STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115532	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Social Circle Nsg & Rehab Ctr	671 North Cherokee Road Social Circle, GA 30025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled, Enteral Tube Feeding via Continuous Pump, the facility failed to administer nutritional enteral feedings and hydration according to the current physician orders for one of two residents (R) (R33) receiving tube feeding in the facility. The deficient practice had the potential for the resident to not receive the correct amount of nutrition ordered by the physician which could result in negative outcome for resident. Findings include: Review of the facility's policy titled Enteral Tube Feeding via Continuous Pump, dated March 2015 under Purpose revealed, The purpose of this procedure is to provide nourishment to the resident who is unable to obtain nourishment orally. Under Preparation revealed, 1. Verify that there is a physician's order for the procedure . Under General Guidelines revealed, 3. Check the enteral nutrition label against the order before administration. Check for the following information: .(c.) date and time formula was prepared; (d.) route of delivery (f.) method (pump, gravity, syringe); and (g.) Rate of administration (ml/hr). Review for R33's electronic health records (EHR) revealed the resident was with diagnosis that include but not limited to: moderate protein-calorie malnutrition, dementia in other disease classified elsewhere, dysphagia unspecified, gastrostomy status (g-tube), and iron deficiency anemia unspecified. Review of R33's Annual Minimum Data Set (MDS) dated [DATE] for Section C (Cognitive Patterns) revealed, R33 had a Brief Interview for Mental Status (BIMS) of 00, which indicated severe cognitive impairment; Section GG (Functional Abilities and Goals) revealed, R33 was total dependent on with assistance for activities of daily living (ADL); Section K (Swallowing/Nutritional status) revealed, R33 received tube feeding as a sole source of nutrition. Review of R33's physician orders dated 4/1/2025 revealed, a NPO (Nothing by Mouth) Diet. Enteral Feed every shift for feedings, [Name of nutritional supplement] 1.5 R 50 cc (cubic centimeter)/ (per) hour x (times) 22 hours on at 8:00 am and off at 6:00 am, allow 6:00 am to 8:00 am for Activities of Daily Living (ADL) care. Review of the Care Plan for R33 revealed resident is at risk for alteration/decline in nutritional/hydration due to tube feeding. The care plan further revealed that resident was dependent on tube feeding for hydration and nutrition. (continued on next page)

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 5/27/2025 at 9:30 am and 10:56 am revealed R33's g-tube was connected to the feeding pump, but nutrition was not being delivered to the resident. Observation and interview on 5/27/2025 at 1:21 pm in R33's room with the Director of Nursing (DON) confirmed that R33 tube feeding was not being administered. The DON revealed that she would investigate the problem. Further observation on 5/28/2025 at 11:45 am revealed, R33 in her chair outside of the dining room with tube feeding attached to the pump however it was not on. Interview on 5/28/2025 at 2:32 pm with Director of Nursing (DON) revealed the nurse on the floor was responsible for monitoring the tube feeding and the resident.

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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, staff interviews, record review and review of the facility's policies titled, Administering Medication, and Storage of Medication, the facility failed to properly secure a medication cart when not in use or clearly visible to the personnel administering medication and failed to ensure an eye drop medication was dated appropriately when opened to determine the discard date, for one of two medication carts (North Hall medication cart). The facility census was 56 residents. Findings include: Review of the facility's policy titled, Administering Medication dated 2/2020 under Policy Interpretation and Implementation revealed, 7. During administration of medications, the medication cart will be kept closed and locked when out of sight of medication nurse or aide. The cart must be clearly visible to the personnel administrating medication. Review of the undated facility's policy titled, Storage of Medication under the Policy Statement revealed, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Under Policy Interpretation and Implementation revealed, 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe and sanitary manner 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals . 1. An observation and interview was conducted on 5/28/2025 at 9:55 am with Licensed Practical Nurse (LPN) BB revealed that the North Hall medication cart was not locked when administering medication to a resident in B bed. Further observation of LPN BB preparing medications with the medication cart facing toward room while resident in A bed was mobilizing in his wheelchair in the room. In an interview with LPN BB confirmed that the medication cart was unlock and was not clearly visible the entire time. An interview was conducted on 5/29/2025 at 1:06 pm with the Director of Nursing (DON) revealed the expectation was for nurses to lock the cart. She revealed, nurses should lock the cart even if the nurse was giving medication in the room and the cart was facing the room. 2. An observation conducted on 5/29/2025 at 11:05 am of the North Hall medication cart revealed, an open bottle of Latanoprost eye drops without an open date on it. An interview on 5/29/2025 at 11:25am was conducted with the Unit Manager confirmed the open bottle of the eye drop. She revealed that she thinks the expiration date was 45 to 60 days for the Latanoprost drops but would verify that.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident representative and staff interviews, and record review, the facility failed to document care for one 28 sampled residents (R) (R160). Specifically, personal, bowel, and bladder care were not documented in the medical record. Findings include: Review of the most recent annual Minimal Data Set (MDS) dated [DATE] for Section C (Cognitive Pattern) revealed that R160 has a Brief Interview for Mental Status (BIMS) score of 13, indicating little to no cognitive impairment. Section I (Active Diagnoses) revealed diagnoses of but not limited to urinary tract infection (UTI), dementia, type two diabetes mellitus (DM), congestive heart failure (CHF), and atrial fibrillation. Section GG (Functional Abilities and Goals) revealed that R160 was substantial/maximum assistance for most activities of daily living (ADL) except she required supervision for eating. Section H (Bladder and Bowel) revealed that R160 was occasionally incontinent for urine but had frequent bowel incontinence. Review of the care plan dated 1/16/2025 revealed that R160 was to remain neat and clean while maintaining maximum level of independence, check for incontinence on rounds and perineal care as needed. Review of the electronic medical record (EMR) for R160 revealed that personal, bowel, and bladder care was not documented for three-day shifts and 13-night shifts. According to documentation dated 1/30/2025, the facility was treating residents bottom with barrier cream. An interview with R160's representative on 5/28/2025 at 4:30pm revealed that R160 was incontinent prior to hospital discharge and transfer to the skilled nursing facility. R160 was bed bound. R160's representative reported that R160 did not have any skin integrity breakdown prior to the admission to the facility but that at discharge the resident had some redness to her sacral region. An interview on 5/29/2025 at 12:15 pm with Certified Nursing Assistant (CNA) CC revealed that empty blanks in documentation meant that nothing was done. She reported that CNA's do not like to chart but when she trained another CNA, she instructed them to document care provided. An interview on 5/29/2025 at 12:21 pm with the Unit Manager (UM) revealed that she expected CNA's to take care of the resident. If they were unable to perform care, then she expected them to contact the nurse or the UM for help. The UM reviewed the personal hygiene record for R160 with empty blanks and she stated that empty blanks meant that they did not follow through with documentation. She would not confirm they did not provide the care. The expectation was that the CNA's will document the care provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and record review, the facility failed to properly disinfect a glucometer before use for one of eight residents (R) (R22) that have glucometer checks ordered. The deficient practice has the potential to place residents at high risk for infection. Findings include: Review of the facility provided Manufacturer's instruction revealed on page 39 that the facility to disinfect between each patient with [company name] germicidal wipes, [company name] hospital cleaner disinfectant towels with bleach, [company name] wipes, and [company name] Super Sani-Cloth germicidal disposable wipes. Observation and interview on 5/28/2025 at 11:32 am with Licensed Practical Nurse (LPN) BB revealed that LPN BB did not disinfect the glucometer according to manufacturer's instructions. LPN BB removed one of two glucometers on the cart and after successfully completing the blood sugar check for R22, LPN BB used an alcohol wipe to disinfect the glucometer. An interview with LPN BB revealed that she was using [name of manufacturer] glucometer. LPN BB stated that the protocol to clean the device was to wipe at the beginning of shift with bleach wipe and then alcohol wipe between residents. An interview on 5/28/2025 at 2:37 pm with the Director of Nursing (DON) revealed her expectation was that staff should clean the glucometer between each resident. An interview on 5/28/2025 2:57 pm with the Infection Perfectionist (IP) Nurse revealed that the process to disinfect a glucometer was to use bleach solution wipes that were provided on the medication cart for three-minute dwell time and change glucometers between each resident while the first device dried. The IP nurse stated that there were two glucometers on each cart for that reason. She stated that they were to use bleach wipes on the carts to clean the glucometers. The IP nurse revealed that nurses should not use alcohol wipes.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policy titled, Maintenance Service, the facility failed to keep one call light in working condition in one out of 18 rooms on North Hall (Room North 3-B). This deficient practice had the potential to place the resident at risk for unmet care needs, delayed response during emergencies, and increased likelihood of injury due to the inability to request assistance. Findings include: A review of the facility's policy titled Maintenance Service revealed under the Policy Interpretation and Implementation: 1. The maintenance department is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times. Observation conducted on 5/27/2025 at 10:54 am and on 5/28/2025 at 9:14 am in Room North 3-B revealed the call light was not functioning. When tested, the hallway indicator light did not activate. Interview on 5/28/2025 at 9:16 am with Certified Nursing Assistant (CNA) CC confirmed after testing the call light device, it was not working and noted that it had been functioning on Monday. She stated she would submit a maintenance order through TELS work order system. Interview on 5/28/2025 at 9:25 am with the Director of Nursing (DON) revealed she was previously unaware of the issue. After checking, she confirmed the call light was not functioning. Interview on 5/28/2025 at 9:35 am with the Maintenance Director (MD) confirmed he had been informed about the call light not functioning in Room North 3-B. He explained that different call lights required specific outlet [NAME], and sometimes CNAs mistakenly switched them. After testing, he stated the light itself was operational, but mismatched connections may have caused the malfunction. He acknowledged that nonfunctional call lights could lead to increased wait times and pose resident safety risks. Follow-up interview on 5/29/2025 at 10:09 am with the DON confirmed that staff were expected to report issues immediately and submit a TELS order. She emphasized that all call lights must be operational, as failure to respond could result in a resident being in distress, attempt tasks independently, or even signaling for a roommate in need. Interview on 5/29/2025 at 10:29 am with the Administrator reinforced that broken call lights must be reported and entered into TELS as soon as they were identified. Once maintenance was informed, repairs should be completed immediately. He stated that call lights must always remain functional to ensure residents can communicate urgent needs. Administrator stated delays or failures in response could result in falls, missed hygiene care, or the development of bedsores, posing serious safety risks.