STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spalding Post Acute LLC	415 Airport Road Griffin, GA 30224

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38997 Based on resident interviews, staff interviews, review of the facility policy titled, Patient/Resident Trust Funds, and review of the facility-provided document titled, Resident Fund Accounts, the facility failed to provide resident trust fund account quarterly statements for three of 100 residents (R) with trust fund accounts managed by the facility (R4, R6, and R9). This deficient practice had the potential to affect all residents who had a trust fund account with the facility. Findings include: Review of the facility policy titled, Patient/Resident Trust Funds, dated 2/1/2024, revealed the Procedure section included .3. At the time of admission, the resident will sign an authorization indicating understanding of the policy and giving the healthcare center authorization to handle such funds. This authorization is to be maintained in the financial file. Review of the undated document located in the resident admission packet titled, Resident Fund Accounts revealed, The center shall furnish resident/patients with quarterly statements at the end of each calendar quarter. 1. Review of R6's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was assessed as 15 (indicating intact cognition). Review of the document titled Resident Fund Accounts revealed it was signed by R6's resident representative and the facility representative on 11/4/2018. Review of the Trial Balance dated 10/31/2024 and Resident Fund Statement revealed R6 had a resident trust fund account managed by the facility. In an interview on 11/7/2024 at 10:25 am, R6 stated she had a trust fund account that the facility managed. The resident stated the last quarterly statement the facility provided to her was in February 2024. The resident stated she would like to receive statements and to know how much money is in the account. In an interview and observation on 11/12/2024 at 1:15 pm with the Business Office Manager (BOM) and R6, R6 stated she had not received a statement since February 2024. The resident gave the BOM permission to look through the nightstand for a statement. The BOM did not locate a quarterly statement. (continued on next page)

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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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R4's Annual MDS assessment dated [DATE] revealed a BIMS was assessed as 15 (indicating intact cognition). Review of the Trial Balance dated 10/31/2024 and Resident Fund Statement revealed R4 had a resident trust fund account managed by the facility. In an interview on 11/8/2024 at 11:25 am, R4 stated she had a trust fund account that the facility managed. The resident stated she did not receive a quarterly statement for the trust fund account. The resident stated someone in the front office would tell her the balance in the account if she (R4) asked. 3. Review of R9 MDS Quarterly assessment dated [DATE] revealed a BIMS was assessed as 15 (indicating intact cognition). Review of the Trial Balance dated 10/31/2024 and Resident Fund Statement revealed R9 had a resident trust fund account managed by the facility. In an interview on 11/12/2024 at 10:50 am, R9 stated he had a trust fund account that the facility manages and did not receive the quarterly statements. R9 stated he did not know how much money was in his account. In an interview and observation on 11/12/2024 at 1:25 pm with the BOM and R9, R9 stated he did not receive bank statements. The resident gave the BOM permission to look through his dresser drawers for a quarterly statement. The BOM did not locate a quarterly statement. In an interview on 11/12/2024 at 11:51 am, the BOM stated she managed the residents' trust fund accounts. She stated the statements were provided to the residents quarterly. The BOM stated the resident quarterly statements were placed in an envelope by the business office and provided to the Receptionist and Activities Director for distributing to the residents. The BOM stated it was ultimately the responsibility of her office to ensure the residents received the quarterly bank statement.

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F 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38997

Based on resident and staff interviews, record review, and review of the facility policies titled, Grievances Policy, Missing Items (Including Misappropriation of Property), and Resident Council Meetings, the facility failed to make a prompt effort to file a grievance for two of 25 sampled residents (R) (R7 and R9) who verbally reported grievances. This deficient practice had the potential to place residents at risk of not having their grievances resolved in a timely manner.

Findings include:

Review of the facility's policy titled, Grievances Policy, dated 2/1/2024, revealed the Policy Statement was It is the policy for healthcare centers to have and follow an established process whereby residents and/or other customers may have their grievances and complaints resolved in a prompt, reasonable and consistent manner. All employees will take an active part in efforts to resolve grievances voiced without discrimination or retaliation.

Review of the facility's undated policy titled, Missing Items (Including Misappropriation of Property), revealed the Additional Instructions section included, Complaints of missing property from patients should be immediately reported to the Social/Patient Services Director. If reports of missing property are made to the Nursing Department or any other department head, the department head or staff person should fill out a Tracking system grievance form and return the completed form(s) to the Social/Patient Services Director within 24 hours or the next business day.

Review of the facility's policy titled, Resident Council Meetings, dated 1/1/2023, revealed the Policy Explanation and Compliance Guidelines included . 7. The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to an extent practicable, and communicate its decisions to the Council.

1. Review of the Admission Record for R7 revealed he was admitted to the facility on [DATE] with diagnoses of, but not limited to, asthma and chronic obstructive pulmonary disease.

Record review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) assessed at 15 (indicating cognitively intact).

Review of the facility document used for notes/minutes during resident council meetings revealed the Comments/Concerns/Recommendations section dated 1/24/2024 revealed that R7 voiced concern that the facility did not have enough nebulizers for resident use and residents' not receiving medications at night.

Review of the Grievance Log for January 2024 revealed there were five grievances filed for the month. There was no documented grievance filed for R7.

2. Review of the Admission Record for R9 revealed he was admitted to the facility on [DATE] with diagnoses of, but not limited to, blindness and chronic obstructive pulmonary disease.

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	115537	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Quarterly MDS quarterly assessment dated [DATE] revealed a BIMS assessed at 15 (indicating cognitively intact). Review of the facility document used for notes/minutes during resident council meetings revealed the Housekeeping/Laundry/Maintenance section dated 2/8/2024 revealed that R9 voiced concerns that the washcloths were dirty, the clothes returned from laundry smelled bad, and his wallet was missing. Review of the Grievance Log for February 2024 revealed there was one grievance filed for the month of February, and there was no documented grievance filed or R9. In an interview on 11/22/2024 at 12:00 pm, R9 stated he had never found his wallet. He stated he reported the missing wallet but was never told if the wallet was located. The resident stated, I am blind, and the only way to know the wallet was found would be by someone telling him. In an interview on 11/12/2024 at 10:57 am, the Social Service Director (SSD) stated they were responsible for tracking the grievance on the Grievance Log form. The SSD revealed anyone can complete a Grievance/Concern Form, and stated a grievance can be verbal or in writing. The SSD further stated after the Grievance/Concern Form was completed, the form was turned in to the Social Service Department, and the grievance was reviewed and discussed with the Administrator. After the grievance was reviewed a copy of the grievance was given to the appropriate department to investigate. The SSD stated the facility had three days to respond/resolve the grievance. In an interview on 11/13/2024 at 2:39 pm, the Activities Director stated when a resident voices concerns in the resident council meeting, she will have the person in charge of the department step in the meeting immediately. She stated if the person in charge of the department was not available, she would complete the Grievance/Concern Form and give the form to the Administrator or the SSD. In an interview on 11/21/2024 at 11:00 am, the SSD stated she did not have a grievance for R7 for January 2024. She stated R7 never verbalized concerns to the Social Service Department. She further stated it was never reported in February or any other time that R9 was missing a wallet.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38997 Based on record review, staff interviews, and review of the facility policy titled, Transfer and Discharge Including AMA [against medical advice], the facility failed to ensure the Ombudsman was notified for six of six residents (R) (R5, R1, R2, R7, R8, and R11) reviewed for discharge from the facility. Findings include: Review of the facility's undated policy titled, Transfer and Discharge Including AMA, revealed the Policy was It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. The Policy Explanation and Compliance Guidelines section included . 4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: . h. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman. 12. h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices. 1. Review of R5's Admission Record revealed she was admitted to the facility on [DATE], transferred to the hospital on 11/15/2023, did not return to the facility, and was discharged from the facility on 11/22/2023. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Section Q (Resident Participation in Assessment and Goal Setting) documented active discharge planning was not occurring for the resident to return to the community. Review of the care plan dated 11/16/2023 revealed no documentation of a care plan for discharge planning. Review of a Social Service Note dated 11/24/2023 revealed, SSD [Social Service Director] called the resident's legal guardian and notified that the resident was off of bed hold and we would not be able to take her back. Review of R5's electronic medical record (EMR) revealed no documentation that the Ombudsman was notified that R5 was discharged from the facility. 2. Review of R1's Admission Record revealed she was admitted to the facility on [DATE], transferred to the hospital on 1/19/2024, did not return to the facility, and was discharged from the facility on 1/19/2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Annual MDS assessment dated [DATE] revealed Section Q (Resident Participation in Assessment and Goal Setting) documented active discharge planning was not occurring for the resident to return to the community. Review of the care plan dated 1/7/2024 revealed no documentation of a care plan for discharge planning. Review of a Social Service Note dated 1/19/2024 revealed, The resident's daughter called the facility on 1/18/2024 and stated she was discharging her mother from the facility . Review of R1's EMR no documentation that the Ombudsman was notified that R1 was discharged from the facility. 3. Review of R2's Admission Record revealed he was readmitted to the facility on [DATE] and was discharged from the facility on 3/14/2024. Review of the Annual MDS assessment dated [DATE] revealed Section Q (Resident Participation in Assessment and Goal Setting) documented active discharge planning was not occurring for the resident to return to the community. Review of the care plan revealed no documentation of a care plan for discharge planning. Review of the Progress Notes eINTERACT Change in Condition Evaluation V5 dated 3/12/2024 documented that R2 was assessed by the Nurse Practitioner and was transferred to the hospital. Review of R2's EMR revealed no documentation that the Ombudsman was notified that R2 was discharged from the facility. 4. Review of R7's Admission Record revealed he was admitted to the facility on [DATE], transferred to the hospital on 9/3/2024, did not return to the facility, and was discharged from the facility on 9/10/2024. Review of the Quarterly MDS assessment dated [DATE] revealed Section Q (Resident Participation in Assessment and Goal Setting) documented active discharge planning was not occurring for the resident to return to the community. Review of the care plan dated 4/12/2023 revealed no documentation of a care plan for discharge planning. Review of the Progress Notes eINTERACT Change in Condition Evaluation V5 dated 9/3/2024 documented that R7 was sent to the emergency room . There was no documentation that the Ombudsman was notified that R7 was discharged from the facility. 5. Review of R8's Admission Record revealed he was readmitted to the facility on [DATE] and was discharged from the facility on 10/19/2023. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Spalding Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Airport Road Griffin, GA 30224	

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Discharge MDS assessment dated [DATE] revealed Section Q (Resident Participation in Assessment and Goal Setting) documented active discharge planning was not occurring for the resident to return to the community. Review of the care plan dated 4/12/2023 revealed no documentation of a care plan for discharge planning. Review of the Progress Note (general) dated 10/19/2023 revealed R8 left the facility with emergency medical service to be admitted to hospice care. There was no documentation that the Ombudsman was notified that R8 was discharged from the facility to hospice care. 6. Review of R11's Admission Record for R11 revealed he was admitted to the facility on [DATE], transferred to the hospital on 12/21/2023, did not return to the facility, and was discharged from the facility on 12/23/2023. Review of the Admission MDS assessment dated [DATE] revealed Section Q (Resident Participation in Assessment and Goal Setting) documented active discharge planning was not occurring for the resident to return to the community. Review of the care plan dated 12/22/2023 revealed no documentation of a care plan for discharge planning or desires. Review of the Progress Notes eINTERACT Change in Condition Evaluation V5 dated 12/23/2023 revealed R11 was transferred to the hospital. There was no documentation that the Ombudsman was notified that R11 was discharged from the facility. In an interview on 11/12/2024 at 10:57 am, the SSD stated she was unaware the Ombudsman should be notified when a resident is discharged from the facility. She stated the Ombudsman visited the facility frequently and had never communicated she wanted to be notified of discharges. In an interview on 11/12/2024 at 3:45 pm, the Administrator stated she spoke with the SSD and was made aware that the Ombudsman had not been notified of resident discharges from the facility. The Administrator stated she has also spoken with the Ombudsman regarding the preference of communication of the resident discharges. The Administrator stated a process would be implemented to ensure that the Ombudsman was aware of the discharged residents going forward.

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	115537	A. Building B. Wing	12/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 38997 Based on observations, staff interviews, and review of the facility's policies titled, Glucometer Disinfection, and Infection Prevention and Control, the facility failed to ensure the infection control process was followed by two of three nurses observed using a glucometer (a device used to measure blood glucose) to check resident's blood sugar levels. The deficient practices had the potential to increase the potential for cross-contamination and spread of infection. Findings include: Review of the facility's policy titled, Glucometer Disinfection, dated 11/2017, revealed the Policy stated, The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood sampling devices to prevent transmission of blood borne diseases to residents and employees. The Policy Explanation and Compliance Guidelines section included 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. 3. Glucometers should be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. Review of the facility's policy titled, Infection Prevention and Control, dated 2/1/2024, revealed the Policy Statement was An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The Policy Interpretation and Implementation section included . 11. Prevention of Infection a. Important facets of infection prevention include: . (3) educating staff and ensuring that they adhere to proper techniques and procedures. An observation on 11/8/2024 at 10:57 am of Licensed Practical Nurse (LPN) EE performing a glucometer test on R25 revealed the LPN removed the glucometer from the medication cart and placed the glucometer on top of the medication cart without a barrier. The LPN gathered additional supplies, carried the supplies to the resident's room, and placed the glucometer and supplies on the overbed table without placing a barrier on the table or sanitizing the table. After obtaining the resident's blood sugar, the LPN exited the room and placed the glucometer in the medication cart on top of the pill crushers. The LPN stated that before placing the glucometer in the medication cart, it should have been cleaned with a sanitizing wipe. An observation on 11/8/2024 at 11:57 am of LPN DD performing a glucometer test on R9 revealed the LPN removed the glucometer and supplies from the medication cart and placed the items on top of the medication cart without a barrier. After entering R9's room, the LPN placed the glucometer and supplies on the overbed table without a barrier or sanitizing the table. The LPN stated a barrier should have been used before placing the items on any surface. In an interview on 11/8/2024 at 12:10 pm, the Director of Nursing (DON) stated the glucometer machines should be cleaned with a germicidal disposable wipe after each use. She further stated a barrier must be used when placing the glucometer and supplies on any surface. The DON stated she would start educating the staff on the proper way to disinfect the glucometer and use a barrier.