STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115483	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dawson Health and Rehabilitation	1159 Georgia Ave. S.E. Dawson, GA 39842

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on observation, record review, interviews, and facility policy review, the facility failed to assess for self-administration of medication for one of one resident (Resident (R) 11) reviewed for self-administration of medication out of a total sample of 19 residents. This had the potential to affect resident medication safety at the facility. Findings include: Review of R11's Admission Record in the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE]. The Admission Record revealed R11's diagnoses included centrilobular emphysema and malignant neoplasm of bronchus/lung. Review of R11's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/24 and located in the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident had intact cognition. Review of R11's physician order written 07/28/22 located in the Orders tab revealed, Creon [lipase/protease/amylase], 36,000 unit-114,000 unit-180,000-unit capsule delayed release take two capsules, by mouth with meals. During an observation in R11's room on 02/02/25 at 11:49 AM, two blue and clear capsules in a medicine cup were observed on R11's bedside table. R11 was next to the bedside table and sleeping in his wheelchair. R11 woke up when surveyor knocked on the door. Surveyor asked R11 if those were his pills. He answered, Yes. Surveyor asked him what medicine the pills were. R11 answered, I don't know. [Certified Medication Aide (CMA) 1] gave them to me. Then I fell asleep before taking them. I'll take them now. Surveyor picked up the medicine cup with the pills in it and stopped Licensed Practical Nurse (LPN) 1 in the hallway as she walked by R11's doorway. Surveyor asked her, Did you give medicine to this resident this morning? LPN1 responds, No and we're not supposed to leave medicine [meds] with residents. The policy is that we don't leave meds at the bedside. I did not leave those meds with him. During an interview on 02/02/25 at 6:14 PM, CMA1 stated, No, we're not supposed to leave meds at the bedside, and I wouldn't do that. I put the meds in his hand, and he kept the medicine cup. I saw him raising it up to his mouth as I was walking away. So, I thought he took his meds. Otherwise, I wouldn't have left. I never leave meds at the bedside. We don't even leave medicated creams at the bedside. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/02/25 at 6:20 PM, the Administrator stated, We do not have anyone at this facility that self-administers their own meds. If we do, we have to first do a self-administration of meds assessment, then go over the request with the interdisciplinary team (IDT) on whether they are capable of self-administering their own meds. It's not something our residents do in this facility though. During an interview on 02/02/25 at 6:35 PM, Registered Nurse (RN) 1 stated, We don't leave medicine at the bedside according to our policy. I would have to look at the actual policy to go over what requirements there are for allowing self-administration of meds. During an interview on 02/02/25 at 6:41 PM, the Director of Nursing (DON) stated, We don't have anyone that self-administers their own medication. It is our policy that nursing staff do not leave meds at the bedside. We have to do a self-administration of meds assessment with the resident, discuss it with the IDT and family. There must be a doctor's order for it as well. My staff know they are not allowed to leave any meds at the bedside. Review of a list compiled on 02/02/25 and provided by the DON, revealed there were two independent ambulatory residents and seven residents that were mobile by propelling themselves in a wheelchair residing on the hall with R11 that potentially could have access to R11's room while he was not in his room. Review of the facility's policy titled, Pharmacy Services: Self-Administration of Medication by Patients, undated, indicated under the section Intent: To facilitate a process for safe self-administration of medications by patients when appropriate. Indicated under the section Guideline: Each patient who desires to self-administer medication is permitted to do so if the nursing center's IDT has determined that the practice would be safe for the patient and other patients of the nursing center and that the patient is able to accurately self-administer. Ability to appropriately self-administer medications should be documented in the patient's care plan. Indicated under the section Guideline: Nurses and aides are required to report to the charge nurse on duty on duty any medications found at the beside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party.

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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** 03115 Based on record review, interviews, and policy review, the facility failed to ensure the accurate code status was documented in the medical record to ensure the resident/family's wishes would be honored for one of 24 residents (Resident (R)23) reviewed for code status in the initial pool. This failure could result in a resident receiving cardiopulmonary resuscitation in the event they coded when their wishes were to not receive cardiopulmonary resuscitation. Findings include: Review of R23's code status revealed there was a discrepancy in the documentation between the physician's order, electronic medical record (EMR), and the Physician Orders for Life-Sustaining Treatment (POLST). Review of R23's current physician's order located under the Orders tab of the EMR revealed she had an order for a full code. The order had a start date of [DATE]. The top section of the EMR stated R23 was a full code. Review of a document located in the Document tab of the EMR titled Georgia Department of Public Health Physician Orders for Life-Sustaining Treatment (POLST) signed by R23's daughter on [DATE] and the physician on [DATE] revealed Section A Code Status had a check mark on Allow Natural Death and Do Not Attempt Resuscitation [DNR]. During an interview on [DATE] at 2:54 PM, the Director of Nursing (DON) and Social Service Director (SSD) each verified that both the top portion of the resident's record in the EMR and the physician's order stated R23's code status was documented as a Full Code. The SSD stated R23 must be a DNR since the POLST was marked DNR and was signed by the physician and a Family Member (FM)1. Review of R23's quarterly Minimum Data Set (MDS) assessment located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 99 indicating R23's was severely cognitively impaired. Her admitted was [DATE]. Review of her diagnosis located in the Diagnosis tab of the EMR revealed her diagnoses included but was not limited to Alzheimer's disease and dementia. On [DATE] at 3:50 PM, Licensed Practical Nurse (LPN) 2 was asked if R23 were to code or be found without vital signs what she would do. LPN2 she would check the EMR for R23's code status. After checking R23's EMR, LPN2 stated R23 was a full code so she would start CPR. On [DATE] at 4:10 PM the SSD stated she spoke to FM1 on the phone on [DATE] and explained to her that the code status was a full code in the EMR and orders but that the POLST signed when R23 was admitted was for a DNR. She stated FM1 responded by saying let's just leave her code status a DNR as signed on the POLST when R23 was admitted to the facility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:23 PM Assistant Director of Nursing (ADON) was asked about the facility's process for code status, and she stated the EMR would be checked and if it stated full code she would initiate CPR. On [DATE] at 2:10 PM FM1 stated R23 was to remain a DNR. Review of the facility policy titled Skilled Nursing Services Cardiopulmonary Resuscitation with a review date of [DATE] stated cardiopulmonary resuscitation (CPR) would be performed on residents who do not have an order to allow for natural death. The policy for Advanced Directives was requested on [DATE] at 2:54 PM. The DON provided a copy of an undated form titled Advanced Directives which was a form the resident/responsible representative completes to document the if they have an advanced directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview, record review, and review of the facility's policy, the facility failed to notify the physician for one of two residents (Resident (R) 29) reviewed for change of condition out of 19 sampled residents. R29 was ordered medication as an intervention for pain; however, the resident missed three doses of medication, and the physician was not notified. Additionally, R29 could not fully complete an x-ray due to pain and the nurse failed to notify the physician. This failure prevented the medical provider the opportunity to make changes to the plan of care. Findings include: Review of the facility's policy titled, Changes in a Patient's Condition, reviewed 12/27/24 revealed .It is the intent of this center to notify the patient, his/her attending physician, and responsible party/patient representative of changes in the patient's condition and/or status .Nursing services is responsible for notifying the patient's attending physician when: .There is a significant change in the patient's physical, mental, or emotional status; .Changes in the patient's medical condition should be promptly recorded in the patient's medical record . Review of R29's undated Face Sheet, provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of R29's physician order Summary Report, provided by the facility revealed on 09/10/24 the resident was ordered tramadol [opioid pain medication] 50 mg tablet, 1 tablet by mouth 2 times per day 7 days .Dx [diagnosis]: Acute pain due to trauma . The Summary Report also revealed that R29 was ordered a thoracic spine x-ray for acute pain due to trauma (a fall on 09/08/24). Review of R29's Electronic Medication Administration Record [eMAR], dated September 2024 and located in the resident's EMR under the Medications tab revealed on 09/10/24 the resident's pain was assessed to be a 10 on a scale of 1-10, with 10 being the highest pain level possible. Continued review of the eMAR revealed R29 was administered physician ordered PRN (as needed) acetaminophen with a post pain level of 1. Review of R29's Nurses Note, dated 09/10/24 and located in the resident's EMR under the Nurses Notes tab revealed Tramadol did not come in tonight, will start when it arrives from pharmacy. During an interview on 02/06/25 at 9:43 AM, Licensed Practical Nurse (LPN) 4 verified that she did not notify the physician on 09/10/24 when R29 missed the dose of tramadol because the pharmacy had not delivered it to the facility. Review of R29's Nurses Note, dated 09/11/24 and located in the resident's EMR under the Nurses Notes tab revealed 8am medication Tramadol 50mg not administered[.] Medication not in from pharmacy. F/U [follow up] with pharmacy stated medication will be in tonight. Will pass to on-coming nurse. Review of R29's complete EMR revealed no documented evidence the physician was notified of the resident not receiving her ordered pain medication. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R29's Nurses Note, dated 09/11/24 and located in the resident's EMR under the Nurses Notes tab revealed Resident was scheduled for x-ray today due to pain. Writer assisted x-ray tech [technician] with the task, but was unable to complete all the test due to the resident being in too much discomfort. The note was completed by Registered Nurse (RN) 1. Review of an email provided by the facility, dated 02/06/25 and from the x-ray contractor revealed 9/11/24 exam: PAIN .Best obtainable, PT [patient] was in pain and could not hold position for long .Nurse decided to stop exam before finishing due to PT pain . During an interview on 02/06/25 at 9:27 AM, the Director of Nursing (DON) stated when R29's medication did not arrive to the facility from the pharmacy on 09/10/24, it was her expectation LPN4 would have notified the provider that the tramadol had not arrived and get an order to hold the medication, and request an alternate medication be given. The DON also stated it was her expectation when R29 did not complete the x-ray as ordered on 09/11/24 due to being in pain, RN1 would have notified the provider that the x-ray could not be fully completed due to the resident being in pain and get further instruction from the provider. During an interview on 02/06/25 at 8:40 AM, in regard to R29's Nurses Note, dated 09/11/24 completed by RN1, RN1 stated she did not notify the resident's physician or another provider that R29 was not able to complete the ordered x-ray due to being in pain. The RN stated she should have notified the resident's physician. During an interview on 02/06/25 at 11:58 AM, NP1 stated on 09/10/24 she was notified R29 was complaining of increased pain. NP1 stated she ordered tramadol and an x-ray for R29. Continued interview revealed when the x-ray was not able to be fully completed as ordered because the resident was in pain, NP1 stated it was her expectation RN1 would have notified her or the physician to get further direction on what to do for R29's pain. During an interview on 02/06/25 at 1:59 PM, the Medical Director, who was also R29's attending physician, stated when R29 could not complete all of the x-ray because of being in pain, it was his expectation that the nurse would have notified him to get an order to treat the resident's pain. The Medical Director also stated that when R29's ordered tramadol did not arrive on 09/11/24 and the resident was in pain, the nursing staff should have notified himself or another provider to get an order to use the E-Kit.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on documentation review, record review, interviews, and policy review, the facility failed to ensure one of three residents (Resident (R) 23) reviewed for abuse out of a total sample of 19 residents was not physically abused by Certified Nursing Assistant (CNA) 1 while CNA2, CNA3, and CNA4 witnessed the abuse, did not intervene to stop the abuse, and did not report the abuse to the Administrator or Director of Nursing (DON) until 30 minutes after the abuse was witnessed. This resulted in the continued abuse of Resident (R) 23 and put 55 residents in the facility at risk of abuse while CNA1 continued to work for 30 minutes after the abuse was witnessed. The facility's Administrator, the DON, and the Regional Corporate Nurse were informed on 02/03/25 at 4:29 PM that Immediate Jeopardy (IJ) existed at F600L: Free from Abuse and Neglect related to the failure to ensure R23 was not abused and failure to ensure the witnesses stopped the abuse and reported it immediately. The Immediate Jeopardy began on 01/28/25, the date CNA1 hit R23 in the face, twisted her arm, and put a pillow over her face. The survey team validated the implementation of the removal plan through observations, staff interviews, and review of resident records. The immediacy of IJ was removed on 2/5/2025. Findings include: Review of a [NAME] Police Department (PD) incident report dated 01/28/25 revealed the facility and the police department completed an investigation of an alleged staff to resident abuse. According to the report, on 01/28/25 between 11:45 AM and 12:34 PM, CNA1 was witnessed by CNA2, CNA3, and CNA4 to hit R23 in the face with both an open palm and closed fist strike. According to the report and the written statements of each witnesses, CNA1 grabbed R23's arm and began to twist it into a position that would be uncomfortable for most people but especially for someone R23's age. The witnesses stated CNA1 placed a pillow over R23's face, to the point where R23's face was red. Each of the CNA's stated R23 was bleeding from her lower lip and that CNA1 gave R23 a wipe to clean the blood off her face. After R23 wiped her face CNA1 wheeled the resident to the lobby. According to the police report, the police spoke to R23 and due to their age and cognitive ability they were not able to obtain much information of the incident from the victim's point of view. The police noted the lower lip seemed to be cut and her face looked more of a red color, compared to the rest of her complexion. CNA1 was charged with elder abuse, aggravated assault, battery against patient in personal care home on 01/28/25, the date the abuse occurred. Review of R23's quarterly Minimum Data Set (MDS) assessment located in the MDS tab of the electronic medical record (EMR) dated 12/04/24 revealed she had a Brief Interview for Mental Status (BIMS) score of 99 indicating her cognitive status was severely impaired. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of her care plan with a 12/12/24 reviewed date and located under the Care Plan tab of the EMR revealed she had cognitive impairment due to Alzheimer's dementia, short and long-term memory problems, and poor decision making. Under the self-care deficit care area, it stated R23 required staff assistance with her activities of daily living. R23 had a care plan area for behaviors with a review date of 12/12/24 stating her behaviors included physical aggression, grabbing, agitation, biting, crying, delusions, and rejecting care. Interventions for behaviors included maintain a tolerant, calm manner; use a gentle friendly tone of voice, with slow, deliberate gestures and avoid sudden movements . The facility's investigation was reviewed in its entirety and was silent to any immediate actions taken by CNA2, CNA3 and CNA4 to stop CNA1 from hitting R23, twisting her arm, and putting the pillow over her face. On 02/02/25 at 4:41 PM the DON was asked if during the investigation she had asked the CNA's who witnessed the abuse what they had done to potentially stop CNA1. The DON stated she did, and the CNAs had a stunned look on their faces and were unable to say what they did to stop the abuse. On 02/03/25 at 12:10 PM the DON provided a typewritten report dated 01/28/25 and signed by the DON. In the report the DON wrote that she asked the three witnesses how soon they reported it after they witnessed it, and they all stated 30 minutes because they had not yet seen the DON. She wrote she asked them if they stopped CNA1 from abusing R23 and if not why? The all began to look at each other and did not have a clear explanation. During the interview, the DON stated she did immediately train each of the CNAs that they should have stopped the abuse and reported it immediately. She stated they also covered it during the trainings however she did not have documentation to prove she trained the CNA's that they should have intervened immediately to stop the abuse and her training/inservice records were also silent to this. On 02/02/25 at 6:15 PM CNA4 was interviewed via telephone; on 02/02/25 at 6:30 PM CNA2 was interviewed via telephone; and on 02/02/25 at 6:38 PM CNA 3 was interviewed via telephone. During the interviews each of the CNAs were asked what action they took while CNA1 was slapping, twisting R23's arm, and putting a pillow over her face. CNA4 stated they really did not do anything to intervene because they just wanted to hurry up and rush to end the situation. She stated she had never seen anything like this ever happen. CNA2 stated she told her to stop but CNA1 did not stop and after she removed the pillow from R23's face CNA1 stated sorry y'all but it had to be done. CNA2 stated other than telling CNA1 her to stop, CNA2 did not do anything else. CNA3 stated CNA2 said, O my God you have twisted her arm like a chicken wing. CNA3 stated they did not do anything else while the events were occurring. She stated CNA1 stated sorry y'all it had to be done after she removed the pillow from R23's face. CNA3 stated they were shocked, and they did not do anything else to stop it. CNA3 stated when they (CNA2, CNA3, and CNA4) went to the break room, they reported it to the DON and Administrator. On 02/03/25 from 12:10 PM to 1:04 PM, CNA2, CNA3, and CNA4 were again each individually interviewed. The were each asked how long it was before they reported it, CNA4 stated it was not quite an hour; CNA2 stated it was reported within 15 minutes; and CNA3 stated it was between 30 and 35 minutes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/02/25 at 3:00 PM, the Regional Corporate Nurse provided a letter dated February 4, 2025 addressed to the State Agency and signed by the Administrator. The letter described the abuse and interventions that were put in place to prevent any future abuse. Under the Conclusion section of the letter it stated, Based on witness statements and physical symptoms noted during assessment, the facility is substantiating that abuse occurred. The Regional Corporate Nurse verified that CNA1 did abuse R23. Review of the facility policy titled Skilled Nursing Services Abuse Prohibition with a review date of 12/29/23 stated residents in our center will not be subject to abuse by anyone and any person observing any abuse must immediately report it to the Administrator, DON, SSD, or any person in charge. 43353

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on record review and interview, the facility failed to ensure one of one resident (Resident) (R) 40) out of a total sample of 19 residents comprehensive social assessments were completed accurately to reflect diagnoses of mental illness and/or intellectual disability (ID). Failure to accurately identify diagnosis of mental illness or ID had the potential to result in the resident not receiving additional specialized services. Findings include: Review of R40's electronic medical record (EMR) revealed an admitting and current diagnosis located under the Diagnosis tab of Undifferentiated Schizophrenia and mild intellectual disabilities. Review of the Admission section of the EMR revealed R40 was admitted to the facility on [DATE]. Review of the Comprehensive Social Assessment V2.0 located in the Assessment tab of the EMR with completion dates of 02/3/25, 11/08/24, 07/31/24, 05/9/24, 02/5/24, and 11/13/23 revealed no diagnoses of Undifferentiated schizophrenia and/or Mild intellectual disability. Each of these assessments was signed by the Social Service Director (SSD). In the Mental Development section of each of these assessments the SSD wrote No history of Mental Illness. On 02/06/25 at 9:05 AM, the SSD was asked about the mental illness and mild intellectual disability diagnosis., The SSD stated she was not aware R40 had those diagnoses. On 02/06/25 at 10:15 AM, Registered Nurse Resident Assessment Instrument (RAI) Director stated the SSD was expected to review the comprehensive social assessments to ensure they were accurate. The RAI Director stated the facility did not have a policy but followed the instructions in the RAI manual.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on record review and staff interview, the facility failed to ensure an accurate Level I screening prior to admission for one of one resident (Resident (R)40) reviewed for Preadmission Screening and Resident Review (PASRR) out of a total sample of 19 residents. This failure resulted in R40 not receiving a Level II screen for specialized services for mental illness (MI) and/or intellectual disability (ID). Findings include: Review of R40's electronic medical record (EMR) revealed his admitting and current diagnosis located under the Diagnosis tab included Undifferentiated Schizophrenia and mild intellectual disabilities. Review of the Admission section of the EMR revealed he was admitted to the facility on [DATE]. Review of the Comprehensive Social Assessment V2.0 located in the Assessment tab of the EMR with completion dates of 02/3/25, 11/08/24, 07/31/24, 05/9/24, 02/5/24, and 11/13/23 revealed no diagnoses of Undifferentiated schizophrenia and/or Mild intellectual disability. Each of the assessments were signed by the Social Services Director (SSD). In the Mental Development section of each of these assessments the SSD wrote No history of Mental Illness. The resident's EMR was reviewed in its entirety and was silent for a Level I or Level II Preadmission Screening/Resident Review (PASRR). On 02/06/25 at 8:38 AM the SSD provided a Level I PASRR that the hospital completed. Review of the document titled PreAdmission Screening/Resident Review (PASRR) Level I Assessment Form DMA-613, dated 10/23/23 revealed No was marked for the question Does the resident have a primary diagnosis of serious mental illness, developmental disability, or related condition? The SSD stated the hospital inaccurately completed the Level I PASRR and as a result a Level II was never completed. On 02/06/25 9:05 AM the SSD was asked about the Mild Intellectual Disability diagnosis, and she stated she was not aware R40 had that diagnosis. The SSD stated she would update the application and send in per the PASSR company's request. The SSD provided an undated document titled Best Practice for PASRR and stated the facility followed the document as they did not have a policy for PASRR. Review of the document revealed PASRR status should be reviewed for all new admissions; the SSD should maintain an active, ongoing, and a current list of PASRR patients; and the list should contain, at a minimum, the patient's name, DMI or ID/DD, if they require services or do not require services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview, record review, and review of the facility's policy, the facility failed to ensure a baseline care plan was developed within 48 hours of a resident's admission for one of one resident (Resident (R) 45) reviewed for baseline care plans out of 19 sampled residents. Findings include: Review of the facility's policy titled, Baseline Care Plan, reviewed 12/27/24 revealed .To promote person-centered continuity of care and communication with the resident and representative, if applicable, regarding the initial plan for delivery of care and services .The center will complete and implement a baseline care plan within 48 hours of a resident's admission in collaboration with the resident and the representative, if applicable . Review of R45's undated Face Sheet, provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of R45's entire electronic medical record (EMR) revealed no documented evidence a baseline care plan was developed for R45. During an interview on 02/05/25 at 2:53 PM, the Resident Assessment Instrument Director (RAI) stated the facility did not develop a baseline care plan for R45. The RAI stated she was responsible for completing resident's baseline care plans. The RAI also stated during the time the baseline care plan was supposed to be developed for R45, she was on leave and someone in the facility's corporation was covering for her remotely.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview, record review, and review of the facility's policy, the facility failed to ensure the care plan was revised to address pain for one of 19 sampled residents (Resident (R) 29). This deficient practice placed the resident at risk for her pain not to be effectively managed. Findings include: Review of the facility's policy titled, Patient's Plan of Care, reviewed 12/27/24 revealed Intent .To promote person-centered patient care through a comprehensive care plan. Guideline. Each patient will have a person-centered comprehensive care plan developed and implemented to address the patients' medical, physical, mental, and psychosocial needs .Procedure .The comprehensive care plan should also be updated as ongoing clinical assessments identify changes . Review of the facility's policy titled, Pain Assessment, reviewed 12/27/24 revealed .Each patient identified with pain should have a care plan addressing pain management . Review of R29's undated Face Sheet, provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of R29's Nurses Note, dated 09/08/24, located in the resident's EMR under the Nurses Notes, tab revealed Summoned to resident's room by CNA [Certified Nursing Assistant] @ [at] 2:00 am. CNA stated, 'She said she is hurting.' Resident observed lying in bed C/O [complain of] lower back pain. Resident stated, 'It hurts a little bit.' CNA stated, 'Upon movement resident yelled and Hollard [sic] out. Notified [Nurse Practitioner's (NP) name] @ 2:06 am. Received TO [telephone order] : Give PRN [as needed] Tylenol and Get X-Ray of Lumbar and Spine. Notified Mobile Images @ 2:10 am. Mobile Image operator stated, We will have someone come out on tomorrow. Will pass on to oncoming nurse. Review of R29's Nurses Note, dated 09/11/24 and located in the resident's EMR under the Nurses Notes tab revealed Resident was scheduled for x-ray today due to pain. Writer assisted x-ray tech [technician] with the task but was unable to complete all the test due to the resident being in too much discomfort. Review of R29's Care Plan, located in the resident's electronic medical record (EMR) under the Care Plan tab revealed the care plan did not include any problems, goal, or interventions related to pain. During an interview and record review on 02/06/25 at 8:40 AM, RN1 verified R29's care plan did not include a problem area of pain, did not include a goal related to pain, nor any interventions to address the resident's pain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 02/06/25 at 10:06 AM, the RAI [Resident Assessment Instrument] Director verified R29 did not have a care plan that addressed her pain. The RAI Director stated R29's care plan should have been revised to include a problem area of pain with a goal and interventions on 09/08/24 when she complained of pain and received and pharmacological intervention for pain. During an interview on 02/06/25 at 11:58 AM, Nurse Practitioner (NP) 1 stated it was her expectation R29's care plan would have been revised to include the problem area of pain after the resident complained of pain on 09/08/24 and then complained of increased pain on 09/10/24. During an interview on 02/06/25 at 1:59 PM, the Medical Director who was also the resident's attending physician stated it was his expectation R29's care plan would have included pain as a problem area after the resident complained of pain.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 03115 Based on observations, record review, interviews, and policy review, the facility failed to consistently implement a low bed and fall mats for one of four residents (Resident (R) 48) reviewed for accidents out of a total sample of 19 residents. Failing to consistently implement measures when the resident transfers self out of bed and/or chair increased the risk of R48 sustaining an injury. Findings include: Review of R48's Care Plan located in the Care Plan tab of the electronic medical record (EMR) revealed a care plan area titled fall risk with a review date of 12/17/24. The Care Area/Problem section of the care plan stated the resident will get out of bed or chair unassisted related to always being incontinent, right below the knee amputation, fall in the past six months, highly impaired vision, unsteady gait, fall within last 2 to 6 months and fall with in past month. The interventions included frequent checks, frequent observations, low bed, mat at both sides of bed, and place the resident in open area for maximum observation opportunities as tolerated. His care plan for limited mobility with a review date of 12/17/24 stated he needed assistance with functional activities of daily living because he had a right below the knee amputation. The interventions included assistance with activities of daily living as needed; Hoyer lift sling for transfers, manual wheelchair, and two person assist with transfers. His care plan area for Behaviors with a revised date of 12/23/24 stated he had behaviors related to psychosocial factors and as evidenced by anxiety, verbal behavior issues, agitation, and crawling on the floor. The care plan problem area stated he got on floor from the bed and the chair at times. Review of Fall Event documents provided by the Administrator on 02/05/25 at 1:30 PM revealed R48 had documentation of falls/sliding out of the bed or chair on 08/31/24 at 7:00 AM, 09/26/24 at 4:50 AM, 11/12/24 at 8:00 AM, 11/16/24 at 3:00 PM, 11/25/24 at 6:50 AM, 12/03/24 at 10:23 AM, 12/04/24 at 8:06 AM, 12/11/24 at 7:35 PM, 02/02/25 at 9:36 AM and 02/02/25 at 10:50 PM. The Fall Event report dated 02/02/25 and timed 10:50 PM stated the resident got out of his chair and started crawling around on the floor and obtained a skin tear to his right stump and right elbow. On 02/02/25 at 9:00 AM, R48 was observed in his room on the floor crawling around. His bedside table was overturned on its side, water was observed on the floor, and the resident's geriatric chair with the footrest in the up position was positioned across the door to the room. No staff were in the area or observed in the corridor and the resident's room was the last room on the hall furthest from the nursing station. The staff at the nursing station were alerted to the resident being on the floor. The Social Service Director (SSD) and Certified Nursing Assistant (CNA)5 went to the resident's room and verified he was crawling on the floor. CNA1 stated he was up in his chair in his room prior to him being on the floor. The SSD and CNA5 stated he often gets out of his chair and/or bed and crawls around on the floor. They verified he was alone in his room at the time of him getting out of his reclined geriatric chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/04/25 at 3:08 PM, R48 was observed in his bed sleeping. The bed was not in the lowest position and there were no mats on the floor on the sides of the bed. On 02/04/25 at 3:15 PM the Director of Nursing (DON) was informed of the situation. She verified the resident was in the room alone and the bed was not in the lowest position and the mats were not on the floor. She stated the mats should have been on the floor and the bed should have been in a lower position before the staff left him in the room unsupervised. Review of the facility policy titled Skilled Nursing Services Fall Management with a review date of 12/27/24 revealed it was the facility policy to provide the resident with adequate supervision, assistive devices and or functional programs as appropriate to minimize risk for falls.

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on observation, interview, record review, and review of the manufacturer's manual, the facility failed to ensure residents' bedframes were equipped with the correct mattress dimensions per the manufacturer's manual to reduce the risk of entrapment; and failed to ensure consent for the use of bedrails was obtained prior to the resident's use of bedrails for one of one resident reviewed for bedrails (Resident (R) 155) out of a total sample of 19 residents. R155 was discovered unresponsive in his bed with his upper left extremity in between the bedrail and the mattress. Additionally, review of a facility provided list of all residents' bed frames with the incorrect mattresses and with attached bedrails revealed this failure had the likelihood to affect 47 off 55 residents increasing their risks of entrapment. An Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE] when R155 was admitted and bedrails were added to the bed without consent and with the wrong size of mattress, in S483. 25 F700: Bedrails. The Administrator was notified on [DATE] at 4:29 PM of the Immediate Jeopardy. The survey team validated the implementation of the removal plan through observations, staff interviews, and review of resident records. The immediacy of IJ was removed on [DATE]. Findings include: Review of a document titled, Resident Room List, dated [DATE] and provided by the facility revealed the facility identified 47 out of 55 residents who resided at the facility had a bed frame with bedrails that was equipped with the wrong mattress dimensions. Review of R155's undated Face Sheet, provided by the facility revealed the resident was admitted to the facility on [DATE] and expired at the facility unexpectedly on [DATE]. Review of R155's Bed Rail/ Assist Bar Assessment V.20, dated [DATE] and provided by the facility revealed Current Status. Does the patient need assistance to get out of bed? [answered] Yes. The assessment did not include any further assessment information including medical necessity and/or other alternatives prior to the bed rails being applied to the bed. During an observation on [DATE] at 11:56 AM, a surveyor discovered R155 halfway off the bed and it appeared he had fallen from the bed. The surveyor immediately got assistance. During an observation on [DATE] at 11:57 AM, the surveyor and the Social Services (SS) returned to the resident's room and observed R155 unresponsive with his upper body on his bed and his lower extremities hanging from the side of the bed. The resident's left upper body was against the left mobility bed rail which prevented the resident from sliding to the floor. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation and interview with the Maintenance Director on [DATE] at 1:13 PM of R155's bed frame, mattress, and mobility bedrails, the surveyor moved the mobility bed rail on each side of the resident's bed. The mobility bed rails had movement from side to side. The Maintenance Director measured the right mobility bed rail to have 2 ,d+[DATE] inches between the mattress and mobility bed rail at its widest position. The Maintenance Director measured the left mobility bed rail to also be 2 ,d+[DATE] inches between the mattress and mobility bed rail. The Maintenance Director stated the mobility bed rails were adjustable to be able to slide out and make wider if the mattress was a bariatric mattress and that was why the mobility bed rails had as much play (movement) as they did. During an interview on [DATE] at 12:56 PM, Registered Nurse (RN) 1 stated she assisted the SS and lifted R155's lower extremities back into bed. RN1 stated R155's knees were on the floor and his upper body was against the left mobility bed rail. During an interview on [DATE] at 1:11 PM, the SS stated when she arrived to his room, R155's left arm was in between the mobility bedrail and the mattress. SS stated the bedrail prevented R155 from falling to the floor. The SS stated the resident was in a fetal like position with his legs hanging off the side of the bed. The SS stated she could not have lowered the mobility side rail by pushing the red button to lower it because R155's arm was in there (in between the mattress and bedrail) and had she been able to lower the rail, the resident would have ended up in the floor. During an observation and interview on [DATE] at 2:25 PM, the Maintenance Director measured the dimensions of a Geo-Matt Prob mattress which was the same mattress R155 utilized with the bed frame manufactured by Drive. The dimensions of the mattress were 80 inches long, 35 inches wide, and 6 inches tall. Review of a medical supplies invoice dated [DATE] and provided by the Maintenance Director revealed the Geo-Matt Pro mattresses the facility ordered for the Drive bed frames were 80 inches long, 35 inches wide, and 6 inches tall. Review of the Manufacturer's Manual for the Drive bed frame dated [DATE] revealed .Entrapment Warning . Incompatible mattress .can create hazards. Make sure the mattress is the correct size for bed frame and the assist bars [mobility bed rails] are secured to frame to decrease the risk of entrapment .Mattress Specifications Warning. Possible ENTRAPMENT Hazard may occur if you do not use the recommended specification mattress. Resident entrapment may occur leading to injury or death .It is recommended that a 36", 39", or 42" wide mattress that is made to fit an 80" .length bed frame is used .WARNING Incompatible mattress and rotating assist bars/rails can create hazards .Rotating Assist Bar/Rails add 3" to each side of the bed .Inspections .Quarterly Inspection .Inspect bed and Rotating Assist Bars/Rails .if loose tighten and if missing replace . (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 4:12 PM, the Maintenance Director confirmed the mattress on R155's bed frame did not meet the manufacturer's recommendation of 36 inches. The Maintenance Director stated the bed frame was approximately one year old and he did not install the mobility bed rails until given the ok by nursing staff. The Maintenance Director stated he inspected the bed frame every three months which included inspecting the mobility bed rails. He also stated he was aware the rails were loose as he installed them per the manufacturer's manual and them having play (movement) was the characteristics of the bed frame and the rails. The Maintenance Director stated he was not aware the bed frame recommendations were for a mattress measuring 36 inches as the medical supply company matched the bed frame and the mattress together. The Maintenance Director stated if the mattress had been 36 inches, there would have been less space between R155's mattress and mobility bed rail. Review of the facility's undated Tels Logbook Documentation and Work History Report revealed the bed frames were inspected [DATE] and [DATE]. During an interview on [DATE] at 4:45 PM, the Maintenance Director stated he inspected the bed frames every six months and not every three months as indicated in the manufacturer's manual. He stated corporate set the schedule of the bed frame inspection in the Tels system and that was what he went by. During an interview on [DATE] at 1:57 PM, the Regional Corporate Nurse (RCN) stated the facility did not have a policy or procedure related to bed rails use; however, it was best practice to provide education on the risks vs benefits of the mobility bed rail use and then have the responsible party sign consent for the resident to use the rails. The Regional Nurse stated the facility did not obtain consent and/or educate the R155's responsible party on the risks vs benefits. During an interview on [DATE] at 2:11 PM, the Medical Director stated it was at the discretion of the nurse and provider to implement the use of bedrails on a resident's bed until they had a chance to sit down and discuss it with the resident and/or the resident's family and he would not expect the facility to obtain consent for the use of bedrails prior to the use of them. The Medical Director also stated it was his expectation that if the facility had the bed frame manufacturer's manual, then they facility should have had the correct mattress on the bed frame; however, he is not sure if a nursing home facility would know that unless it was during the acquisition of the mattress. 43353

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview, record review, and review of the facility's policy, the facility failed to ensure pain medication was procured from the pharmacy and administered as ordered by the physician for one of 19 sampled residents (Resident (R) 29). The facility's failure increased the potential for R29 to have untreated pain when three doses of the pain medication were not available from the pharmacy. Findings include: Review of the facility's undated policy titled, Pharmacy Services Medication Unavailable for Administration, revealed .DEA [drug enforcement agency] Schedule II through V controlled substance medications require a signed prescription from the physician. At times, medications may become unavailable due to no prescription on file. The administering nurse should contact the dispensing pharmacist for further instruction on the necessary steps needed to obtain the medication .At any time a medication is not available for a specified time of administration, the nurse notifies the prescriber that the medication is not available and obtains a 'hold until medication available from pharmacy . Review of the facility's undated policy titled, Pharmacy Services Emergency Medication Kits (portable), revealed Intent. To facilitate emergency needs for medication by special delivery from the pharmacy or by using the center's approved emergency medication supply. Emergency pharmacy is available on a 24-hour basis. A limited supply of medications used in emergencies and/or starter doses of antibiotics is maintained in the center by the provider pharmacy in portable, sealed containers. The Emergency Kit is the property of the pharmacy . Review of the facility's Controlled Substances Emergency Box, dated 05/01/20 and provided by the facility revealed a list of medications kept in the facility's E-Kit. Included in the inventory was Ultram [tramadol] tablets, 50mg, and the quantity of 5 tablets. Review of an email from the facility's pharmacy dated 02/06/25 and provided by the facility revealed .Below is a timeline from the pharmacy's perspective for [R29's Name] Tramadol, a CIV [controlled schedule IV] prescription drug. 9/10 358 pm-received order for Tramadol 50 [mg] bid [twice a day] x [times] 7 days; pharmacist processed that order by 445pm; he did not fax that order to MD [medical doctor] because there was another order (below) that would have included these tabs within it on the prescription from the MD. 9/10 358PM-received a second order for Tramadol 50 mg bid prn to start after the 50 mg routine is complete; pharmacist processed that order at 446pm; requested prescription for tramadol electronically from [Medical Director's Name] @ [at] 447pm. 9/11 828am-received signed prescription back from [Medical Director's Name] electronic prescribing software; pharmacist processed medication @ 1121am and sent to filling station to be filled. 9/11 1206pm-meidcation filled and checked by second pharmacist then prepared for delivery to center on regular courier. 9/11 956pm-medication accepted at center . Review of R29's undated Face Sheet, provided by the facility revealed the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the electronic medical record (EMR) revealed a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/24. Review of this MDS revealed R29 was not interviewable due to her cognitive status. Review of R29's Nurses Note, dated 09/08/24, located in the EMR under the Nurses Notes, tab revealed Summoned to resident's room by CNA [Certified Nursing Assistant] @ [at] 2:00 am. CNA stated, 'She said she is hurting.' Resident observed lying in bed C/O [complain of] lower back pain. Resident stated, 'It hurts a little bit.' CNA stated, 'Upon movement resident yelled and Hollard [sic] out. Notified [Nurse Practitioner's (NP) name] @ 2:06 am. Received TO [telephone order] : Give PRN [as needed] Tylenol and Get X-Ray of Lumbar and Spine. Notified Mobile Images @ 2:10 am. Mobile Image operator stated, We will have someone come out on tomorrow. Will pass on to oncoming nurse. Review of R29's Electronic Medication Administration Record [eMAR], dated September 2024 and located in the resident's EMR under the Medications tab revealed on 09/08/24 the resident's pain was assessed to be a 10 on a scale of 1-10, with 10 being the highest pain level possible. Continued review of the eMAR revealed R29 was administered the ordered PRN acetaminophen on 09/08/24 at 2:13 AM with a post pain level documented as one. Review of R29's physician order Summary Report, provided by the facility revealed on 09/10/24 the resident was ordered tramadol [opioid pain medication] 50 mg tablet, 1 tablet by mouth 2 times per day 7 days .Dx [diagnosis]: Acute pain due to trauma [fall on 09/07/24] . Review of R29's Nurses Note, dated 09/10/24 and located in the resident's EMR under the Nurses Notes tab revealed Tramadol did not come in tonight, will start when it arrives from pharmacy. Review of R29's Nurses Note, dated 09/11/24 and located in the resident's EMR under the Nurses Notes tab revealed 8am medication Tramadol 50mg not administered[.] Medication not in from pharmacy. F/U [follow up] with pharmacy stated medication will be in tonight. Will pass to on-coming nurse. Review of an email provided by the facility, dated 02/06/25 and from the x-ray contractor revealed 9/11/24 exam: PAIN .Best obtainable, PT [patient] was in pain and could not hold position for long .Nurse decided to stop exam before finishing due to PT pain . Review of R29's Nurses Note, dated 09/11/24 and located in the resident's EMR under the Nurses Notes tab revealed Resident was scheduled for x-ray today due to pain. Writer assisted x-ray tech [technician] with the task but was unable to complete all the test due to the resident being in too much discomfort. Review of the eMAR for September 2024 revealed no acetaminophen was administered for pain other than on 09/08/24 at 2:13 AM. Review of R29's Nurses Note, dated 09/11/24 and located in the resident's EMR under the Nurses Notes tab revealed 6pm medication Tramadol 50 mg not administered[.] F/U with pharmacy[.] Stated medication will be in tonight. Will pass to on-coming nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115483	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dawson Health and Rehabilitation	1159 Georgia Ave. S.E. Dawson, GA 39842

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R29's Electronic Medication Administration Record [eMAR], dated September 2024 and located in the resident's EMR under the Medications tab revealed the eMAR for tramadol 50 mg tablet was scheduled to be administered starting on 09/10/24 and ending on 09/17/24 at 8:00 AM and 6:00 PM. Continued review of the eMAR revealed R29 was not administered the 6:00 PM dose on 09/10/24, the 8:00 AM dose, nor the 6:00 PM dose of the tramadol medication on 09/11/24, which indicated the resident missed three doses of the physician ordered medication. During an interview and record review on 02/06/25 at 11:16 AM, Licensed Practical Nurse (LPN) 1 stated on 09/10/24 R29 was complaining about being sore and when the CNA touched R29, she did not want to be touched. LPN1 stated R29 did not indicate a pain level; however, R29 never complained of pain so when she said she was in pain, she immediately notified NP1 who ordered tramadol for pain and an x-ray. The LPN stated she put in both orders around 3:30 PM and the medication should have been delivered by the pharmacy that night. During an interview on 02/06/25 at 9:27 AM, the Director of Nursing (DON) stated when R29's medication did not arrive at the facility for it to be administered to the resident, it was her expectation that the nurse would have notified the provider that the tramadol did not arrive for it to be administered. The DON stated she had reviewed the information provided by the pharmacy and learned the pharmacy was waiting for a signed prescription from the physician. The DON stated the nurse could have called the pharmacy to see if the tramadol could have been pulled from the E-Kit and then the physician would needed to be notified for an order. During an interview on 02/06/25 at 11:58 AM NP1 stated on 09/10/24 she was notified R29 was complaining of increased pain. NP1 stated she ordered tramadol and an x-ray for R29. NP1 stated when the tramadol did not arrive at the facility for the resident's 09/11/24 dose, it was her expectation nursing would have called the pharmacy to get permission for tramadol to be used from the E-Kit (emergency medicine kit) and to get the expected arrival time of the ordered tramadol. During an interview on 02/06/25 at 1:59 PM, the Medical Director, who was also R29's attending physician, stated when R29's ordered tramadol did not arrive on 09/11/24 and the resident was in pain, the nursing staff should have notified himself or another provider to get an order to use the E-Kit which included tramadol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115483	A. Building B. Wing	02/06/2025

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on record review and review of the facility's Administrator's Job Description, the facility failed to be administered in a manner that 1. ensured mattresses were the correct size for 47 out of 55 beds and the safe use of bed rails for resident (Resident (R) 155) and 2. ensured staff did not abuse resident (R23) and additional staff protected the resident from further abuse. Findings include: Review of the Skilled Inpatient Services Job Description, revised ,d+[DATE] revealed Job Title: Administrator for Inpatient Services .Responsible for directing the day-to-day functions of the Nursing Center in accordance with current federal, states, and local regulations that govern long-term care centers, and as may be directed by the Regional [NAME] President, to provide appropriate care for our patients .Essential Duties and Responsibilities .Assumes responsibility for and honors patients' rights .Assumes responsibility for procedural guidelines relative to the prevention and reporting of patient abuse .Skills and Abilities .Provides for the purchase and availability of all necessary supplies .Language Skills. Ability to read and interpret document such as safety rules, operating and maintenance instructions procedure manuals . 1. The facility ordered mattresses which did not meet the bed frame's manufacturer's recommendations for the dimensions of the mattresses. The facility identified 47 out of 55 bed frames with bedrails had the incorrect mattress size. The facility's failure placed the 47 residents at risk of entrapment. On [DATE], Resident (R) 155 was found unresponsive with his upper left extremity in between the mattress and bedrail which prevented him from falling to the floor. R155 was unable to be revived. Cross Reference: F700L 2. The facility failed to protect R23 from witnessed physical abused by facility staff. Three additional staff members witnessed the abuse and failed to intervene to protect the resident. Cross Reference: F600L The facility's Administrator, the DON, and the Regional Corporate Nurse were informed on [DATE] at 4:29 PM that Immediate Jeopardy existed at F835: Administration related to F600L and F700L. The Immediate Jeopardy at F835L began on [DATE] when the survey team identified systemic failures that resulted in F600L and F700L. The survey team was able to validate the IJ was removed on [DATE] prior to the survey team exiting. 43353