| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115473 | A. Building<br>B. Wing | 09/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Traditions Health and Rehabilitation | 2816 Evans Mill Road<br>Lithonia, GA 30058 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50272<br><br>Based on observations, resident and staff interviews, and review of the facility's policy titled, Bedside Storage of Medications, the facility failed to assess one of eight residents (R) (R88) for self-administration of medication and failed to maintain medication in a secure location for one of three residents (R43). The deficient practice had the potential to allow unauthorized access to unsecured medications to residents and visitors at the facility.<br><br>Findings Include:<br><br>1. A review of the undated facility policy titled, Bedside Storage of Medications revealed under section titled Intent, To support self-administration of medication by appropriate patients within the nursing center while facilitating medication security.<br><br>Under section titled GUIDELINE revealed, The Pharmacy supports bedside medication storage for patients who are able to self-administer medications upon the written order of the prescriber and when it is deemed appropriate in the judgment of the nursing center's interdisciplinary patient assessment team. Under section titled PROCEDURE, revealed, A medication-specific order is required from the prescriber for bedside medication storage (e.g., add May keep at bedside to each applicable medication order). Bedside medications may be labeled May keep at bedside by the provider pharmacy upon request. An assessment for self-administration of medications is completed and kept in patients care plan in the medical records.The manner of storage must prevent access by other patients. Lockable drawers or cabinets are REQUIRED.<br><br>A review of clinical record for R88 revealed diagnoses including, but not limited to, Alzheimer's disease with early onset and Dementia.<br><br>A review of the Annual Minimum Data Set (MDS) dated [DATE] revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 09, indicating moderate cognitive impairment.<br><br>A review of the care plan for R88 dated 7/1/2024 revealed a focus area of risk for communication difficulties related to diagnosis of dementia and Alzheimer's. Further review of care plan revealed a focus area of risk for cognitive deficit related to dementia and Alzheimer's.<br><br>(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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 9/3/2024 at 1:41 pm revealed R88 bed side table contained the following medications: Tiger Balm; Pain Relieving Ointment 0.63 ounces (oz.) and Asper creme Lidocaine (2 in 1 pain relief + moisturization) 4 oz.<br><br>An interview on 9/3/2024 at 1:41 pm with R88 revealed resident stated he has a bad knee, and he puts pain reliving ointment for the pain and that the facility was aware he had the pain-relieving ointment.<br><br>An interview on 9/4/2024 at 10:55 am with Certified Nursing Assistant (CNA) EE revealed she was familiar with R88 care, but she was not aware if R88 is supposed to be self-administering pain relieving ointment.<br><br>An interview on 9/4/2024 at 11:03 am with Licensed Practical Nurse (LPN) BB revealed that if residents are self-administering medications they are supposed to be care planned and will need a physicians' order. LPN BB was not aware that R88 was self-administering pain-relieving ointment, and states she checks in on residents as frequent as she can, but never realized he had ointments on his bedside table. LPN BB stated the possible outcome of residents self-administering medication without physicians' orders or proper care planning is that residents can over medicate.<br><br>An interview on 9/4/2024 at 11:16 am with Assistant Director of Nursing (ADON) revealed that residents who self-administer medications are given an assessment and residents must demonstrate that they are able to self-administer medication on their own. ADON further stated the Nurse Practitioner will then write an order and fill out an inform care consent form. She further states depending on the medication it is kept in medication cart and sometimes it is kept in the resident's room, locked away in a safe box. ADON revealed she visits residents every day and was not aware that R88 had pain relieving ointment on his bedside table. ADON further revealed it is her expectations that all CNA's should be aware of residents who self-administer medication and if they see medication in a resident room, they should inform a nurse. ADON revealed that a possible negative outcome would be medication interactions.<br><br>50524<br><br>2. Review of the Electronic Medical Records (EMR) revealed R43 was admitted to the facility with diagnosis including but not limited to obesity, lower abdominal dermatitis, vaginitis and diabetes mellitus.<br><br>Review of the Annual MDS dated [DATE] documented in Section C R43 has a BIMS score of 15 which indicated intact cognition.<br><br>Review of care plan dated 6/21/2024 revealed no focus area for medications to be left at R43's bedside.<br><br>Review of the Physician Orders revealed there was no order for R43 to have medications left at bedside.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and interview on 9/03/2024 at 12:04 pm with R43 in her room revealed there were three medication cups on the bedside table. One cup had a powdery substance, one cup had a white gel substance, and the other cup had a clear gel substance. The resident stated one ointment was for her face, another was for her abdominal fold and the third was for the bottom of her feet since she has diabetic neuropathy, and her feet has tingling sensation. She stated the nurse leaves the ointments on the table for the CNAs to put them on after she has her bath.<br><br>Interview on 9/4/2024 at 1:18 pm with CNA CC revealed, the nurse gives the ointments to the CNAs to apply on the resident.<br><br>Interview on 9/4/2024 at 2:01pm with Registered Nurse Supervisor (RNS) DD stated medications of any sort should not be left unattended in the residents' rooms. She stated the nurses should not be leaving ointments or powders in the resident's room for the CNA to administer. She stated her expectations were for the nurses to administer the resident's medications themselves and not leave medications at the resident's bedside unattended.<br><br>Interview on 9/4/2024 at 2:23 pm with CNA EE, she stated she was on duty on 9/3/2024 and was assigned to R43. She stated she saw the three medication cups on the table beside the resident's bed. She stated medications are left at R43's bedside sometimes at least twice per week and with different nurses. She stated the nurses usually give the ointments to the CNAs to apply on the resident or they leave it at the R43's bedside.<br><br>Interview on 9/4/2024 at 2:28 pm with DON, she stated that medications should not be left at the resident's bedside. She stated her expectations were for nurses not to leave medications at the resident's bedside and if they cannot administer the medications themselves, they should keep them instead of leaving the medications at the resident's bedside. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50524<br><br>Based on staff and resident interviews, record reviews, and review of the facility's policy titled, Best Practice for PASRR, the facility failed to screen one of five residents (R) R43 for Pre-Admission Screening and Record Review (PASRR) level two. The deficient practice had the potential to cause R43 not to receive care and services in the most integrated setting appropriate to her needs.<br><br>Findings include:<br><br>Review of the facility's undated policy titled, Best Practice for PASRR documented There are two areas a person can be a PASRR patient: Significant Mental Illness (SMI) or Intellectual Disability/Developmental Disability (ID/DD) To be included in the PASARR population, a patient must have a SMI, or an ID/DD as determined on their level two assessment.<br><br>Review of the Electronic Medical Record (EMR) revealed R43 was admitted to the facility with diagnosis that included but not limited to paranoid schizophrenia.<br><br>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] documented in Section C (Cognitive Patterns) R43 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated little to no cognitive impairment, and Section N (Medication) reported, takes anti-psychotropic and anti-depressant medications.<br><br>Review of care plan dated 6/21/2024 revealed no focus area for R43 screening for PASARR level two. The care plan included but not limited to, Focus: Paranoid schizophrenia, Trazodone (3/29/2024) Intervention: CARENOW services, labs as ordered, monitor closely for worsening of depression and/or suicidal behavior or thinking, especially during initiation of therapy and during any change in dosage. Focus: Resident requires psychotropic medication for dx of paranoid Schizophrenia (6/21/2024) Has period of anxiety, with risk for adverse reactions relating to medication Lithium. Intervention: Administer medication as ordered. Focus: Behavior easily annoyed/angered (6/18/2023). Patient will demonstrate effective coping skills through the review period. Intervention: Encourage patient to verbalize feelings and provide reassurance as needed.<br><br>Review of Physician Orders dated 8/18/2023 revealed orders which included, Lithium carbonate 300 mg (milligram) capsule (Lithium Carbonate) for diagnosis (Dx): bipolar disorder.<br><br>Interview on 9/4/2024 at 1:04 pm revealed R43 was diagnosed with bipolar [AGE] years ago. She revealed being previously diagnosed with manic depressive disorder, but her diagnosis was changed to bipolar. R43 revealed she takes Lithium medication for the bipolar disorder.<br><br>Interview on 9/4/2024 at 2:01 pm with the Registered Nurse (RN) Supervisor RN DD revealed residents are screened prior to admission for psychiatric conditions and the Social Workers refer the residents to CARENOW for further evaluation. She revealed if a resident had behaviors the Nurse Practitioner (NP) or Medical Doctor (MD) is informed, and they will assess the resident and make the referral for further assessment. She revealed R43 had no behaviors, and the NP was not informed of any behavior for her to make a referral.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 9/4/2024 at 2:28 pm the Director of Nursing (DON) revealed residents are admitted to the facility with a PASRR level one and if they have a major mental disorder they are referred for PASRR level two. If the resident is triggered for further evaluation, the Social Services Director (SSD) or his assistant will send referral information to GAMMIS which is the government service that determines the PASRR level services.<br><br>Interview on 9/4/2024 at 5:22 pm with the SSD revealed residents come to the facility at PASRR level one but if they have a psychiatric disorder, they are PASARR level two and are referred for specialized services. He stated referrals are sent to GAMMIS by the Social Services Assistant. The SSD confirmed R43 was not referred for PASRR two. The SSD revealed that whatever length of time the resident is in the facility, if there were no behaviors, there was no need for PASRR level two screening. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49673<br><br>Based on observation, staff interview, and review of the facility's policies titled, Skilled Nursing Services Storage Areas and Skilled Nursing Services Cleaning and Sanitizing, the facility failed to ensure opened food items in the dry storage and the walk-in refrigerator area were securely wrapped, labeled, dated, and discarded by the expiration date. In addition, the facility failed to maintain sanitary cleanliness of the ice maker and prevent wet nesting by ensuring clean pots, pans and baking trays were properly stacked and stored to dry. The facility census was 147 residents.<br><br>Findings Include:<br><br>Review of facility's policy titled, Skilled Nursing Services Storage Areas dated [DATE] under the section titled Guidelines revealed, items should be covered, sealed, labeled, and dated appropriately. Under the subsection titled, Ice machines, revealed, ice chest should be cleaned on a routine basis and as needed.<br><br>Review of facility's policy titled Skilled Nursing Services Cleaning and Sanitizing, dated [DATE] under the section titled Guidelines revealed, All small ware equipment should be stored in self-draining position that allows it to air dry.<br><br>Observation on [DATE] at 10:00 am with the Dietary Manager (DM) revealed in the dry food storage pantry one 46 fluid (fl) ounces (oz) thickened orange juice dated [DATE], four vanilla 32 fl oz nutritional drink dated [DATE], and 1 pound (lb) traditional stuffing mix dated [DATE] were all expired. The DM confirmed it was everyone responsibility to check for expiration dates, past use and/or out of date foods. The DM discarded expired items and revealed he had new staff and was still conducting in-services on storage, labeling, and dates. The DM revealed, he moved the older items to the front. Further observation revealed, the walk-in refrigerator had four boxes of 100 count 1 oz single serve packets of sour cream with expiration date of [DATE], one 5 lb. cottage cheese with expiration date of [DATE], two 16 lb cream cheese icing with expiration date of [DATE], one cabbage and carrot mix with expiration date of [DATE]. One clear wrapped head of lettuce was observed with no label or date. The DM revealed they use open food items only for three days then discard. The DM confirmed all dietary staff clean the ice machine daily, weekly, as needed, and the maintenance contact provider would deep clean the ice machine quarterly or as needed.<br><br>Review of the work order revealed the last service date the ice machine was deep cleaned was on [DATE]. The DM confirmed the observation of the reddish- black substance on the inner/outer side of the white casing and on the white paper towel.<br><br>Observation on [DATE] at 10:05 am with the DM confirmed the sanitizing process was being performed by rewashing dishes through the low temperature dishwasher. During this time, wet nesting was observed.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on [DATE] at 3:00 pm with the Registered Dietitian (RD) revealed, the kitchen audit consists of equipment base, label/dating, and cleanliness once a month. The RD confirmed she did not physically label, and date food items and that she conducted observation and generate monthly reports. The RD emphasized when the truck come on Tuesday or Friday, she informs the staff to label and date food items. The RD revealed she review opened, received, and used by dates and if she found anything expired, she would pull the items and notify staff. The RD revealed that she would emphasize the three day rule for open foods to staff if its passed the date to be thrown out. The RD revealed she put on last month report for the ice machine to be cleaned. The RD confirmed staff was responsible for spot cleaning ice machine daily.<br><br>Interview and Observation on [DATE] at 3:10 pm confirmed wet nesting with DM and RD. The DM revealed he would complete an in-service today and ongoing for new staff. The DM shared he would ensure the dietary aid spread pots out to dry and rearrange another drying rack to open more space. The DM revealed he was working with maintenance in utilizing limited space and racks. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>46579<br><br>Based on observations, staff interviews, and review of the policy titled, Cleaning of Shared Equipment, the facility failed to clean and disinfect a shared blood pressure cuff before and after use between residents. The deficient practice had the potential to increase the probability of cross transmission of bacteria that could cause infections for residents that the equipment was utilized for.<br><br>Findings:<br><br>Review of the facility policy titled, Cleaning of Shared Equipment with a review date of 12/29/2023, revealed that the purpose was to decrease the risk of cross transmission of bacteria that could colonize or infected patients. It was revealed that medical equipment which is shared between patients shall be cleaned with soap and water or other appropriate cleaner and then disinfected prior to and again after its use on another patient. Sharded equipment include but are not limited to blood pressure cuffs and pulse oximeters.<br><br>An observation on 9/4/2024 at 9:20 am revealed that Certified Nurses Aid (CNA) JJ, removed an electronic blood pressure cuff out of a room and went across the room, into another room. In the room, she took the vital signs, which include blood pressure, heart rate and pulse oximetry, of one of the residents in the room. While in that room, she was observed, going to the roommate and taking the vital signs of the other resident in the room.<br><br>Observation of CNA JJ, on 9/4/2024 at 9:26 am, revealed CNA left the room with the electronic blood pressure machine and cuff. At that time, she was asked by this surveyor, when does the cuff get cleaned, and she stated, they are supposed to be cleaned in between residents. She then stated that she did clean it. She was then asked where the cleaning and disinfected wipes were that are used, and she stated that they are found and kept at the nurse's station. She then stated that she had completed all her vitals and was going to clean it now and headed to the nurse's station. At the nurse's station, she was observed looking for the disinfecting wipes, and then asked someone where they were kept, so that she could clean and disinfect them. She then was observed going to a medication cart, to remove a purple topped disinfecting wipe.<br><br>An interview on 9/4/2024 at 11:25am with the Assistant Director of Nurses (ADON) revealed that blood pressure cuffs and other shared equipment is to be cleaned before and after use and in between each resident.<br><br>CNA JJ, revealed at 9/5/2024 at 2:55 pm, that she was nervous, and should not have told me that she had cleaned and disinfected the blood pressure cuff in between use, as observed the shift prior. |