STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on record review and resident and staff interviews, the facility failed to ensure the advanced directive was documented accurately throughout the Electronic Medical Record (EMR) for one resident (R) (R397) of 40 residents reviewed for advanced directive. Findings include: Review of the EMR revealed R397 was originally admitted to the facility on [DATE] with multiple diagnoses including, but not limited to Sepsis, Chronic Diastolic (Congestive) Heart Failure, Acute Kidney Failure, Respiratory Failure with Hypoxia, Psoriatic Arthritis and Hyperlipidemia. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed that R397 had a Brief Interview for Mental Status (BIMS) score of 13, indicating R397 is cognitively intact. Review of the Physician Order for Life-sustaining Treatment (POLST) form dated 7/24/2024, revealed R397's code status as Allow Natural Death- Do Not Attempt Resuscitation. The POLST code was signed by R397, the Medical Director and an additional facility physician. Review of Social Services Progress Note for R397 dated 9/25/2024 at 8:42 am revealed The POLST was reviewed with the patient, and she confirmed her decision to remain a DNR (Do Not Resuscitate). Review of R397's care plan dated 9/24/2024 revealed that R397 has completed an Advanced Directive. POLST FULL CODE. During an interview on 10/3/2024 at 2:28 pm, the Director of Nursing (DON) confirmed that R397's care plan should have been updated with the DNR advanced directive status. In an interview on 10/9/2024 at 8:47 am, R397 confirmed the correct code status was DNR.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 49687 Based on record review and staff interviews, the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) (Form CMS-10123), and facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) Form CMS-100550) to two of three residents (R) (R94 and R397) reviewed that were discharged from Medicare Part A coverage. Findings include: Review of the Beneficiary Notice-Residents discharged Within the Last Six Months form, provided by the facility, revealed the following: 1. R94 was discharged from Medicare Part A skilled services on 9/23/2024 and remained in the facility. 2. R397 was discharged from Medicare Part A skilled services on 9/24/2024 and returned home. There was no documented evidence that the SNF ABN and/or NOMNC were provided to either R94 and R397 or their respective responsible parties. During an interview on 10/3/2024 at 4:22 pm, the Business Office Manager (BOM) revealed the facility did not provide the SNF ABN and NOMNC documents to R94 or R397. The BOM stated the Social Services and Therapy employees were new to the facility and did not provide those documents upon discharge from Medicare Part A skilled services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25680 Based on record review, review of facility policy titled Care Plan, Comprehensive Person-Centered, and staff interviews, the facility failed to follow the care plan for skin assessments for one resident (R) (R145) of six residents reviewed for pressure ulcers. On 10/10/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator, Regional Director of Operations, Regional Director of Clinical Operations, and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on 10/10/2024 at 10:53 am. The noncompliance related to the IJ was identified to have existed on 2/16/2024. An Acceptable IJ Removal Plan was received on 10/11/2024. Based on observation, record reviews, review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 10/11/2024. Findings include: Review of the undated facility policy titled Care Plans, Comprehensive Person-Centered revealed that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. R145 was admitted to the facility on [DATE] with diagnoses including encephalopathy due to subdural hematoma, chronic kidney disease and cerebrovascular accident with hemiplegia. R145 was discharged to the hospital on 4/5/2024. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R145 was cognitively impaired with a Brief Interview of Mental Status (BIMS) score of 4 of 15, indicating severe cognitive impairment. The MDS documented R145 was at risk for pressure ulcers, but no ulcers present at the time of the assessment. R145 was dependent on staff for all activities of daily living. Review of the care plan for R145 dated 11/29/2023, documented R145 had potential for skin breakdown. Interventions included for staff to assess skin daily, keep dry, and monitor nutrition. Review of the Physician's Orders revealed an order with a start date of 10/27/2023 for skin assessments weekly on Fridays. However, the order was discontinued on 3/8/2024. Review of the Medication Administration Record (MAR) revealed skin assessments were signed off through 3/1/2024 as being completed. The 3/8/2024 skin assessment was not signed off. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Certified Nursing Assistant (CNA) Bath Report dated 2/16/2024 documented an open area to the sacrum that was reported to the Licensed Practical Nurse (LPN). Further review of the medical record revealed no documented evidence of any additional bath skin assessments during the resident's stay at the facility. Review of the Skin Checks, which documented details of the skins assessments were not completed after 2/16/2024. The 2/16/2024 Skin Check revealed the weekly skin check, daily documentation of skin notes, and other skin assessments were reviewed as part of the skin care plan. However, there are no other Skin Checks after 2/16/2024 and the 2/16/2024 Skin Check does not include the area to the sacrum. Review of a Nurse's Progress Note dated 3/21/2024 documented R145 noted with open area on her tailbone related to pressure. Barrier cream applied. Review of the medical record revealed no documented evidence of any additional assessment or documentation of the wound until an unstageable wound to the sacrum measuring 7 cm x 7 cm x 0.1cm was identified on 3/27/2024 by the Wound Nurse Practitioner (NP). During an interview on 10/8/2024 at 2:34 pm, Corporate Wound Nurse (CWN) EE stated that during bathing the CNA is supposed to examine the skin and report any changes to the unit nurse right away. CWN EE further stated that the facility wound nurse should also complete a full body check for other wounds during rounds. During an interview on 10/15/2024 at 12:20 pm, MDS Coordinator RR revealed interventions are included in the care plan and should be followed. She stated it is a team effort to ensure all measures are completed that are documented in the care plans. Weekly skin assessments are done by nursing staff (LPN, RNs and Wound Care Nurse). CNA information is placed on bath sheets. The nursing staff should confirm any issues that the CNA observed on bath sheets. Cross Refer to F686. The facility implemented the following actions to remove the IJ: 1. R145 was discharged from the facility to the hospital on 4/4/2024 (sic) for a septic wound and did not return to the facility. 2. An AD-HOC meeting was held on 10/10/2024 with the Administrator, Director of Nursing (DON), Regional Director of Operations (RDO), Regional Director of Clinical Operations (RDCO), and Chief Medical Officer (CMO) to address the concerns identified related to the Immediate Jeopardy Citations. 3. On 10/10/2024, the RDO, RDCO, and CMO reviewed the center policy on Developing a Comprehensive Care Plan. No policy changes or recommendations were made because of this review. 4. On 10/10/2024, a Root Cause Analysis (RCA) of the wound management system breakdown was completed by RDO, RDCO, CMO, Administrator and DON. Documentation of analysis was put on the RCA Tool and was included in the Ad Hoc Quality Assurance Performance Improvement QAPI meeting. The Root Cause for the immediate jeopardy was identified as staff not following the center's policy for Pressure Ulcer Prevention and Management secondary to education deficit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. On 10/10/2024, all residents had a pressure ulcer risk assessment performed. Care plans were reviewed and updated by the MDS Coordinators for 139 of 140 (1 hospitalized) residents to ensure that the weekly skin check was listed as an intervention under the at-risk skin care plan. 6. On 10/10/2024, the center MDS Coordinator, Wound Care Nurse, and Regional Wound Care Specialist (RWCS) conducted an audit for 5 of 5 residents with pressure ulcers/injuries to ensure that all residents have a comprehensive wound care plan that is being implemented. 7. On 10/10/2024, nursing employees, 6 of 7 RN's, 27 of 29 LPN's and 43 of 46 CNA's were educated by the RWCS, Staff Development Coordinator (SDC), and DON on implementation of the care plan for pressure ulcer prevention and management including location of the care plan in the electronic health record and viewing the care plan prior to the start of the shift. LPNs were educated regarding following physicians orders and the person-centered care plan. Any staff not educated during the initial education will have the education prior to the start of their shift or during the orientation period. The facility implemented the following actions to remove the IJ: 1. Record review showed R145 was discharged from the facility to the hospital on 4/5/2024 with a septic wound and did not return to the facility. 2. A review of the facility QAPI sign in sheet showed facility held an ad-hoc meeting on 10/10/2024, a total of twenty staff signed off as attendees, which included, the Administrator, DON, Social [NAME] Director (SSD), Rehabilitation Director (RD), CMO, Maintenance Director, RDO, Dietary Manager (DM) and Unit Managers. 3. Review of the facility policy Care Plans, Comprehensive Person-Centered showed the policy was signed and dated on 10/10/2024 by RDO, RDCO and the CMO with no changes to the policy. 4. Review of the root cause analysis showed LPNs and CNAs were educated to ensure weekly skin assessments will be completed on a weekly basis and documented. DON will ensure the completion of assessments in a timely manner. Interview on 10/15/2024 at 1:03 pm, the DON verified the DON in-serviced staff along with RN PP. The DON stated CNAs were re-educated on how to fill out shower sheets (and give a copy to the charge nurse and DON), as soon as a skin condition was identified and to notify the nurse immediately. Interview on 10/15/2024 at 5:37 am, CNA GG revealed she attended an in-service training hosted by the DON. CNA GG stated the in-service focused on reporting and documentation of skin changes for all residents. 5. Review of a Daily Census dated 10/10/2024 revealed 139 of 140 residents were reassessed for risk for pressure ulcers and that residents had a care plan to include weekly skin assessments. This was verified by review of the pressure ulcer risk assessments and care plans for R12, R395, R400 R402 and R403. 6. Review of the pressure Ulcer/Injury Care Plan Update Tool revealed 5 of 5 residents care plans were reviewed for accuracy of wound location and care plan reflective of care provided. Review of five residents, R12, R395, R400, R402 and R403, showed the residents had comprehensive care plans for pressure ulcers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Review of in-service sign in sheets revealed 27 of 29 LPNs, 43 of 46 CNA's and 6 of 7 RN's were in-serviced by the RWCS on 10/10/2024 on care plans for pressure ulcer prevention and management. Also verified via the following staff interviews on 10/15/2024 at 5:37 am with CNA GG, 5:59 am with LPN JJ, 6:29 am with CNA HH, 6:39 am with CNA II, 6:59 am with LPN LL, 7:19 am with LPN MM, 11:27 am with LPN OO, 11:39 am with RN PP, 12:04 pm with RN QQ, and 12:20 pm with RN RR, the staff confirmed that they received the in-service information and were able to demonstrate an understanding of the education information provided. There were no new hires. 9. All corrections were made by 10/10/2024. 10. The immediacy of the IJ was removed on 10/11/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25680 Based on closed records review, interviews, and review of facility policy titled Blood Glucose Monitoring, the facility failed to ensure professional standards were followed for blood sugar monitoring of one resident receiving insulin of seven residents (R) (R146) reviewed for unnecessary medications. Findings include: Review of the facility policy titled Blood Glucose Monitoring dated March 2024 revealed it is the policy of the facility to perform blood glucose monitoring to a diabetic resident as per physician orders. There was no documentation related to the protocol for blood glucose monitoring for resident's receiving insulin. R146 was admitted to the facility on [DATE]. R146's diagnoses included diabetes. Review of the care plan dated 6/21/2024 revealed the resident has Diabetes Mellitus with interventions including but not limited to diabetes medication as ordered by doctor, and monitor/document for side effects and effectiveness. Review of the admission history and physical (H/P) dated 6/21/2024, completed by Nurse Practitioner (NP) JJJ documented: Type 2 diabetes mellitus with diabetic retinopathy- continue insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine). Review of Physician Orders by NP JJJ dated 6/21/2024 documented Glargine insulin 12 units daily. NP JJJ had not documented orders for blood glucose monitoring. Review of the Medication Administration Record (MAR) documented Glargine insulin 12 units was given daily from 6/21/2024 to 7/4/2024. The MAR revealed no documented evidence of glucose monitoring from 6/21/2024 to 7/3/2024. The vital signs record documented a fingerstick blood glucose of 373 milligrams per deciliter (mg/dL) on 7/4/2024 prior to R146 being transferred to the hospital. R146 was transferred to hospital due to an altered mental status on 7/4/2024. Review of the hospital records revealed that R146 was diagnosed with a complicated urinary tract infection and received intravenous antibiotics. The resident was discharged from the hospital to a different nursing home. Interview with Chief Medical Officer (CMO) on 10/16/2024 at 3:02 pm revealed diabetic residents were initially checked four times per day, then adjusted based on whether they were stable or not. The CMO stated if the blood sugars were stable, the blood sugar would be checked weekly. The CMO further stated that if a resident was on long-acting insulin, the fingerstick needed to be administered at least once a day. The CMO revealed the facility was responsible for ensuring the blood sugars were monitored even if hospital discharge orders had not included fingerstick monitoring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 9:56 am, Licensed Practical Nurse (LPN) MMM revealed LPN MMM had administered insulin to R146. LPN MMM stated if there was no finger sticks ordered for the resident, then it was missed. LPN MMM further stated if a resident has long-acting insulin ordered, whoever did the admission orders should have entered finger sticks, which would have shown up on the MAR as an order that should have been followed. Interview on 10/17/2024 at 10:12 am with the admission nurse, LPN FF, revealed the NP should have been contacted to clarify if finger sticks should have been ordered. LPN FF was unable to state why finger sticks had not been ordered. Interview with the Director of Nursing (DON) on 10/17/2024 at 11:19 am revealed the orders were sent from the hospital when residents were admitted . DON further stated the orders were entered by the charge nurse or the unit manager and then reviewed by a clinical team the following morning. DON also stated the clinical team included the Minimum Data Set (MDS) nurse, Infection Control Preventionist, DON and NP who would determine if any changes needed to be made. DON denied being aware of any issues with blood glucose monitoring of residents receiving insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25680 Based on observations, record review, review of facility policy titled Pressure Injury Prevention and Management, and staff interviews, the facility failed to provide the necessary care and services to prevent the development and worsening of pressure ulcers for one of six residents (R) (R145) reviewed for pressure ulcers. Specifically, the facility failed to ensure weekly skin assessments and wound observations were completed for R145 and failed to provide the recommended treatment for a sacral pressure ulcer. On 10/10/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator, Regional Director of Operations, Regional Director of Clinical Operations, and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on 10/10/2024 at 10:53 am. The noncompliance related to the IJ was identified to have existed on 2/16/2024. An Acceptable IJ Removal Plan was received on 10/11/2024. Based on observations, record review, review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 10/11/2024. Findings include: Review of the facility policy titled Pressure Injury Prevention and Management last reviewed 10/10/2024 revealed the facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment . Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Assessments of pressure injuries will be performed by a licensed nurse and documented on the Weekly Wound Observation Tool. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task. Review of a Face Sheet revealed R145 was admitted to the facility on [DATE] with diagnoses including encephalopathy due to subdural hematoma, chronic kidney disease and cerebrovascular accident with hemiplegia. R145 was discharged to the hospital on 4/5/2024. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R145 was cognitively impaired with a Brief Interview of Mental Status (BIMS) score of 4 of 15, indicating severe cognitive impairment. The MDS documented R145 was at risk for pressure ulcers, but no ulcers present at the time of the assessment. R145 was dependent on staff for all activities of daily living. Review of the Certified Nursing Assistant (CNA) Bath Report dated 2/16/2024 documented an open area to the sacrum that was reported to the Licensed Practical Nurse (LPN). Further review of the medical record revealed no documented evidence of any additional bath assessments during the resident's stay at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Skin Assessments ordered weekly with start date of 10/27/2023 to be checked off as completed on the Medication Administration Record (MAR). However, no skin assessment was ordered after 3/8/2024, with the last skin assessment checked off on 3/1/2024, with no documentation of a sacral wound. Review of a Wound Consult Note dated 2/21/2024 documented R145 was seen for a left elbow unstageable wound measuring 4 centimeters (cm) x 6 cm x 0.1 cm. The responsible party was notified of the wound to the left elbow. There was no documentation of a sacral wound. Review of Wound Weekly Observation Forms dated 2/29/2024, 3/19/2024, and 3/25/2024 revealed no documentation of the resident's sacral wound. Review of physician orders, treatment records and progress notes revealed no documentation of any care provided to the sacral wound. R145 was seen by a physician for an elbow wound on 3/20/2024 with no sacral wound documented. Review of a Nurse's Progress Note dated 3/21/2024 documented R145 noted with open area on her tailbone related to pressure. Barrier cream applied, will notify wound care. Review of the medical record revealed no documented evidence of any additional assessment or documentation of the wound until an unstageable wound to the sacrum measuring 7 cm x 7 cm x 0.1cm was identified on 3/27/2024 by the Wound Nurse Practitioner (NP). Review of R145 Progress Note dated 3/27/2024, revealed Wound NP SSS documented an unstageable wound measuring 7 cm x 7 cm x 0.1 cm with odor and drainage with a planned treatment of Medihoney and calcium alginate dressing three times per week. There was no order written for the planned treatment. Review of the Treatment Administration Record (TAR) for R145 revealed orders dated 3/26/2024 which instructed staff to cleanse R145's left buttock and right buttock wounds with saline and cover with colloidal dressing every three days. The treatment was followed from 3/27/2024 to discharge on 4/5/2024. There were no other documented wound treatments for R145. The NP recommendation for Medihoney and calcium alginate dressing three times per week was never implemented. Review of a Wound Physician Progress Note dated 4/3/2024 documented the sacral wound measured 13 cm x 11 cm x 1.5 cm. The note also documented there was a heavy amount of foul purulent (consisting of, containing, or discharging pus) drainage noted which has a strong odor. Review of R145 Progress Note dated 4/3/2024, NP (JJJ) documented R145 was seen with an unstageable sacral wound, and wound culture ordered. Review of the wound culture results revealed it was collected on 4/4/2024, and results received after R145 was already hospitalized showing multiple bacteria. Review of R145 Weekly Wound Assessment Form dated 4/3/2024 documented the sacral wound was acquired on 3/28/2024 and the resident's responsible party was made aware of the wound. Review of R145 Physician's Order dated 4/4/2024 documented staff to cleanse the wound with Dakins' solution. There was no documented evidence this was started prior to R145 being transferred to hospital on 4/5/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of NP (JJJ) Note dated 4/4/2024 documented she was alerted to resident condition change by family members of R145 who were visiting. NP JJJ documented R145 was dehydrated and gave an order for normal saline 1/2 liter at 100 milliliters (ml) /hour (hr). The Medication Administration Record documented the intravenous (IV) fluid was administered before transferring R145 to hospital on 4/5/2024. Review of R145 Progress Note dated 4/5/2024, revealed a change of condition note documenting that R145 was not eating or drinking and was transferred to hospital. Review of the Hospital Transfer Form dated 4/5/2024 revealed no documentation of a sacral wound. Review of the hospital record revealed R145 presented on 4/5/2024 with a decline and was refusing to eat or drink over the past few days. A significant pressure ulcer was noted with active purulent foul-smelling drainage. R145 was diagnosed with septic shock secondary to pressure injury of deep tissue of sacral region with necrotizing soft tissue infection. R145 was intubated and had debridement of the sacral wound on 4/6/2024 and 4/13/2024. R145 had a diverting colostomy placed on 4/13/2024. The hospital record also documented on 4/20/2024, R145 was transitioned to comfort care, compassionate extubation, and consult with inpatient hospice. During a telephone interview on 10/8/2024 at 1:10 pm, LPN TTT stated the CNA should report any skin conditions directly to the floor nurse who reports to the unit manager. LPN TTT stated they were the nurse on record who signed the CNA bath sheet but did not recall being told about the opening to R145's sacrum. LPN TTT further stated that the resident should have been examined and the wound nurse made aware. LPN TTT also stated the wound nurse worked Monday to Friday and the weekend supervisor would have been responsible to notify them during the weekends. The wound should have been documented in a progress note and the treatment orders would have been up to the wound care nurse. During an interview on 10/8/2024 at 2:32 pm, CNA HH revealed that if they see a skin issue during bathing it is reported to the nurse right away by filling out the bath sheet and handing it to the nurse who signs it right away. CNA HH also stated sometimes, she reported directly to the wound nurse if they are in the facility. During an interview on 10/8/2024 at 2:34 pm, Corporate Wound Nurse (CWN) EE stated that during bathing the CNA is supposed to examine the skin and report any changes to the unit nurse right away. CWN EE further stated that the facility wound nurse also does a full body check for other wounds during rounds. CWN EE continued to state when a nurse is notified, they are supposed to inform the floor manager or the wound nurse to examine the resident. Once a facility acquired wound is identified, a change of condition, Braden scale, and a care plan should be initiated. CWN EE also stated that if a resident has co-morbities such as poor appetite or circulation issues, the facility completes an unavoidable wound document which is then uploaded in the electronic record. CWN EE was not able to find any such document for R145. CWN EE also stated that the Wound Care NP made rounds on residents on Mondays and Thursday. On other days, the unit nurse should write a progress note and obtain interim treatment orders which change would be revised by the wound nurse as needed. During an interview on 10/9/2024 at 9:15 am, Wound Care Nurse, LPN FF, revealed the bath sheet is completed by the CNA and given to the nurse. The nurse would be responsible for obtaining and administering treatment orders until the resident was seen by the Wound Care NP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/9/2024 at 10:08 am, the Medical Records Clerk revealed she was responsible for uploading the bath sheets and other paper documents to the electronic health record (EHR) and would provide requested copies. On 10/9/2024 at 11:00 am, the Medical Records Clerk returned stating there were no additional bath skin assessment records for R145. During a follow-up interview on 10/9/2024 at 11:30 am, LPN FF stated that hydrocolloidal dressings were suitable for protection and not for large open wounds. LPN FF stated updating the orders to include the Wound NP's planned treatment of Medihoney and calcium alginate dressing would have been the responsibility of the then wound care nurse. During a telephone interview on 10/9/2024 at 1:40 pm, the former Wound Care Nurse VVV stated the Wound NP was responsible for entering orders and she just followed what was written. During an interview on 10/9/2024 at 3:20 pm, the DON stated she had no specific knowledge of the concerns regarding R145. The DON further stated the wound care nurse was responsible for obtaining and reviewing treatment orders for any new wounds. The DON also stated skin changes should be discussed during morning clinical meetings and monthly quality meetings and she was not aware of any problem with wounds. The facility implemented the following actions to remove the IJ: 1. R145 was discharged from the facility to the hospital on 4/4/2024 (sic) with a septic wound and did not return to the facility. 2. An Ad-Hoc meeting was held on October 10/10/2024 with the Administrator, Director of Nursing (DON), Regional Director of Operations (RDO), Regional Director of Clinical Operations (RDCO), and Chief Medical Officer (CMO) to address the concerns identified related to the Immediate Jeopardy Citations. 3. On 10/10/2024, the RDO, RDCO, and CMO reviewed the facility policy regarding Pressure Ulcer Prevention and Management. Facility did not make any policy changes or recommendations on this review. 4. On 10/10/2024, a Root Cause Analysis (RCA) regarding the pressure ulcer prevention and skin management system was completed by RDO, RDCO, CMO, Administrator and DON. Documentation of the RCA was put on the RCA Tool and was included in the Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting. The Root Cause for the immediate jeopardy was identified as staff not following the center's policy for Pressure Ulcer Prevention and Management secondary to education deficit. 5. The facility Unit Managers and Wound Care Nurse conducted skin assessments on 131 of 140 (One in hospital and eight refused) residents residing in the center on 10/10/2024. Audit revealed no new in-house acquired pressure ulcers/injuries. 6. On 10/10/2024, five of five residents residing in the center identified with pressure ulcers/injuries were reassessed including measurements and documented on by the wound care nurse practitioner. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On 10/10/2024, orders were verified for five of five Residents with pressure injuries by the Regional Skin Management Specialist to ensure orders in the electronic medical administration record (E-MAR) matched the recommendations of the wound care nurse practitioner. The facility implemented an audit conducted by the DON after each wound care nurse practitioner visit to ensure the orders match the recommendations of the wound care nurse practitioner. This audit will be conducted once a week. 8. On 10/10/2024, Nursing employees 6 out of 7 registered nurses (RN's), 27 out of 29, licensed practical nurses (LPN's) and 43 out of 46 certified nursing assistants (CNA's) were educated by the Regional Wound Care Specialist (RWCS) Staff Development Coordinator (SDC), and DON on the pressure ulcer prevention and treatment. Specifically, CNAs received education to notify the licensed nurse anytime a new skin area was identified and to document the findings on the body sheet. The LPNs/RN's received education on conducting weekly skin assessments and notifying the Medical Provider or Wound Care Nurse Practitioner NP anytime a new skin area is identified as well as following physician orders and plan of care for wound care treatments. Anyone that was not educated during the Initial education sessions will be educated prior to start of their shift or during the orientation process. 9. The Regional Skin Management Specialist (RSMS) educated three of three wound care nurses on ensuring pressure wounds are measured weekly and are assessed on the Weekly Wound Assessment Tool. 10. On 10/10/2024, 139 of 140 (One in hospital) residents' charts were audited the DON will ensure staff have an order to perform a weekly skin check. 11. On 10/10/2024, the facility implemented a process to ensure that skin checks are monitored daily to ensure completion. The DON will conduct daily audits to ensure skin checks are completed daily and to ensure any newly identified pressure ulcer was reported to the MD or Wound Care Provider and an appropriate treatment ordered. 12. All corrections were made by 10/10/2024. 13. The immediacy of the IJ was removed on 10/11/2024. The facility implemented the following actions to remove the IJ: 1. R145 was discharged from the facility to the hospital on 4/5/2024 with a septic wound and did not return to the facility. 2. A review of the facility QAPI sign in sheet showed facility held an ad-hoc meeting on 10/10/2024, a total of twenty staff signed off as attendees, which included, the Administrator, DON, Social [NAME] Director (SSD), Rehabilitation Director (RD), CMO, Maintenance Director, RDO, Dietary Manager (DM) and Unit Managers. 3. Review of the facility policy Pressure Ulcer Prevention and Management showed the policy was signed and dated on 10/10/2024 by RDO, RDCO and the CMO with no changes to the policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Review of the root cause analysis showed LPNs and CNAs were educated to ensure weekly skin assessments will be completed on a weekly basis and documented. DON will ensure the completion of assessments in a timely manner. Interview on 10/15/2024 at 1:03 pm, the DON verified the DON in-serviced staff along with RN PP. The DON stated CNAs were re-educated on how to fill out shower sheets (and give a copy to the charge nurse and DON), as soon as a skin condition was identified and to notify the nurse immediately. Interview on 10/15/2024 at 5:37 am, CNA GG revealed she attended an in-service training hosted by the DON. CNA GG stated the in-service focused on reporting and documentation of skin changes for all residents. 5. Facility Unit Managers, LPN 00, LPN MM, LPN LL and LPN JJ verified skin assessments were completed for 131 of 140 residents. Review of four sampled residents revealed R36, R104, R68 and R89's skin assessments were completed on 10/10/2024. 6. Review of the Pressure Ulcer/Injury Order Audit Update Tool revealed five of five residents with pressure ulcers and documented, R12, R395, R400, R402 and R403 skin assessments were completed, and pressure ulcer measurements were verified by the NP and correctly documented. 7. Review of the electronic medical records (e-MAR) showed orders for R12, R395, R400, R402 and R403 matched the recommendations of the wound care nurse practitioner. During an interview on 10/15/2024 at 1:03 pm, the DON confirmed she will continue to audit following each Wound Care NP visit to ensure recommendations are followed for wound treatments. 8. Review of in-service sign in sheets revealed 27 of 29 LPNs, 43 of 46 CNA's and 6 of 7 RN's were in-serviced by the RWCS on 10/10/2024 on pressure ulcer prevention and treatment. Also verified via the following staff interviews on 10/15/2024 at 5:37 am with CNA GG, 5:59 am with LPN JJ, 6:29 am with CNA HH, 6:39 am with CNA II, 6:59 am with LPN LL, 7:19 am with LPN MM, 11:27 am with LPN OO, 11:39 am with RN PP, 12:04 pm with RN QQ, and 12:20 pm with RN RR, the staff confirmed that they received the in-service information and were able to demonstrate an understanding of the education information provided. There were no new hires. 9. Review of in-service sign in sheets revealed LPN FF, LPN LL, and RN VV were educated by RSMS regarding timely skin assessments and timely documentation of pressure wounds. Interview on 10/15/2024 at 11:27 am LPN- FF revealed she was the wound care nurse. LPN FF completed in-service and stated education focused on skin impairment and timely notification of the physician. 10. Review of resident charts showed 139 of 140, residents' charts were audited by the DON and documented the DON will ensure staff completed and documented weekly skin checks. Review of four sampled residents revealed R36, R104, R68 and R89's had a Physician's Order for weekly skin assessments. 11. Review of the Daily Audit Skin Assessments and New Skin Issues revealed daily audits from 10/11/2024 through 10/18/2024 ensuring all ordered skin assessments were completed and provider notification and treatment ordered for any new skin issues identified. There were no new skin issues identified. During an interview on 10/16/2024 at 12:03 pm the RDO CC revealed she is monitoring audits on a weekly basis. 12. All corrections were made by 10/10/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	13. The immediacy of the IJ was removed on 10/11/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on staff/resident interviews, record review and review of the facility policy titled Ostomy Care-Colostomy, Urostomy and Ileostomy, the facility failed to obtain a physician order for colostomy care for one of one resident (R) (R396) who required colostomy services. Findings include: Review of the facility policy titled Ostomy Care-Colostomy, Urostomy and Ileostomy, last reviewed in January 2024 revealed that as part of the comprehensive assessment and care planning process, a licensed nurse will determine the actual type of ostomy through physical assessment, medical record, and collaboration with the attending physician. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed that R396 had a Brief Interview for Mental Status (BIMS) score of 14; indicating R396 was cognitively intact. Additionally, review of Section H of the MDS - under ostomy (including urostomy, ileostomy, and colostomy) was marked yes. Review of R396's Electronic Medical Record (EMR), R396 was originally admitted to the facility on [DATE] with multiple diagnoses including, but not limited Ulcerative Colitis and Intestinal Obstruction. Review of R396's care plan initiated on 9/11/2024 revealed that R396 is at risk for skin breakdown, colostomy left side on admit. The intervention in place was colostomy care every shift and PRN (as needed), change as ordered/needed. Record review of R396's September 2024 Medication Administration Record (MAR) for colostomy care was not found. Further review of the Physician Orders revealed no orders for colostomy care and no orders for wafer or frequency to change the colostomy drainage bag. During an interview on 9/24/2024 at 4:09 pm, R396 revealed he had a stoma and there was a time that they had to clean it five times. R396 stated, if it gets too full it could burst. During an interview on 10/8/2024 at 2:19 PM, Director of Nursing (DON) revealed there was no order for the colostomy care and that's why it didn't show up on the MAR or Treatment Administration Record (TAR). The DON also revealed there was no diagnosis about the colostomy on the resident's medical diagnosis list. During an interview on 10/10/2024 at 4:08 pm, Licensed Practical Nurse (LPN) FFF revealed that R396 does have a colostomy on his left lower side. LPN FFF stated R396's colostomy routine care would be to change out the wafers every three days and empty the bag every shift. LPN FFF also confirmed the orders for care should be on R396's MAR. LPN FFF was asked to review R396's MAR to point out where the orders are. LPN FFF confirmed the order is not on the MAR.