown when providing care. A few minutes later, CMT3 returned and stated that it made sense for the CNAs to wear a gown while providing this resident's ADLs On 04/08/25 at 10:38 AM, an interview with Licensed Practical Nurse (LPN)2 confirmed R44 was on EBP for her gastrostomy tube; and the staff should don a gown and gloves when providing care to this resident. LPN2 also stated that CNA10 should have sanitized the sit-to-stand lift after using it on R44. 2. A review of R81's Face Sheet located in the resident's EMR section titled Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease with late onset and stage IV sacral pressure ulcer. A review of the R81's Quarterly MDS with an ARD 03/13/25 located in the resident's EMR section titled MDS revealed the resident had a Brief Interview for Mental Status score of three out of fifteen, indicating the resident had severely impaired cognition. The resident was assessed to have an unhealed sacral ulcer. Observation on 04/08/25 at 9:30 AM revealed the resident sitting in a recliner chair in the day room, dressed. No Personal Protective Equipment (PPE) cart was observed outside the resident's room. Observation 04/09/25 at 8:12 AM revealed R81 in a low bed with a specialty mattress, call light within reach. The PPE cart was located outside the resident's room, with signage for EBP. The cart contained a gown, gloves, and foot coverings. An observation on 04/09/25 at 8:15 AM revealed the Hospice CNA entered the room with towels and washcloths and did not don personal protective equipment (PPE) as indicated on the signage before entering the room. An interview on 04/09/25 at 8:40 AM with the Hospice CNA revealed that she had just finished providing the resident with a bath and changing the linen on her bed. The Hospice CNA stated the resident had a sacral ulcer that required a dressing change. The Hospice CNA stated that she was unaware that the resident was on Enhanced Barrier Precautions. The CNA further stated that the facility will usually send a communication informing Hospice staff of such issues, however, this information was not communicated. An interview on 04/09/25 at 9:08 AM with LPN2 revealed the resident was on EBP due to her sacral wounds, which required dressing changes. LPN2 stated there was supposed to be a PPE cart outside the resident's room and had noticed this morning the cart was not long there, so she replaced the cart. LPN 2 was informed that the PPE cart was not present on 04/07 and 04/08. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Infection Control Preventionist (ICP) on 04/10/25 at 9:00 AM revealed that any unnatural opening (such as wounds, gastrostomy tube, tracheostomy, or Foley catheters) in the body that puts residents at risk for infections. So those residents will be placed on EBP. The ICP stated R44 was placed on EBP for her gastrostomy tube even though it was not being used. The staff were expected to don gloves and gowns when providing any type of care to this resident. Also, it is an expectation that staff will sanitize the lifts after each resident lift. The ICP further stated that R81 was on EBP due to her open sacral wound and the Hospice CNA should have donned PPE when providing care to this resident. The ICP stated she would follow up with communicating to the Hospice Program that the resident was on EBP.