STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115520	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sears Manor Nursing Home	3311 Lee Street Brunswick, GA 31521

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to ensure residents were treated with dignity for one of 25 sampled residents (Resident (R) 34). This failure had the potential to cause residents to feel intimidated when staff feed them while standing up next to them. Findings include: Review of the facility's policy titled Assistance with Meals, dated 02/04/01, provided by the facility, revealed Policy Statement Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Policy Interpretation and Implementation Dining Room Residents: a- All residents will be encouraged to eat in the dining room. b. Facility Staff will serve resident trays and will help residents who require assistance with eating. c. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: (l) Not standing over residents while assisting them with meals; . Review of R34's undated admission Record in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] and had a diagnosis of severe vascular dementia with other behavioral disturbance. Review of R34's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/24/25, found in the EMR under the MDS tab revealed the resident had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated the resident was severely impaired in cognition. The MDS indicated R34 had no limitations in range of motion (ROM) to the upper and lower extremities on both sides and required supervision or touching assistance with eating. Review of R34's comprehensive Care Plan, dated 04/26/22, found in the EMR under the Care Plan tab indicated, [R62] has an ADL self-care performance deficit r/t [related to] Alzheimer's, impaired balance, weakness, need for personal assistance. The care plan also indicated the intervention for Eating: [34] requires set up/touch assistance from staff to eat. Assist with eating as she will allow. Observation of R34 sitting in a geriatric chair in the dining room at a table, on 05/19/25 at 12:26 PM, revealed Registered Nurse (RN) 1 standing next to R34 while feeding her bites of her food off the meal plate. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/25 at 12:29 PM, RN1 confirmed she was standing while feeding R34 so that she could watch the other residents eating their food in the dining room. RN1 stated she should have fed R34 by sitting next to her at the table. RN1 also stated it was a dignity issue to stand while feeding residents. During an interview on 05/21/25 at 10:42 AM, the Administrator stated RN1 should follow the policy on feeding residents and that all staff had been trained to sit while feeding the residents. During an interview on 05/21/25 at 11:46 AM, the Director of Nursing (DON) stated she expected staff to sit next to the residents while feeding them and it was considered a dignity issue and it was intimidating to the residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to 1. ensure resident rooms, dining rooms, and hallways were clean and in good repair and 2. ensure a homelike environment was maintained by repairing three indentions measuring 16 inches x 3 inches in the wall behind the resident's bed for one resident (Resident (R) 9) out of a total sample of 25 residents. This failure had a potential to create the lack of a homelike environment for 19 out of 52 resident rooms and facility common areas. Findings include: 1. Observations on 05/20/25 beginning at 3:38 PM, identified the following maintenance and environmental concerns. Main dining room: The wall across from the kitchen dish room was observed with identified areas where items had been pushed and scraped against the sheetrock causing indentations and loss of the blue-green paint in eight to 10 areas approximately ¼ to 5 inches long. The right side of the doorway, beside the door to the kitchen dish room and going into the small dining room where vending machines were located had areas in need of sheetrock repair. Along the far wall from the main entrance, the sheetrock near the baseboard was observed with large elongated blackened spots. Tile flooring on the 100 Hall: Entering the 100 hall through the double doors, one floor tile had a portion of the tile missing. Between rooms [ROOM NUMBERS], there were six tiles that were cracked and broken with a portion of tile missing. Between rooms [ROOM NUMBERS], there were 10 floor tiles that had broken and cracked pieces. At room [ROOM NUMBER], going toward the hallway exit door, there were tiles that are chipped/broken and have pieces missing. The exit door on the 100 hall outside rooms [ROOM NUMBERS] had a gap at the bottom, large enough for light to pass through and allow rodents and pests into the building. This exit door also had areas of missing paint at the bottom of the door where items had scraped against it. On the inside of the bathroom door of room [ROOM NUMBER], below the door handle and near the bottom of the door at the corner, the veneer was observed to be unattached, splintered, and not secured. In an interview on 05/21/25 at 11:14 AM, the Administrator stated the cracks in the tiles would be expected to be reported. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/21/25, at 10:44 AM with the Maintenance Director (MD), the document titled, Proposed maintenance priorities for fiscal year 2025 was reviewed. The MD was asked if there was a date or projected date for the work to be done or completed. The MD responded by saying that there was no specific date, but that these were the items identified as needing to be completed. The surveyors proceeded to conduct a walk-through of the building pointing out the observed items in need of maintenance or repair to the MD. The MD confirmed all above observations. 2. Review of R9's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE] with a diagnosis of spinal stenosis, cervical region. Review of R9's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/25, located in the EMR under the MDS tab, revealed R9 had a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated the resident was severely cognitively impaired. Observation on 05/19/25 at 9:10 AM in R9's room revealed three large indentions on the wall behind her bed. Interview with R9 at this time revealed she was unaware of the indentions in the wall behind her bed. During an interview on 05/20/25 at 4:17 PM, the Maintenance Supervisor stated he had not received any work orders for R9's room recently and although he performed monthly room rounding, he had not identified the three indentions in the wall behind her bed. The Maintenance Supervisor also stated the headboard caused damage to the wall when the bed was moved against it. The Maintenance Supervisor confirmed he had no documentation to show that he had completed room rounds. Observation on 05/20/25 at 4:30 PM in R9's room with the Maintenance Supervisor revealed three large indentions in the wall behind the resident's bed measuring 16 inches by 3 inches. During an interview on 05/21/25 at 9:04 AM, the Administrator stated the Maintenance Supervisor was to performed monthly room rounds and work orders were completed by staff when there were items that needed to be repaired in the resident's room. The Administrator also stated the Maintenance Supervisor did not have time to complete monthly room rounds and there was no documentation for it.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure a gradual dose reduction of psychotropic medication was attempted when indicated for two of five residents (Resident (R) 38 and R13) reviewed for unnecessary medications out of a total sample of 25 residents. This failure had the potential to contribute to avoidable side effects of psychotropic medication, including sedation, dizziness, and increased falls. Findings include: 1. Review of R38's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] and had diagnoses of major depression and insomnia. Review of R38's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/12/25 and located in the MDS tab of the EMR, revealed he scored 11 out of 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R38 did not exhibit any mood or behavioral symptoms. He received an anti-anxiety medication and experienced two falls in the last quarter. Review of R38's Orders tab in the EMR revealed a physician's order, dated 06/12/23, for lorazepam (an anti-anxiety medication), 0.5 milligrams (mg) twice a day for a diagnosis of alcohol dependence. Review of R38's Care Plan, dated 06/16/23 and located under the Care Plan tab of the EMR, revealed, [R38] is at risk for adverse effects of anti-anxiety medication. [R38] uses anti-anxiety medications r/t [related to] increased anxiety/agitation. The approaches included: Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness Q [every] shift . Monitor the resident for safety. The resident is taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs . Monitor/document/report PRN [as needed] any adverse reactions to anti-anxiety therapy . [and] Monitor/record occurrence of for target behavior symptoms. Review of R38's 09/14/24 Physician Progress Note, provided to the facility on [DATE] and located under the Documents tab of the EMR, revealed the Medical Director (who served as R38's primary physician), documented, Generalized anxiety disorder: Chronic, stable. Decrease lorazepam to 0.25mg BID. The document was noted on 11/24/24 by the MDS Coordinator (MDSC). Review of R38's EMR revealed there was no corresponding order for a decreased dosage of the lorazepam. Review of R38's September 2024, October 2024, and November 2024 Medication Administration Records (MARs), located under the Orders tab of the EMR, revealed R38 continued to receive 0.5mg of lorazepam twice daily. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R38's Note to Attending Physician/Prescriber written by the pharmacist, dated 11/13/24 and located under the Documents tab of the EMR, revealed, [R38] currently has an order for lorazepam 0.5mg BID [twice daily] for alcohol dependence. Regulations require periodic reviews of psychotropic making trial dosage reductions with the goal of discontinuation or lowest effective dose. He/she may benefit from a dosage reduction at this time. If a dosage reduction is contraindicated at this time, please, document in the space provided below, the clinical reason why a dosage reduction should not be attempted. Nurse Practitioner (NP) 1 responded on 11/18/24 by checking the box next to the statement, The patient is receiving the lowest effective dose of the medication. A GDR [gradual dose reduction] would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. There was no rationale documented specific to R38's diagnosis, behaviors, or continued need for the current dose of the lorazepam. Review of R38's 11/16/24 NP Progress Note, provided to the facility on [DATE] and located under the Documents tab of the EMR, revealed NP1 documented, Generalized anxiety disorder chronic, continue lorazepam 0.5mg BID. The document was noted on 12/03/24 by the MDSC. Review of R38's December 2024 MAR, located under the Orders tab of the EMR, revealed R38 continued to receive 0.5mg of lorazepam twice daily. Review of R38's 01/18/25 Physician Progress Note, provided to the facility on [DATE] and located under the Documents tab of the EMR, revealed the Medical Director documented, Generalized anxiety disorder - Chronic, stable. Decrease lorazepam to 0.25mg BID. The document was noted on 04/03/25 by the MDSC. Review of R38's EMR revealed there was no corresponding order for a decreased dosage of the lorazepam. Review of R38's January 2025, February 2025, March 2025, and April 2025 MARs, located under the Orders tab of the EMR, revealed R38 continued to receive 0.5mg of lorazepam twice daily. Review of R38's Note to Attending Physician/Prescriber written by the pharmacist, dated 05/13/25 and located under the Documents tab of the EMR, revealed, [R38] currently has an order for lorazepam 0.5mg BID for alcohol dependence. Regulations require periodic reviews of psychotropic making trial dosage reductions with the goal of discontinuation or lowest effective dose. He/she may benefit from a dosage reduction at this time. If a dosage reduction is contraindicated at this time, please, document in the space provided below, the clinical reason why a dosage reduction should not be attempted. NP2 responded on 05/20/25 by checking the box next to the statement, The patient is receiving the lowest effective dose of the medication. A GDR would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. There was no rationale documented specific to R38's diagnosis, behaviors, or continued need for the current dose of the lorazepam. Review of R38's May 2025 MAR, located under the Orders tab of the EMR, revealed he continued to receive 0.5mg of lorazepam twice daily. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/25 at 12:31 PM, NP2 stated she took over for NP1 at the end of March 2025. She stated he had only seen R38 to address his dry scalp. NP2 stated she had received a recent GDR request from the pharmacist for R38's lorazepam; however, she was not very familiar with the resident and wanted to speak with the Medical Director before making any medication changes. NP2 stated she would question why the medication was not reduced to 0.25mg BID per the Medical Director's recommendations. During an interview 05/21/25 at 1:38 PM, NP1 stated she took over from the previous NP who was not decreasing the medication, so she chose not to decrease the medication as well. NP1 stated R38 could push back if he was upset about a dose reduction so the dose was not changed. NP1 stated she was not aware the Medical Director was recommending a dose reduction, and stated, If I would have known, I would have decreased it too. During an interview on 05/21/25 at 2:46 PM, the MDSC stated she typically received the Medical Director's notes about three months after the actual visit occurred. She stated his recommendation to decrease the lorazepam dose slipped through the cracks. The MDSC stated because the notes did not come to the facility in a timely manner, there was a potential for recommendations and new orders from the notes to be missed. During an interview on 05/21/25 at 3:42 PM, the Director of Nursing (DON) stated the Medical Director recommended a dose reduction of the lorazepam in the notes; however, she was unable to find an order to decrease it. She stated the dosage should have been reduced based on the Medial Director's recommendation. During an interview on 05/21/25 at 4:43 PM, the Medical Director stated R38's lorazepam was no longer used for a diagnosis of alcohol dependence but for generalized anxiety disorder. He stated he visited R38 every month and spoke with staff to determine if the medication was effective or if behaviors were occurring. He stated he thought R38's lorazepam had been decreased in December 2024 or January 2025, and stated R38 was unable to tolerate the reduction and the dosage was again increased. When it was pointed out the dosage had not been decreased since its origination on 06/12/23, the Medical Director stated maybe he was remembering wrong and it could have been just a missed dose and not a dose reduction. 2. Review of R13's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, major depression, anxiety, and insomnia. Review of R13's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/19/25 and located under the MDS tab of the EMR, revealed she scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. She did not exhibit behavioral symptoms and received an antipsychotic medication. A dose reduction of the antipsychotic had not been attempted. Review of R13's Care Plan, dated 06/27/24, revealed, [R13] is/has potential to be verbally aggressive to other residents r/t [related to] dementia . [R13] has impaired cognitive function/dementia or impaired thought processes r/t dementia, acute metabolic encephalopathy r/t CVA [stroke]. Has a history of hallucinations, confusion, AMS [altered mental status], and combative behavior . [R13] is at risk for adverse effects of psychotropic medication. [R13] uses psychotropic medications r/t behavior management. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R13's Orders tab of the EMR revealed a physician's order, dated 06/13/24, for olanzapine [an antipsychotic medication], 2.5mg daily for a diagnosis of dementia. Review of an 02/07/25 Physician Progress Note, provided to the facility on [DATE] and located under the Documents tab of the EMR, revealed, Vascular dementia with behavioral disturbance -Chronic, worsening. Continue . [olanzapine] 2.5mg in AM and 5mg in evening, so continue those as ordered. There was no rationale documented specific to R13's behaviors, risk factors, or continued need for the current dose of the olanzapine. Review of R13's Note to Attending Physician/Prescriber by the pharmacist, dated 04/22/25 and located under the Documents tab of the EMR, revealed, [R13] currently has an order for olanzapine 2.5mg qd [daily] for dementia with psychotic symptoms. Regulations require periodic reviews of psychotropic making trial dosage reductions with the goal of discontinuation or lowest effective dose. He/she may benefit from a dosage reduction at this time. If a dosage reduction is contraindicated at this time, please, document in the space provided below, the clinical reason why a dosage reduction should not be attempted. Nurse Practitioner (NP) 1 responded on 04/24/25 by checking the box next to the statement, The patient is receiving the lowest effective dose of the medication. A GDR [gradual dose reduction] would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. There was no rationale documented specific to R13's behaviors, risk factors, or continued need for the current dose of the olanzapine. During an interview on 05/21/25 at 12:38 PM, NP2 stated she had spoken with nursing staff, who reported continued behaviors for R13 like hallucinations and increased confusion in the evenings. NP2 stated she did not document information regarding R13's behaviors, reports from staff, or specific risks and benefits of the olanzapine. NP2 stated the check-marked statement on the pharmacist's recommendation to decrease the dosage was not a rationale specific to R13 related to risks, benefits, and need of the current dose of olanzapine. During an interview on 05/21/25 at 3:49 PM, the Director of Nursing (DON) stated the check-marked statement on the pharmacist's recommendation for a dose reduction was not a rationale specific to the individual's behaviors, diagnosis, and need for the medication. Review of the facility's Medication Monitoring and Management policy, dated 01/02/23, revealed, During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility attempts a GDR during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated. 1. The GDR is considered clinically contraindicated if: a) Target symptoms returned or worsened after the most recent attempt at a GDR and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. -OR- (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b)The continued use is io accordance with relevant current standard of practice and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. Review of the facility's Drug Regimen Reviews policy, dated February 2017, revealed, A review of the resident's drug regimen is made by the consultant pharmacist at least monthly. The purpose of this review is to: Study the medications taken by the resident to determine if a potential hazard exists from an interaction between two (2) drugs or between food and drugs; . Determine if the resident is receiving the right medications as ordered by the attending physician; . Determine if medications are given at the right time; . Determine if medications are given in the right dosage and right dosage form; . Keep up with signs and symptoms of adverse drug reactions as well as interactions; and identify medication and charting errors.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy, the facility failed to complete a thorough investigation of an allegation of an injury of unknown origin/physical abuse for one resident (Resident (R)37) of two residents reviewed for abuse out of 25 sampled residents. The facility's failure to complete a thorough investigation placed residents at risk of being unprotected from abuse. Findings include: Review of the facility's policy titled, Accidents and Incidents-Investigating and Reporting, dated 03/23/17 indicated All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The nurse supervisor/charge nurse shall promptly initiate and document investigation of the accident or incident .The following data shall be included on the incident/accident form: The name(s) of witnesses and their accounts of the accident/incident .The date/time the injured person's family was notified and by whom .The time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions. Review of R37's Face Sheet found in R37's electronic medical record (EMR) under the Resident tab indicated the resident was admitted to the facility on [DATE]. Review of R37's nursing Progress Note, dated 05/19/25 and located under the Resident tab of the EMR revealed Registered Nurse (RN1) had observed bruising to R37's right hand and forearm. When RN1 questioned R37 about the bruising, she stated I got into a fight with two girls last night. An investigation was started immediately. Review of a five-day report sent to the Long-Term Care Complaint Unit in Georgia revealed that the Administrator completed the report with all investigations and interviews. R37 would not allow anyone to provide care all night and was yelling and banging on her bedside table. R37 was convinced that staff was sent to kill her daughter and that her daughter was locked up downstairs. Banging continued until R37's headboard was found on the floor behind the bed. No names of staff were mentioned in the report or that the attending physician was notified. R37's responsible party was notified after the investigation was completed. Interview with the Administrator on 05/21/25 at 11:07 AM revealed I do not have an incident report on this investigation. I just finished the five day because you asked for it. I can give you the names of the staff involved, but I do not have a written statement from them. What I gave you is what I sent to the state of Georgia. The Administrator verified that the investigation did not include other resident interviews for possible abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 4. Review of R38's admission Record, located under the Profile tab of the EMR revealed he was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis affecting left non-dominant side, anemia, left hand contracture, and history of stroke. Review of R38's quarterly MDS, with an ARD of 03/12/25 and located under the MDS tab of the EMR, revealed he scored 11 out of 15 on the BIMS, indicating moderately impaired cognition. R38 had impaired range of motion in the upper and lower extremities on one side. He was independent with bed mobility, required touching/supervision with lying to sitting, and required partial/moderate assistance with bed to chair transfers. In the past quarter, R38 had one fall with no injury and one fall with minor injury. Review of R38's Care Plan, dated 06/16/23 and located under the Care Plan tab of the EMR, revealed, [R38] is at risk for falls r/t [related to] gait/balance problems and impaired mobility secondary to history of CVA [stroke]. The approaches included placing his call light in reach, ensuring he wore non-skid footwear when mobilizing, ensuring the wheelchair brakes were locked before transfers, and providing physical therapy as needed. Review of R38's Fall note, dated 09/05/24 and located under the Progress Notes tab of the EMR, revealed, The nurse saw the resident sitting on the floor of his room at 1545 [3:45 PM]. The resident stated that he was trying to reach for something that [sic] he slid down the bed . skin tear was noted on the BLE [bilateral lower extremities] and bruise on the right forearm . Fall Precaution was performed by securing that the bed is in low position, arrange his personal belonging near him so he can reach it easily, informed him to click his call light if he needs assistance from the staff. At this time, the intervention to keep R38's personal belongings within reach was not added to the Care Plan. Review of R38's Change in Condition note, dated 01/08/25 and located under the Progress Notes tab of the EMR, revealed, Resident fell out of bed attempting to reach cup from side table. The bed was lowered to the lowest position where fall mat was present . a small skin tear on the left hand was noted . Call light was placed beside PT [resident] and resident was educated on using the call light when he should need assistance. At this time, the intervention to keep R38's personal belongings within reach was not added to the Care Plan. Review of R38's Health Status Note, dated 01/24/25 and located under the Progress Notes tab of the EMR, revealed, During my morning rounds, seen [sic] resident sitting on the floor in [sic] the right side of the bed with a fall mat on, resident trying to crawl back to his bed, bed is at low position. Resident said that his [sic] trying to reach the water but then rolled down. R38 did not sustain injury. At this time, the intervention to keep R38's personal belongings within reach was not added to the Care Plan. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sears Manor Nursing Home	3311 Lee Street Brunswick, GA 31521

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R38's Care Plan, revised 03/11/25, revealed he experienced falls 01/08/25 and 01/24/25. The approaches, dated 11/09/23, included: Be sure [R38's] call light is within reach and encourage him to use it for assistance as needed . Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs . Encourage [R38] to keep bed in lowest position except during resident care with staff present . Ensure wheels are locked on wheelchair before transfer to and from chair . [and] Have spills in floor cleaned as soon as possible to prevent slip/fall. On 09/06/24, the intervention was added to place fall mats to the side of the bed. There were no additional interventions added after 09/06/24, and the Care Plan did not reflect the planned intervention to ensure personal items were in reach. During an interview on 05/20/25 at 4:03 PM, the Director of Nursing (DON) stated root cause analysis of a fall should include an investigation of contributing factors and interventions to address those factors. The DON stated all fall interventions should be added to the Care Plan. During an interview on 05/20/25 at 3:51 PM, the DON stated any post-fall interventions determined in the team fall review would be communicated to the MDS Coordinator (MDSC) to add to the Care Plan. During an interview on 05/21/25 at 11:55 AM, the MDSC stated the intervention to ensure R38's personal items, especially beverages, were within reach should be included in the Care Plan. 5. Review of R50's undated admission Record located in the electronic medical record (EMR) under the Profile tab revealed he was admitted on [DATE] with multiple diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, and unspecified dementia. Review of R50's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/17/25, located in the EMR under the MDS tab, revealed staff assessed him as severely impaired in daily decision-making skills. The MDS indicated that R50 had one fall with injury since the prior assessment. Review of R50's Care Plan, dated 03/11/25, located in the EMR under the Care Plan tab revealed a focus of [R50] is at risk for falls r/t [related to] deconditioning, impaired mobility secondary to history of CVA, incontinence, and dependence on staff for ADLs and transfer with actual fall on 01/12/25 and 01/18/25 with interventions of anticipate and meet his needs, be sure his call light is within reach and encourage him to use it for assistance as needed, encourage him to participate in activities that promote exercise, physical activity for strengthening and improved movability such as: physical and occupational therapy, ensure wheels are locked on wheelchair before transfer to and from chair, neuro-checks per protocol, and therapy to evaluate and treat as ordered or PRN [as needed] dated 12/27/23. Review of R50's Fall Note, dated 01/12/25, located in the EMR under the Prog Note tab revealed Resident was observed at 6:00 AM lying on the right side of his bed on his left side. Resident was observed for injury with an abrasion noted to right shoulder . Review of R50's Fall Note, dated 01/12/25, located in the EMR under the Prog Note tab revealed Fall mat present at the time of the fall with bed located in the lowest position. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R50's Fall Note, dated 01/18/25, located in the EMR under the Prog Note tab revealed This nurse is having rounds and has seen the resident's half of the body on the floor besides his bed around 4:28 AM. The resident is unable to give a description of the incident . No new injuries or skin tear noted . Fall precaution was performed by securing that the bed is in low position, secured fall matt is in place . Observations on 05/19/25 at 10:59 AM, 05/20/25 at 9:00 AM, and 05/21/25 at 10:16 AM revealed R50 was lying in a low bed close to the right edge of mattress with a fall mat on the right side of the bed. During an interview on 05/20/25 at 3:21 PM, the MDS Coordinator (MDSC) confirmed she was responsible for revising the care plan after R50 fell on [DATE] and 01/18/25 from the bed but did not add any new interventions to the care plan. The MDSC stated she added the actual fall dates to the care plan but did not add any new interventions to the care plan and was not aware she had to do so. During an interview on 05/20/25 at 3:47 PM, the Director of Nursing (DON) stated the MDSC was responsible for revising the care plan with fall interventions and falls were discussed in the morning daily meeting in which the MDSC attended. During an interview on 05/21/25 at 10:48 AM, the Administrator stated the MDSC revised the care plans and attended PAR meetings weekly in which resident fall interventions were discussed. Review of the facility's policy titled Falls Management, dated 05/17/17, provided by the facility, revealed . 7. The Interdisciplinary Care Plan Team will review all falls and initiate appropriate interventions. The care plan will be reviewed and revised as needed following all resident falls. The Interdisciplinary Care Plan Team will evaluate each resident individually and initiate interventions to decrease the likelihood of recurrent falls . Review of the facility policy titled Care Plans - Comprehensive, dated 04/18/17, showed: Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans. Based on observation, interview, record review, and policy review, the facility failed to ensure five out of a total of 25 sampled residents (Resident (R) 11, R22, R43, R38, and R50) comprehensive Care Plans had been updated to reflect the current needs of the residents. Findings include: 1. Review of R11's Clinical Census found in the electronic medical record (EMR) under the Clinical Census tab revealed an admission date of 09/20/22. Review of R11's diagnoses found in the EMR under the Medical Diagnosis tab revealed pressure ulcer of left lower back, unstageable 04/16/25. Review of R11's 04/14/25 Brief Interview for Mental Status (BIMS) found in the EMR under the Evaluations tab revealed a score of 15 out of 15, indicating intact cognition. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R11's 04/15/25 initiated pressure ulcer Care Plan in the EMR found under the Care Plan tab revealed R11 had an inner left medial thigh Stage II (partial-thickness skin loss, presenting as an open blister or a shallow, open sore without dead tissue or bruising). Interventions included in the Care Plan included Administer treatments as ordered and monitor for effectiveness, Follow facility policies/protocols for the prevention/treatment of skin breakdown. Review of R11's 05/13/25 and 05/21/25 Wound Evaluation & Management Summary found in the EMR under the Documents tab revealed she had a non-pressure wound of the left, medial ischium full thickness. Recommendations for : Additional Care Plan Items were to limit sitting to 60 minutes, off-load wound, and reposition per facility protocol. The recommendations had not been added to her Care Plan. 2. Review of R22's Clinical Census found in EMR under the Medical Diagnosis tab revealed an admission date of 06/12/24. R22 had a recent hospitalization from 05/04/25 to 05/08/25. Review of R22's diagnoses found in the EMR under the Medical Diagnosis tab revealed diagnoses including end stage renal disease, peripheral vascular disease, diabetes mellitus type 2, and anemia in chronic kidney disease. Review of R22's 05/14/25 BIMS found in the EMR under the Evaluations tab revealed a score of 15 out of 15, indicating intact cognition. Review of R22's 05/15/25 weekly skin evaluation revealed left heel with 2 pressure areas and right foot with 1 pressure area. Boot on bilateral feet. Review of R22's 05/20/25 skin & wound evaluation revealed he had an unstageable pressure ulcer to his left medial foot. Review of R22's 05/12/25 readmission skin Care Plan revealed: [R22] has a potential risk for skin impairment related to mobility, history of skin impairments, and advanced age. Goal was skin will remain intact through next review. Intervention(s) included: Apply barrier cream as needed, use moisturizing cream to prevent dryness, encourage fluids to promote hydration, encourage consumption of meals to promote adequate nutrition, complete skin assessment on admission, put in place any treatment needed per findings. The care plan had not been updated for actual skin impairments and the use of the boots. 3.Review of R43's Clinical Census found in the EMR under the Clinical Census tab revealed an admission date of 04/09/25. Review of R43's diagnoses found in the EMR under the Medical Diagnosis tab revealed diagnoses including toxic encephalopathy (a brain dysfunction caused by exposure to toxins, resulting in a range of neurological and cognitive symptoms.), urinary tract infection, and diabetes mellitus type 2. Review of R43's 04/15 /25 BIMS found in the EMR under the Evaluations tab was a one out of 15 which showed severe cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R43's Progress Note found in the EMR under the Progress Note tab revealed Progress Notes including on 04/26/25 at 7:00 PM Resident c/o [complained of] to CNA [certified nursing assistant] who was making rounds, that she could not urinate and her lower abs [abdomen] hurt. I called DR [doctor] who gave orders to do in/out cath [catheterization] to relieve her bladder than [then] watch her for 6 to 8 hrs [hours]. If she still could not urinate to put in a Foley [urinary catheter] and leave it. Entered the room with off going nurse. We performed the in/out cath without difficulty removing 700 ml [milliliters] urine. On 04/27/25 at 7:13 AM Resident continue to not urinate so a Foley cath 16F [size of catheter] was inserted per protocol and order from DR without difficulty. Review of R43's 04/22/25 Care Plan in the EMR found under the Care Plan tab revealed the focus area for Activities of Daily Living self-care had an intervention for toilet use R43 is not toileted due to bowel and bladder incontinence. Please offer the use of the bedpan for elimination needs. The Care Plan had not been updated when the urinary catheter had been started.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to consistently implement interventions to offload pressure for one of four residents (Resident (R)29) out of a total sample of 25 residents. This failure increased the risk for the resident to develop pressure ulcers. Findings include: Review of the Skin Integrity/Wound Care Policies and Guidelines dated 01/25/24 revealed To promote a systematic approach and monitoring process to identify residents at risk for pressure ulcers and devise an appropriate plan of care to meet the resident's skin integrity needs. The guidelines included: A skin evaluation will be performed on each resident admitted to the facility by a licensed nurse .Results of this evaluation will be used to develop the resident's individual plan of care. The Pressure Ulcer Documentation included: Compliance or non-compliance with the care plan Pressure Reduction Devices, .Physician notification, .a wound evaluation will be completed by the skin integrity nurse with nurse's findings documented in the electronic health record . Review of R29's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] and had diagnoses including dementia and pressure ulcer of left heel. Review of R29's Orders tab of the EMR revealed a physician's order, which originated on 01/07/25, to Use heel manager while in bed to relive pressure. Review of R29's Care Plan, located under the Care Plan tab of the EMR and dated 02/26/25, revealed it addressed her pressure ulcer risk and healing of the left heel ulcer. The approaches included, The resident requires heels to be floated using heel manager while in bed. The Care Plan also addressed R29's refusal to turn off of her back while in bed. Review of R29's Braden Scale for Predicting Pressure Ulcer Risk, dated 03/24/25 and located under the Evaluations tab of the EMR, revealed R29 was at moderate risk of developing pressure sores. Review of R29's quarterly Minimum Dat Set (MDS), with an Assessment Reference Date (ARD) of 03/28/25, revealed she scored three out of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. R29 required substantial to maximal assistance with bed mobility and used a pressure-reducing device on the bed. She had a stage IV pressure ulcer. Review of R29's Wound Evaluation, dated 05/14/25 and located under the Skin and Wound tab of the EMR, revealed her left heel pressure ulcer was resolved. During an observation on 05/19/25 at 9:49 AM, R29 was lying in bed on her back. Her heels were not floated and were in direct contact with the mattress. The resident was not using an air mattress to reduce pressure. During observations on 05/20/25 at 8:32 AM, 10:32 AM, 2:20 PM, and 4:32 PM, R29 was lying in bed on her back with her heels directly in contact with the mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 05/21/25 at 9:08 AM and 10:15 AM, R29 was lying in bed on her back with her heels directly in contact with the mattress. During an interview on 05/21/25 at 10:18 AM, Registered Nurse (RN) 2 stated a heel manager was a device placed under the ankles to relieve pressure from the heels while in bed. During a concurrent observation, RN2 confirmed R29 did not have a heel manager in bed and confirmed R29's heels were not floated and were in direct contact with the mattress. RN2 searched R29's room for a heel manager but was unable to find one. She then placed a pillow under R29's ankles and stated her heels should be floated. RN2 stated the nurses and certified nurse aides (CNAs) could apply the heel manager. During an interview on 05/21/25 at 10:34 AM, CNA3 stated she tried to put a pillow under R29's heels in bed and was not aware of a heel manager. She did not know why R29 did not have a pillow under her heels during the above observations. During an interview on 05/21/25 at 11:02 AM, the Director of Nursing (DON) stated the heel manager was now in place, and should have been in place as ordered to prevent skin breakdown to the heels.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to fix a resident's headboard one out of four residents reviewed for accidents out of 25 sampled residents (Resident (R) 37). This failure had the potential to cause injury to the residents. Findings include: Review of R37's Face Sheet found in R37's electronic medical record (EMR) under the Resident tab indicated the resident was admitted to the facility on [DATE] with diagnoses that included stroke, hypertrophic cardiomyopathy, and delusional disorders. Review of R37's quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/27/25, found in the EMR under the MDS tab revealed she had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated she was cognitively intact. Observation and interview on 05/20/25 at 3:50 PM with the Administrator and R37 revealed R37 in bed and very calm. When she was asked why she had bruising on her right arm, R37 stated I was fighting two girls, and I fought back. One girl was white, and the other one was black. I whooped them [sic] good. When R37 was asked about her headboard being broken, she stated It was broken and maintenance fixed it. R37 did not mention banging on the table or headboard. Cross Reference: F610 Investigate Alleged Violation. On 05/20/25 at 3:54 PM, interview with Registered Nurse (RN1) revealed I was making rounds at about 7:15 AM on 05/15/25 and R37 was in bed and there was bruising on her right hand and forearm. The headboard was on the floor. A piece of the headboard (metal bracket) was in her bed. Maintenance was called and the bed was fixed, and an investigation was started for the bruising [as an injury of unknown origin]. During a phone interview with Certified Nursing Assistant (CNA4) on 05/20/25 at 4:47 PM, revealed I make three rounds a night. R37 would not let me care for her. She was screaming and stating that I was going to kill her sister. At 5:30 AM, her bed was soaked and needed changed. My partner and I changed the bed and R37 and she tried to kick and bite us. She was banging her arm on the bedside table. R37's left arm is paralyzed. I moved her bedside table so that she did not hurt herself and left the room with her still screaming. I was in the next resident room and could hear her banging on something else. When I looked back into R37's room, she was asleep, and I did not see the headboard on the floor. I was just making sure that R37 was not on the floor. Her headboard had been on the floor a week prior to this. I did not report the headboard to anyone as being broken. Interview on 05/21/25 at 11:07 AM with the Administrator revealed Accident hazards need to be reported so that a resident does not harm themselves. R37 had a piece of the headboard in bed with her that was metal. She [R37] removed the headboard because it had not been fixed or reported.

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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** Based on observation, record review, interview, and facility policy review, the facility failed to properly prime an insulin pen prior to administering it to one of twenty-five residents (Resident (R) 2) observed for medication administration. Medication errors have the potential to result in adverse health outcomes. Findings include: Review of the Insulin Aspart Injection Instructions for Use, undated and provided by the facility, revealed . C. Pull off the big outer needle cap . D. Pull off the inner needle cap and throw it away (dispose of it) . Giving the air shot before each injection . E. Turn the dose selector to select 2 units . F. Hold your insulin Aspart FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge . G. Keep the needle pointing upwards, press the push-button all the way in . The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times . Review of R2's undated admission Record located in the EMR under the Profile tab, revealed R2 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus (DM) with diabetic chronic kidney disease. Review of R2's Physician Orders, dated 02/22/25, located in the EMR under the Orders tab, revealed an order for Insulin Aspart Injection Solution 100 unit/milliliters (ML) inject as per sliding scale . During an observation on 05/20/25 at 12:00 PM, the Infection Preventionist (IP) retrieved R64's insulin pen (a pen contains the vial of insulin inside the pen and has a mechanism where the dose to be administered is set on a dial at the top of the pen, and only that amount can then be injected) from the medication cart, wiped the top with an alcohol wipe, attached a needle to the pen then dialed the dose to four units. The IP carried the pen to R2's room. The IP washed her hands, applied gloves, observed R2's right side of the abdomen, cleansed her abdomen with an alcohol wipe, gently inserted the pen needle into the flesh, injected the dose, then removed the needle after ten seconds. Next, the IP carried the pen to the medication cart, disposed of the needle, and performed hand hygiene. During an interview on 05/20/25 at 12:06 PM, the IP confirmed she did not prime the pen to two units after attaching the needle because she was not aware that she had to do this and did not recall being trained to do so. During an interview on 05/20/25 at 1:07 PM, the Education Coordinator stated that staff should prime the insulin pen by turning the selector to two units then pressing the plunger so the insulin would shoot in the air. The Education Coordinator also stated she had not begun training staff on medication administration since she had worked over a month at the facility. .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility policy review, the facility failed to ensure controlled medications (drugs that can cause physical and mental dependence and have restrictions on how they can be filled and refilled) were stored securely in a compartment that was permanently affixed inside the refrigerator in one of two medication storage rooms. Findings include: Review of the facility's policy titled, Medication Storage in the Facility, dated 05/01/20, revealed ID2: Controlled substance storage . B. Schedule [I-V medications and other medications subject to abuse or diversion are stored in a permanently affixed, double-locked compartment separate from all other medications or per state regulation. Alternatively, in a unit dose system, medications may be kept with other medications in the cart if the supply of medication(s) is minimal and a shortage is readily detectable . C. Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator . Observation on 05/20/25 at 9:45 AM with the Director of Nursing (DON) revealed the locked refrigerator in the medication storage room located on the 100 unit contained the following scheduled medications in a clear plastic locked container and was not permanently affixed to the refrigerator: 1. Six vials of Lorazepam (a controlled antianxiety medication) solution 2 milligrams/milliliters (mg/ml). 2. One oral concentrate of Morphine 2 (mg/ml). During an interview on 05/20/25 at 9:59 AM, the DON verified the Ekit controlled medications were stored in the medication room refrigerator in a clear plastic lock box, but she was not aware they had to be stored in a compartment that was permanently affixed to the refrigerator. The DON also stated the controlled substance medication policy stated the medications had to be stored under a double locked system which was the medication room door lock and the medication box with a lock on it. The DON indicated the charge nurses had a key to the medication room door and they had to get the key from the Omnicell to unlock the medication lock box if they needed that medication in an emergency. During an interview on 05/20/25 at 10:04 AM, Registered Nurse (RN) 1 verified that the controlled medication Ekit in the refrigerator was not permanently affixed to the refrigerator and she was not aware of the regulation requirement. RN1 also stated she had keys to the medication room but none of the other staff had access to the room. RN1 indicated she would have to get the locked box keys out of the Omnicell to open it. During an interview on 05/21/25 at 11:05 AM, the Administrator stated he was not aware the locked boxes in the refrigerators had to be permanently affixed so that no one could take it out of the refrigerator.

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	115520	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sears Manor Nursing Home	3311 Lee Street Brunswick, GA 31521

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 - Some	Provide and implement an infection prevention and control program. Based on interview and policy review, the facility failed to 1. to develop an effective infection surveillance program in order to conduct appropriate prevention or control activities and 2. ensure staff used appropriate personal protective equipment (PPE) for one of five residents (Resident (R) 59) reviewed for enhanced barrier precautions in a sample of 25. These failures had the potential to cause an avoidable spread of infection throughout the facility. Findings include: 1. During an interview on 05/20/25 at 1:57 PM, the Infection Preventionist (IP) stated her surveillance included reporting on the number of antibiotics used and the number of facility-acquired infections. The IP stated there were times she was unaware of residents with sign/symptoms of infection and was unaware of when nurses were sending out urine samples for analysis and culture until antibiotics were ordered. She stated there was no system for the nursing staff to report potential infections and lab tests/cultures for potential infections and she relied on the antibiotic orders in the electronic medical record (EMR) system. The IP stated she evaluated whether each potential infection met the criteria for an actual infection, but did not document the criteria that were met or the final determination in her surveillance. During an interview on 05/21/25 at 3:11 PM, the IP stated the EMR system generated a line listing spreadsheet with information on the resident name, type of infection, symptoms, precautions, type of antibiotic, and organism. The IP stated, however, that she did not like to use the spreadsheet because of the format and because it was hard to follow. She stated she entered this information into the system for each resident she was aware of, but was not always aware of all infections, antibiotics, or potential infections in the facility. The IP stated when an antibiotic was ordered, the nurses were to open a case that would prompt her to complete the surveillance information, but she at times did not have all the information to enter. The IP stated there was no surveillance system in place to alert her to residents experiencing signs or symptoms of infection prior to an antibiotics being ordered, and added, unless they verbally tell me I won't know. The IP stated there were many times that urine analysis labs were ordered and she was not aware, and this was a barrier to her surveillance program. The IP stated infection surveillance was not where it needs to be. The IP stated the surveillance program was a mess and the barrier was communication with other staff who were newer. The IP explained she wanted to give newer staff members a chance to learn the job first before she addressed the creation of a communication system for infection surveillance. Cross-reference F881: Antibiotic Stewardship - the facility failed to monitor and evaluate antibiotic usage for three residents (Resident (R) 25, R10 and R48) and antibiotics were ordered without the criteria being met or without a lab/culture. Review of the facility's policy titled, Surveillance of Infections, dated 09/19/22, revealed: Gathering Surveillance Data 1. The infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and/or QAPI (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	committee may be involved in interpretation of the data. 2. The surveillance should include a review of any or all of the following information to help identify possible indicators of infections: a) Laboratory records; b) Skin care sheets; c) Infection control rounds or interviews; d) Verbal reports from staff; e) Infection documentation records; f) Temperature logs; g) Pharmacy records; h) Antibiotic review; and i) Transfer log/summaries . Surveillance 1. For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: a) Identifying information (i.e., resident's name, age, room number, unit, and attending physician); b) Diagnoses; c) admission date, date of onset of infection (may list onset of symptoms, if known, or date of positive diagnostic test); d) Infection site (be as specific as possible, e.g., cutaneous infections should be listed as pressure ulcer, left foot, pneumonia as right upper lobe, etc.); e) Pathogens; f) Invasive procedures or risk factors (i.e., surgery, indwelling tubes, Foley, fractured hip, malnutrition, altered mental status, etc.); (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g) Pertinent remarks (additional relevant information, i.e., temperatures, other symptoms of specific infection, white blood cell count, etc.). Also, record if the resident is admitted to the hospital, or expires; and h) Treatment measures and precautions (interventions and steps taken that may reduce risk. 2. Using the current suggested criteria for healthcare-associated infections, determine if the resident has a healthcare-associated infection. 2.Observation on 05/20/25 at 10:36 AM of Certified Nursing Assistant (CNA)3 during urinary catheter care for R59 revealed CNA3 entered R59's room without donning a gown prior to performing catheter care for R59. During the catheter care CNA3 did not sanitize her hands before donning gloves or when she changed her gloves. When she had completed the catheter care for R59 she took a bottle of foam cleanser and personal care wipes out of the room and placed them in the covered linen cart next to clean linen. During an interview on 05/20/25 at 11:00 AM, CNA3 agreed she had not put on a gown prior to providing catheter care, did not sanitize her hands before or when she had changed her gloves, and had placed personal care items into the linen cart next to clean linen. She was not aware R59 was on Enhanced Barrier Precautions (EBP). CNA3 stated she thought the other resident in the room was EBP. CNA3 agreed after looking at the signage on the door that both residents were on EBP. During an interview on 05/20/25 at 3:03 PM, the Infection Preventionist agreed the observation conducted with CNA3 did not follow the EBP policy. Interview on 05/20/25 at 3:45 PM, Director of Nursing (DON) agreed CNA3 did not follow the EBP policy. Review of the facility policy titled Enhanced Barrier Precautions, dated 04/04/24, revealed EBPs were utilized to prevent the spread of multi-drug-resistant organisms to residents. EBPs included gown and glove use during high contact resident care activities. The examples of high contact resident care activities included device care or use and included urinary catheters.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Review of R48's undated admission Record located in the electronic medical record (EMR) under the Profile tab revealed R48 was admitted to the facility on [DATE] with diagnoses which included Urinary Tract Infection (UTI). Review of R48's Physician's Orders, dated 03/06/25, provided by the facility, revealed Cipro (broad spectrum antibiotic) 250 milligrams (MG) twice a day for seven days. Review of R48's Health Status Note, dated 03/04/25, located in the EMR under the Prog Notes tab, revealed R48 returned to nursing facility at 3:12 AM on stretcher via transport services. Resident is alert and oriented x 1 [times one] with confusion . Resident will start Cefuroxime [broad spectrum antibiotic] 500 mg [milligrams] BID [twice a day] x [for] 10 days for treatment of UTI. Review of R48's Hospital Lab Results, dated 03/04/25, provided by the facility, revealed the urine culture showed 2 organisms isolated. Suggestive of urethral contamination and/or improper collection. Please recollect specimen. Review of the facility's Antibiotic Stewardship Binder, revealed the infection screening had not been completed for R48 yet. During an interview on 05/20/25 at 2:17 PM, the Infection Preventionist (IP) confirmed she did not complete the McGeer's criteria to determine if R48 was ordered the correct antibiotic for the recent UTI. The IP stated R48 went to and returned from the hospital on [DATE] on an antibiotic for a UTI. The IP also confirmed she received the medication order from Nurse Practitioner (NP) 1 for R48 on 03/06/25 and should have clarified the order with NP1 that a UA culture should have been ordered to determine the correct antibiotic was ordered to treat the UTI. During an interview on 05/21/25 at 11:56 AM, NP1 stated R48 was discharged from the hospital on [DATE] with a UTI and was ordered Cefuroxime for it. NP1 also stated she saw R48 on 03/06/25 in which she ordered a repeat urine analysis (UA) and culture and sensitivity laboratory test to determine which antibiotic R48 should take since the UA was contaminated at the hospital. NP1 indicated she told the nurse not to start R48 on the antibiotic until the laboratory results returned so the correct medication was given to cure the UTI. Review of the Orders tab in the EMR revealed no order for a repeat UA and C&S. Based on interview, record review, review of Center for Disease Control (CDC) guidance, and policy review, the facility failed to monitor and evaluate antibiotic usage for three of six residents (Resident (R) 25, R10, and R48) reviewed for antibiotic usage out of 25 sampled residents. This failure had the potential to affect residents in the facility safety related to antibiotic usage. Findings include: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an undated, untitled CDC document located at http://uprevent.[NAME].com/2855wp/wp-content/uploads/2018/01/nh-hac_mcgreercriteriarevcomp_2012-1.pdf; revealed, The Core Elements of Antibiotic Stewardship for Nursing Homes indicated, .Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority .Antibiotic stewardship refers to a set of commitments and actions designed to 'optimize the treatment of infections while reducing the adverse events associated with antibiotic use' .CDC also recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use .Nursing homes monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship. Clinician response to antibiotic use feedback (e.g., acceptance) may help determine whether feedback is effective in changing prescribing behaviors. Below are examples of antibiotic use and outcome measures .Process measures: Tracking how and why antibiotics are prescribed .Antibiotic use measures . Tracking how often and how many antibiotics are prescribed .Antibiotic outcome measures .Tracking the adverse outcomes . Findings include: 1. Review of R25's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R25 was admitted to the facility on [DATE]. Review of the information provided by the Infection Preventionist's (IP) revealed that on 04/25/25, R24 was started on Keflex for a urinary infection that was not on the infection preventionist line listing. On 04/30/25, a urine analysis (UA) and culture and sensitivity (C&S) was completed and showed no growth. R25 had hematuria (blood in the urine) due to pulling out his catheter. On 05/06/25, another UA and C&S were completed with no growth and R10 was started on Cipro. 2. Review of R10's admission Record located under the Profile tab of the EMR revealed R10 was admitted on [DATE]. Review of the information provided by the IP revealed that on 07/01/24, R10 started on Methenamine Hippurate (prophylactic treatment for recurring urinary tract infections) for chronic dysuria (painful or uncomfortable urination). On 05/17/25, Change in Condition was noted in the Progress Notes located in the EMR that R10 was weak and not feeling well. The doctor ordered a straight catheter for a UA and C&S and to start on Cipro for seven days. The UA and C&S were not available for review. On 05/20/25 at 2:27 PM, interview with the Infection Preventionist (IP) revealed I did not know that R10 was on a prophylactic and this current antibiotic did not meet McGeer's Criteria. When asked if she ever talks to the Medical Director of Nurse Practitioners about starting antibiotics before a UA and C&S are back and reviewed, the IP stated, I do not.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure the bathrooms had ventilation for two residents (Resident (R) 21 and R60) out of 26 residents included in the Initial Pool. This failure had the potential to limit airflow in resident bathrooms causing odors or discomfort. Findings include: Observations throughout the survey revealed the left side of the 200-hallway had six rooms, only two of which were occupied. During resident screening and room observation on 05/19/25 beginning at 9:00 AM, the bathroom vents in rooms [ROOM NUMBERS], which were both unoccupied, were not working. The bathrooms had heavy urine odors in them. During an observation in R21's room on 05/19/25 at 9:08 AM, the vent fan in the bathroom was not working and would not pull up a piece of tissue paper. The bathroom had a musty odor. During an environmental tour with the Maintenance Director (MD) on 05/21/25 at 10:44 AM, the MD checked the vent in R21's bathroom and confirmed the vent was not working. The bathroom had a musty odor. He also checked the vent in R60's room and confirmed it was not working. The bathroom had a musty odor. The MD stated most likely, the vents in all the rooms on that side of the hallway were not working. He stated he kept extra belts on hand to replace as needed and would need to go up on the roof and replace the belt. The MD stated he tried to check the vents for functioning periodically, but he had not worked on the vents on this hallway in a while. A policy on ventilation was requested; however, none was provided prior to facility exit.