

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2024
NAME OF PROVIDER OR SUPPLIER  Crestview Health & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 Springdale Road Atlanta, GA 30315	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47794</p> <p>Based on observations, staff interviews, record review, and review of the facility policy titled, Abuse, Neglect, and Exploitation, the facility failed to protect the resident's right to be free from neglect for four of four residents (R) (R3, R4, R5, and R6) reviewed for neglect. Specifically, R3, R4, R5, and R6 had care plan interventions in place for one-to-one supervision and monitoring but did not receive one-to-one supervision and monitoring. The deficient practice resulted in R3 being found on the floor and sent to the hospital for evaluation, and had the potential for R4, R5, and R6's care and needs not being addressed.</p> <p>Findings include:</p> <p>Review of facility policy titled Abuse, Neglect, and Exploitation last revised 12/5/2022; revealed under Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect . Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. VI. Protection of Resident . C. Increased supervision of the alleged victim and residents.</p> <p>1. Review of the electronic medical record (EMR) for R3 revealed they were admitted to the facility with diagnoses that included, but are not limited to generalized anxiety disorder, bipolar disorder, vascular dementia with other behavioral disturbance, traumatic brain injury, and falls.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for R3 revealed a Brief Interview for Mental Status (BIMS) score of 0, which indicates severe cognitive impairment.</p> <p>Review of the care plan for R3 revealed they need assistance rolling to the right and left, sitting to lying, lying to sitting, sit to stand, chair to bed and bed to chair, requires supervision with walking, can partially walk up to 150 feet, depends on staff for showering, dressing, toileting, eating, oral and personal hygiene. R3 is non-verbal, requires one-on-one at all times.</p> <p>Observation on 7/23/2024 at 6:10 pm revealed R3 dressed and sleeping in bed in the fetal position with one-on-one Certified Nursing Assistant (CNA) seating at the bedside. R3 was nonverbal.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the CNA resident assignments from April 2024 through July 2024 revealed residents received care planned one-on-one supervision intervention on the morning and day shifts (7:00 am to 7:00 pm), but not the same supervision interventions for these residents on night shifts (7:00 pm to 7:00 am).</p> <p>During an interview on 7/23/2024 at 6:15 pm with the Assistant Director of Nursing (ADON), a facility one-on-one census report was requested. The ADON stated they were unaware of why the night charge nurses did not follow care plans and physician orders for one-on-one supervision and monitoring when assigning the CNA's their resident duties.</p> <p>In an interview on 7/24/2024 at 3:36 pm with the Administrator revealed they and the Director of Nursing (DON) investigated the incident and on 7/14/2024 that sent R3 to the hospital for observation and notified R3's responsible party and physician. R3 was discharged from the hospital with no evidence of injury. The Administrator reported that CNA BB did not know R3 was care planned for one-on-one supervision at all times. The Administrator stated that CNA BB reported that the Charge Nurse, Licensed Practical Nurse (LPN) AA assigned CNA BB 14 additional residents to care for during the nightshift.</p> <p>In an interview on 7/24/2024 at 2:55 pm with CNA BB revealed they did not know R3 was care planned for one-on-one supervision at all times. CNA BB stated that the LPN AA assigned them 14 additional residents to care for during the nightshift.</p> <p>Review of nightshift CNA assignment records confirmed that CNA BB was assigned 14 other residents to care for during their 7:00 pm to 7:00 am shift along with R3.</p> <p>2. Review of the EMR for R4 revealed they were admitted to the facility with diagnoses that included, but are not limited to cerebral infarction due to unspecified occlusion or stenosis of left cerebral artery, acute pulmonary edema, atrial fibrillation, dysphagia, retention of urine, intracardiac thrombosis, heart failure, hypertension, hyperlipidemia, lack of coordination, muscle weakness, panic disorder, vascular dementia - severe with other behavioral disturbance, mood disorder due to known physiological condition with mixed features, and legally blind.</p> <p>Review of the quarterly MDS assessment for R4 revealed a BIMS score of 2, which indicates severe cognitive impairment.</p> <p>Review of the care plan for R4 revealed they need assistance rolling to the right and left, sitting to lying, lying to sitting, chair to bed and bed to chair. R4 has no use of extremities for ambulation. R4 depends on staff for showering, dressing, toileting, eating, oral and personal hygiene, is non-verbal, requires one-on-one at all times.</p> <p>3. Review of the EMR for R5 revealed they were admitted to the facility with diagnoses that included, but are not limited to thrombocytopenia, hypertension, schizophrenia, Alzheimer's disease, dementia, psychotic disturbance, mood disturbance, paranoid schizophrenia, fracture of nasal bones.</p> <p>Review of the quarterly MDS assessment for R5 revealed a BIMS score of 0, which indicates severe cognitive impairment.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the care plan for R5 revealed they need assistance rolling to the right and left, sitting to lying, lying to sitting, sit to stand, chair to bed and bed to chair, requires supervision with walking, can partially walk up to 150 feet, depends on staff for showering, dressing, toileting, eating, oral and personal hygiene. R5 is non-verbal, requires one-on-one at all times.</p> <p>Observation on 7/23/2024 at 6:20 pm of R5 revealed them dressed, alert and oriented, walking in the 200 Hall with one-on-one CNA. R5 was nonverbal.</p> <p>4. Review of the EMR for R6 revealed they were admitted to the facility with diagnoses that included, but are not limited to essential hypertension, moderate protein-calorie malnutrition, traumatic brain injury without loss of consciousness, seizures, dementia, insomnia, history of falling.</p> <p>Review of the quarterly MDS assessment revealed a BIMS score of 12, which indicates mild cognitive impairment.</p> <p>Review of the care plan for R6 revealed they require supervision for showering and personal hygiene. R6 can ambulate independently, is verbal, is wanderer related to impaired safety awareness requires one-on-one at all times.</p> <p>Observation on 7/23/2024 at 11:10 am of R6 revealed them dressed, alert and oriented, walking in the 100 Hall with one-on-one CNA. R6 was verbal.</p> <p>In an interview on 7/25/2024 at 11:00 am with the Administrator, they stated they were unaware of why the night charge nurses did not follow care planned orders for one-on-one supervision and monitoring when assigning CNA's their resident duties. They reported the facility suspended LPN AA and CNA BB on 7/15/2024 during their investigation of the incident. The Administrator stated after discussions with Human Resources and review of camera footage, the facility terminated and referred the license of LPN AA for neglect for failure to regularly round on their residents and not following R3's care plan interventions on the morning of 7/25/2024. On the morning of 7/25/2024, CNA BB was also terminated for failure monitor residents every one to two hours.</p>		