STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115480	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archbold Living Thomasville	10629 U.S. Highway 19 South Thomasville, GA 31792

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on interview, record review, and facility policy review, the facility failed to ensure a resident's code status was accurately reflected in the medical record in accordance with his wishes for one resident (Resident (R) 16) out of 24 residents reviewed for advanced directives out of a census of 61 residents. Findings include: Review of R16's Admitting and Discharge Record located in the Facesheet tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. R16 had diagnoses of hemiplegia and hemiparesis following cerebral infarction (stroke) and protein-calorie malnutrition. Review of R16's EMR tab labeled Physician Orders Medispan revealed an order dated [DATE] for Full Code. Review of R16's scanned in document, Georgia POLST (Physician Orders for Life-Sustaining Treatment) located in the Document Management tab as well as a paper copy in the hard chart, revealed a request for Do Not Attempt Resuscitation (DNR), signed by the physician on [DATE]. Review of R16's Care Plan, located in the Care Plans tab of the EMR, revealed a problem, dated [DATE], of Full Code, Manifested by: Physician Order and a goal to Honor resident wishes for Full Code. The care plan did not reflect the change in code status to DNR on the POLST dated [DATE]. Review of R16's hard chart Orders tab revealed orders for [DATE], to include an order for Full Code, electronically signed by the physician. Review of R16's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located in the MDS tab of the EMR, revealed he scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. During an interview on [DATE] at 9:23 AM, R16 did not respond to questions asked. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:21 AM, Registered Nurse (RN) 1 was asked what she would do if a resident was found without a pulse or respirations. RN1 stated she would check the EMR for code status. In addition, someone would check the hard chart for a POLST. If the two conflicted, RN1 went by the POLST. During an interview on [DATE] at 11:23 AM, the Assistant Director of Nursing (ADON) stated she would look at the EMR where the order appeared on the dashboard. The ADON would also look at the POLST. The ADON verified that the order and POLST should match. If they did not match, the ADON followed the code status documented on the POLST. The ADON reported a nurse always went to the POLST during a code. During an interview on [DATE] at 11:30 AM, the ADON verified the conflicting physician's order and POLST for R16 and stated, This is why I look at the [hard] chart first [where the POLST is located]. During an interview on [DATE] at 11:34 AM, the Medical Records Coordinator (MRC) stated she took POLSTs signed by a resident/representative to the doctor to be signed. Once she picked the signed POLST back up from the clinic, the MRC made a copy and gave the original to the social worker. The MRC stated she scanned a copy into the EMR but had no part in entering orders into the EMR. During an interview on [DATE] at 11:39 AM, the Social Services Coordinator (SSC) stated that R16 and his wife stated that with his condition, they wanted his code status changed to DNR. The SSC verified that the new POLST for DNR was signed in [DATE]. During an interview on [DATE] at 11:46 AM, the MDS Coordinator (MDSC) stated she updated Care Plans quarterly or when there was a change. She reported she looked at orders with every care plan meeting, and orders were reviewed daily and discussed in huddle (the morning meeting). The MDSC was unaware of the POLST documenting the DNR request signed by the physician on [DATE]. During an interview on [DATE] at 12:10 PM, the Director of Nursing (DON) stated she expected that all areas matched: POLST, orders, and care plan. During an interview on [DATE] at 12:23 PM, the Medical Director stated he reviewed all POLSTs brought to him in his office or given to him while he was at the facility. Once signed, the Medical Director expected orders in the EMR reflected the resident/family wishes that were reflected on the POLST. During an interview on [DATE] at 3:45 PM, the Administrator stated she always went to the hard chart (POLST). She stated staff should go with the most current POLST. Review of the facility's undated Advanced Directives and Advanced Care Planning policy revealed a POLST served as a medical order. A DNR order informs medical staff that a CPR (cardiopulmonary resuscitation) is not wanted. Without a DNR order, medical staff will attempt every effort to restore your breathing and the normal rhythm of your heart. Review of the facility's undated Code Blue policy revealed BLS [Basic Cardiac Life Support] will be initiated on any resident who sustains a cardiac attest [sic] unless there is a physician's written order stating No CPR or No Code or DNR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on interview, record review, and facility policy review, the facility failed to follow a care plan related to weight loss for one of six residents (Resident (R) 8) reviewed for nutrition out of 20 sampled residents. This had the potential for the resident to have a delayed response to weight loss. Findings include: Review of R8's Admitting and Discharge Record, located in the Facesheet tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) and dementia. Review of orders located under the Physician Orders Medispan of the EMR revealed an order for monthly weights, dated 10/17/22. Review of R8's Care Plan, located in the Care Plans tab of the EMR, revealed a problem of unintended weight loss dated 11/07/24. A goal was to maintain weight for three months. Interventions included for the aides to: weigh me every week. Review of R8's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/08/24 and located under the MDS tab of the EMR revealed she scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. R8 was on a mechanically altered diet and had no significant weight loss. R8 weighed 142 pounds (lbs). Review of the Reports section of the EMR under Weights as well as the Nursing tab of the EMR revealed R8 had the following monthly weights entered but no weekly weights: 07/03/24 153.4 lbs 08/06/24 157.4 lbs 09/05/24 150.0 lbs 10/03/24 148.6 lbs 11/06/24 141.2 lbs 11/07/24 142.6 lbs 12/04/24 140.1 lbs 01/01/25 134.2 lbs (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/12/25 at 1:52 PM, R8 reported that staff weighed her the other day. R8 was unaware of any weight change. During an interview on 01/14/25 at 1:00 PM, Registered Dietician (RD) 2 stated she was unaware of any weight loss for R8 for the month. I tabulate the monthly weights, but I had not tabulated the monthly weights yet at this point. RD2 stated R8 was weighed monthly. During an interview on 01/14/25 at 3:34 PM, the MDS Coordinator (MDSC) reported Residents don't get a weekly weight unless they pop with weight loss or gain. The MDSC stated the care plan for weekly weights was probably from a while back because R8 used to be on weekly weights. During an interview on 01/15/25 at 10:53 AM, the Director of Nursing (DON) stated she expected the care plan to be followed. During an interview on 01/15/25 at 1:05 PM, the Administrator reported the facility did not have a policy regarding the following of care plans. The facility went by the RAI (Resident Assessment Instrument) Manual. Review of the RAI Manual, revised October 2023, revealed, The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 Based on record reviews, interviews, and policy review, the facility failed to timely monitor the weights of two (Residents (R) 39 and R8) of seven residents reviewed for nutrition out of a total sample of 20 residents. Findings include: 1. R39 was originally admitted to the facility on [DATE] with diagnoses that included hemiplegia following intracerebral hemorrhage affecting her left non-dominant side and dysphagia. Review of R39's annual Minimum Data Set (MDS) and with Assessment Reference Date (ARD) of 10/17/24 located in the electronic medical record (EMR) revealed the resident had a Brief Interview for Mental Status (BIMS) of 13 out of 15, indicating R39 was cognitively intact. A review of R39's care plan revealed a focus indicating the resident had unintended weight loss due to a history of not eating or drinking enough as well as losing too much weight in the past. Interventions for this focus included weighing the resident and keeping an eye on how much I drink provide my nutrition and fluids as scheduled . The goal for this focus was to enjoy my meals, stay well hydrated, maintain my weight, be comfortable eating and drinking without choking or coughing, have my nutritional needs met. Another focus revealed a potential for alteration in nutrition related to tube feeding to supplement PO [by mouth] intake. The goal for this focus was to maintain current weight and have no significant weight loss using interventions that included monthly weights and monitoring intake and output. Review of the Reports section under the Weights section in the EMR revealed the residents' weights: 09/05/24 190.2lbs; 10/03/24 192.6lbs; 11/06/24 191.2lbs; 12/04/24 191.8lbs; 01/01/25 182lbs. This revealed a weight loss of 5.11% in approximately 30 days. During an interview with R39 on 01/13/25 at 10:00AM she stated that she eats three meals a day plus snacks and receives tube feedings overnight. An interview was conducted with Certified Nursing Assistant (CNA)1 on 01/13/25 at 1:21PM and she confirmed the resident's intake was typically less than 25% of the given meal. Adding that most times the resident received grilled cheese as a substitute for the provided meal and will only eat a few bites. Review of the CNA charting documentation revealed the resident had eaten 0-25% of the daily meals provided for the last 30 days. An interview was conducted with Registered Dietitian (RD) 1 on 01/13/25 at 1:43 PM, and she confirmed the resident was weighed every 30 days. The RD added that most residents are weighed monthly, unless a concern was identified, and that person would be on weekly weights. RD1 then explained that she pulls the weights weekly or monthly and puts them on a spreadsheet to discuss and share during the weekly staff meetings. RD1 was asked about R39 having significant weight loss and she stated that she was not aware as she and her team were just reviewing the 30-day weights taken on 01/01/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a subsequent interview with the RD1 on 1/13/25 at 2:03 PM, she confirmed that a re-weigh was done and confirmed a weight of 180.2 lbs, revealing a weight loss of 6.05% since 12/04/24. An interview was conducted with the Assistant Director of Nursing (ADON) on 01/14/25 at 11:19 AM, and she stated that the RD team provides the nursing team with a report weekly advising of any significant changes in resident weights. The ADON stated that R39 was not reported as her weight had been consistent before this month. 42440 2. Review of R8's Admitting and Discharge Record, located in the Facesheet tab of the EMR revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) and dementia. Review of orders located under the Physician Orders Medispan of the EMR revealed a diet order for cardiac diet with chopped meats, gravy on the side, mechanical soft, and double portions all meals, dated 11/07/24. An order for monthly weights was dated 10/17/22. Review of R8's Care Plan, located in the Care Plans tab of the EMR, revealed a problem of unintended weight loss dated 11/07/24. A goal was to maintain weight for three months. Interventions included for the aides to: weigh me every week, setup my meal so I can eat, let me take as much time to eat as I need, let me eat uninterrupted, ask me if I like my meal offer me something else if I don't like the meal. Review of R8's Department Notes tab of the EMR revealed a Quarterly Dietary Note dated 11/07/24 which documented a less than one-percent weight loss over one month, three-percent weight loss over three months, and stable weight over six months. The nutritional approach stated, Will continue to follow for labs, intake, weight, skin integrity, GI [gastro-intestinal] status. Review of R8's quarterly MDS with an ARD of 11/08/24 and located under the MDS tab of the EMR revealed she scored 13 out of 15 on the BIMS, indicating intact cognition. R8 was on a mechanically altered diet and had no significant weight loss. R8 weighed 142 pounds (lbs). Review of the Reports section of the EMR under Weights as well as the Nursing tab of the EMR revealed R8 had the following weights entered since July 2024: 07/03/24 153.4 lbs 08/06/24 157.4 lbs 09/05/24 150.0 lbs 10/03/24 148.6 lbs 11/06/24 141.2 lbs 11/07/24 142.6 lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/04/24 140.1 lbs 01/01/25 134.2 lbs The weight loss from 07/03/24 to 01/01/25 was a 12.52 percent loss in six months. During an interview on 01/12/25 at 1:52 PM, R8 reported that staff weighed her the other day. R8 was unaware of any weight change. R8 reported she ate in her room because she chose to, and if she liked something, she asked for more. During an interview on 01/14/25 at 1:00 PM, Registered Dietician (RD) 2 stated she was unaware of any weight loss for R8 for the month. I tabulate the monthly weights, but I had not tabulated the monthly weights yet at this point. RD2 stated R8 was weighed monthly. RD2 stated that R8 had some weight loss prior to January, but it had not reached a significant level, so she (R8) was just monitored. RD2 stated if a resident triggered for a five-percent weight loss in one month or 10 percent weight loss in six months, they were put on the weekly weight list. During an interview on 01/14/25 at 3:34 PM, the MDS Coordinator (MDSC) reported the facility ran a weight change roster when they did the MDS assessments. Residents don't get a weekly weight unless they pop with weight loss or gain. The MDSC reported that the Certified Nursing Assistants (CNAs) did the monthly weights the first part of the month and entered them into the EMR. We discovered either today or yesterday that CNAs couldn't see the previous weight when entering in weights [so were not aware if there had been a change]. Once weights are entered into the EMR, the RDs reviewed them by running a monthly report. During an interview on 01/15/25 at 10:53 AM, the Director of Nursing (DON) stated the restorative CNAs weighed residents. The RDs were to pull the monthly and weekly weight reports. The DON expected the dietician to pull the reports timely. Review of the facility's Weight Assessment and Intervention policy, revised September 2011, revealed Any weight change of 5% or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will immediately notify the Dietician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, interview, record review, and policy review, the facility failed to administer oxygen at the physician prescribed dose for one of two residents (Residents (R) 164) reviewed for respiratory care out of a total sample of 20. This had the potential to cause residents respiratory distress. Findings include: Review of R164's Admitting and Discharge Record, located in the Facesheet tab of the electronic medical record, (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses that included pneumonitis due to inhalation of food and vomit and autistic disorder. Review of R164's Care Plan, located in the Care Plans tab of the EMR, revealed a problem of potential for altered respiratory status dated 12/17/24. Interventions included, Administer oxygen as ordered. Review of R164's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/23/24 and located under the MDS tab of the EMR, revealed R164's Staff Assessment for Mental Status indicated short- and long-term memory problem. R164 utilized oxygen therapy. Review of R164's Medication Administration Record (MAR), located in the under EMR the MAR tab, revealed an order dated 01/02/25 for oxygen at two liters/minute per nasal cannula to keep oxygen saturations greater than or equal to 92% as needed. During an observation on 01/12/25 at 9:09 AM, R164 was observed lying in bed with his eyes closed. The resident had an oxygen cannula in place, running from a concentrator that was set at 3.5 liters per minute (LPM). During an observation on 01/13/25 at 9:30 AM, R164's oxygen concentrator was again set at 3.5 LPM. During an observation on 01/13/25 at 5:15 PM, R164's oxygen concentrator was again set at 3.5 LPM. During an interview on 01/13/25 at 5:20 PM, Certified Nursing Assistant (CNA) 1 stated R164 used oxygen routinely for many months. CNA1 was not aware of the specific oxygen settings for residents and made no adjustments to oxygen settings. During an interview on 01/13/25 at 5:23 PM, Registered Nurse (RN) 2 stated R164's nurse was on break. RN2 observed R164's oxygen concentrator setting and verified it was set at 3.5 LPM. During an interview on 01/14/25 at 04:25 PM, RN2 stated she was unaware on 01/13/25 of R164's oxygen setting when she verified it was set at 3.5 LPM. After the observation, RN2 reported that she spoke to R164's nurse, confirmed the order was 2 LPM, and R164's nurse corrected the concentrator setting to 2 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/15/25 at 10:46 AM, the Director of Nursing (DON) stated when an order was for oxygen at 2 LPM, the setting should not be changed without notification to the doctor and an order. The DON stated using oxygen at a non-prescribed setting could cause adverse effects. Review of the facility's Oxygen Administration policy, revised 11/24/14, revealed the purpose of providing oxygen administration per the physician's orders was to avoid the inappropriate administration of oxygen via incorrect devices or at incorrect liter flows, either of which could be detrimental to the patient. It stated, At no time shall anyone change the administration device or the prescribed liter flow without obtaining an order to do so from the physician.

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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** 42440 Based on observation, record review, interview, and policy review, the facility failed to utilize the proper personal protective equipment (PPE) for enhanced barrier precautions (EBP) for one of one resident (Resident (R) 14) reviewed for EBP out of a sample of 20 residents. This created a potential for the transmission of infection to staff and other residents. Findings include: Review of R14's Admitting and Discharge Record located in the Facesheet tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses of urinary tract infection and diabetes. Review of R14's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/08/24 and located in the MDS tab of the EMR, revealed R14 had short- and long-term memory problems on the Staff Assessment for Mental Status. She had a diagnosis of oral phase dysphagia (difficulty swallowing), had a feeding tube, and received >51% or her total calories through a tube feeding. Review of R14's EMR tab labelled Physician Orders Medispan revealed an order dated 11/11/24 for Enhanced Barrier Precautions (EBP). Review of R14's Care Plan, located in the Care Plans tab of the EMR, revealed a problem, dated 11/11/24, of greater potential for infection related to wounds and PEG (feeding tube inserted through the abdomen into the stomach). An intervention included extended [sic] barrier precautions per protocol. During an observation on 01/14/25 at 12:03 PM, Licensed Practical Nurse (LPN) 1 dispensed liquid medication into a medication cup at the medication cart and walked into R14's room. R14 had no EBP sign posted by her name outside of the door. A caddy containing PPE supplies of gloves and gowns hung on R14's door. LPN1 washed her hands at the sink in the room and prepared cups of water for R14's PEG tube flush. LPN1 walked to the door, grabbed gloves from the caddy, and put the gloves on. LPN1 did not put on a gown. When LPN1 was unable to flush the feeding tube utilizing water in a syringe, she tried to massage the tubing with gloved hands. At 12:12 PM, LPN disposed of the water in the syringe into the sink and changed gloves. LPN1 walked around the bed and hit the button on the wall to page for assistance. At 12:15 PM, LPN1 removed her gloves and left the room to get a pipe cleaner [feeding tube declogger] for the feeding tube. LPN1 washed her hands at the sink upon return to the room and used the pipe cleaner inserted into the feeding tube to attempt to unclog it. LPN1 re-attempted the flush, and after massaging the tube again, the water flowed from the syringe into the feeding tube. LPN1 administered the liquid medication and flushed the tube with water. At 12:20 PM, LPN1 finished administering medication, removed her gloves, and washed her hands at the sink. LPN1 did not wear a gown throughout the medication administration. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/14/25 at 4:20 PM, when asked what residents were on EBP, Certified Nursing Assistant (CNA) 1 stated residents with foley catheters or colostomies. When asked what precautions staff were to take when working with a resident with a catheter, CNA1 responded that if she changed or emptied the bag, she wore gloves and washed her hands. When asked if residents with feeding tubes needed EBP, CNA1 stated, Yes. CNA1 then stated residents with wounds also required EBP. When asked if staff wore gowns when assisting residents on EBP with cares such as dressing or toileting, CNA1 responded, I feel they should wear a gown at any point of contact for infection purposes. CNA1 stated she knew which residents were on EBP because there was a sign by their name outside their door. During an interview on 01/14/25 at 4:25 PM, interview with Registered Nurse (RN) 2 reported residents who were on EBP had an infection such as MRSA (methicillin-resistant enterococcus) in a wound and were on contact precautions. RN2 further stated a resident was on droplet precautions for influenza. When prompted to look at an EBP sign outside a resident's door, RN2 stated a resident was on EBP with wounds, even if the resident did not have an infection. When asked what PPE staff were to utilize when caring for a resident with EBP, RN2 said nurses wore a gown and gloves when treating wounds. When asked if activities such as toileting or dressing would warrant a gown, RN2 stated a gown was not needed. When asked if people with feeding tubes were on EBP, RN2 stated no and that staff wore gloves and did hand hygiene when caring for them. During an interview on 01/14/25 at 4:45 PM, LPN1 stated EBPs were used when someone tested positive for something and needed contact precautions. When prompted to look at an EBP sign outside a resident's door, LPN1 stated there were contact precautions and droplet precautions. LPN stated, we use standard precautions, but EBP if a resident tested positive for something. When asked how they know who is on EBP, LPN1 stated the infection control nurse verbally let staff know. When asked about the EBP signs by residents' names and if staff used the signs as an indicator, LPN1 stated again that the communication was verbal. When asked if R14 was on EBP, LPN1 stated no. During an interview on 01/15/25 at 8:58 AM, LPN2 stated staff wore gowns and gloves when providing direct care to residents on EBP. Residents were on EBP if they had a feeding tube, catheter, or wounds. LPN2 stated she normally looked for an EBP sign by a resident's name to determine if they were on EBP. During an interview on 01/15/25 at 9:03 AM, the Assistant Director of Nursing (ADON) stated nurses can tell if a resident is on EBPs because they had orders which indicated the reason for EBP in the EMR. The ADON stated that in addition, there were signs posted by their names. During an interview on 01/15/25 at 10:34 AM, the Director of Nursing/Infection Preventionist (DON) stated the signs by residents' names, as well as their orders, indicated the need for EBPs. The DON expected nurses to gown and glove when they administered medications via a PEG tube. Review of the facility's Enhanced Barrier Precautions policy, dated 04/01/24, revealed Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition [e.g. residents with wounds or indwelling medical devices].