STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115545	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jonesboro Nursing and Rehabilitation Center	2650 Highway 138 SE Jonesboro, GA 30236

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44959 Based on staff interviews, record review, the facility failed to provide bed hold information, in writing, at the time of transfer or within 24 hours, for one of 40 sampled residents (R) (R16). This failure had the potential to contribute to possible denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital. Findings include: Review of the electronic medical record (EMR) for R16 revealed they were admitted to the facility with diagnoses of but not limited to end stage renal disease, type 2 diabetes mellitus without complications acute on chronic diastolic (congestive) heart failure spinal stenosis, cervical region, generalized anxiety disorder, chronic kidney disease, stage 5, anemia in chronic kidney disease, Alzheimer's disease, unspecified, acute embolism and thrombosis of deep veins of left upper extremity, pruritus, unspecified, depression. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for R16 documented a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive deficit. Further review of physician orders revealed R16 was prescribed Carvedilol Tab 25 MG (milligram) Give 1 tablet orally two times a day related to Acute or chronic diastolic (congestive) heart failure Pharmacy Active 2/15/2025 17:00 (5:00 pm) 2/17/2025 Supply Clopidogrel Bisulfate Tab 75 MG (Base Equiv (equivalent) Give 1 tablet orally one time a day related to Athscl (atherosclerotic) heart disease of native coronary artery w/o (without) [NAME] pctrs (angina pectoris) Pharmacy Active 2/16/2025. Review of R16's EMR revealed R16 was sent to the hospital on 2/4/2025. Further review revealed there was no bed hold policy notice in the EMR or in the paper chart. During an interview on 3/27/2025 at 2:25 pm with Licensed Practical Nurse (LPN) BB regarding the bed hold policy when a resident was transferred to the hospital, she revealed that Admissions was responsible for sending a resident to the hospital with bed hold policy notice and informing them when the bed hold was going to expire. (continued on next page)

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/2025 at 2:36 pm with the Director of Admissions, she revealed that the bed hold policy notice was included in the admission package upon resident admission. She stated that the resident or their responsible party signed the form at admission, and it stayed in the resident file. She stated that when residents transferred to the hospital, they did not send them out with a bed hold policy notice. She stated that when the business office staff came in the next day, they looked at the midnight census to know which residents transferred to the hospital and then put it in their system. During an interview on 3/27/2025 at 2:40 pm with the Business Office Manager, she revealed they were not responsible for sending out a bed hold policy notice to residents when transferring to the hospital. During an interview on 3/27/2025 at 2:37 pm with the Administrator regarding the facility bed hold policy when transferring to the hospital, she revealed that upon admission the bed hold policy was included with the admission package. She stated they do not send residents with a bed hold policy notice when they transfer to the hospital because they already had one in their chart upon admission. She stated the facility had no policy on bed holds.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. 44959 Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Comprehensive Person-Centered Care Plans, the facility failed to implement a care plan for oxygen (O2) therapy for one of 10 residents (R) (R53) receiving O2 therapy. The deficient practice had the potential for R53's needs to go unmet. Findings include: Review of the facility policy titled Comprehensive Person-Centered Care Plans dated January 2025 revealed under Policy: Each resident will have a person-centered plan of Care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. Review of the Physician's Orders for R53 revealed an order dated 3/27/2025 for oxygen at 2 liters per minute (LPM) via nasal cannula (NC) as needed for O2 sats (saturations) oxygen in place for R53. Review of R53 care plan revealed a care plan intervention for the use of oxygen set at 2 L (liters). Observation and interview during the initial screening on 3/25/2025 at 10:00 am revealed R53's O2 level was set at 3 LPM. R53 stated that it should be set at 2 LPM. Observation on 3/25/2025 at 03:28 pm revealed R53's O2 level remained set at 3 LPM. Observation on 3/26/2025 at 10:56 am revealed R53's O2 level was still set at 3 LPM. During an interview on 3/26/2025 at 3:52 pm with Licensed Practical Nurse (LPN) AA regarding R53's O2 setting, she stated that the order was for O2 to be set at 2 LPM. During an interview on 3/26/2025 at 5:40 pm with LPN BB, she confirmed that R53's O2 was set at 3 LPM. She went to the EMR and confirmed that the physician order was for O2 to be set at 2 LPM. During an interview on 3/27/2025 at 8:00 am with the Director of Nursing (DON), she revealed that she expected staff to follow and adhere to the physician order and to ensure that during rounds O2 was set at the ordered level

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50524 Based on observations, record review, resident and staff interviews, and review of the facility's policies titled, Admission/Readmission Orders and Oxygen (O2) Therapy, the facility failed to transcribe and to have physician orders for catheter care for one of one resident (R) (R93) reviewed with an indwelling catheter; and failed to follow physician orders to administer O2 to one of 10 R's (R53) receiving O2 therapy. The deficient practice had the potential to cause risk of complications, urinary tract infections (UTI) and other catheter-related harm to R93, and low O2 levels to R53. Findings include: Review of the facility policy titled Oxygen Therapy dated January 2025 documented under Procedure: 1: Oxygen Therapy is to be provide under the direction of a written physician's order. A physician order for O2 therapy is to contain liter flow per minute via mask or canula/time frame. On an emergency basis, O2 may be used at 2L/minute (liters per minute-LPM) until the oxygen is ordered. Review of the facility policy titled Admission/Readmission Orders revised February 2019 documented under Policy: Upon admission/readmission, orders for care of the resident are received from attending physician, placed on physician's order sheet and filed in the medical record. Under Procedure: . 2. Re-admission to the facility after hospitalization s voids all previous orders. Therefore, all orders pertinent to resident must be re-written upon re-admission. 1. Review of the EMR revealed R93 was admitted to the facility with diagnoses including but not limited to obstructive and reflux uropathy and bladder-neck obstruction. Review of the 5 Day MDS assessment dated [DATE] documented in Section C (Cognition) a BIMS score of 8, which indicated R93 had moderately impaired cognition. Section H (Bowel and Bladder) Indwelling catheter and always incontinent. Section I (Active Diagnoses) Obstructive uropathy. Review of the Physician's Orders revealed no physician's orders for R93's foley catheter care. Review of the care plan dated 12/20/2024 documented including but not limited to: The resident has Indwelling Catheter, diagnosis (dx) of obstructive uropathy. The resident will be/remain free from catheter-related trauma through review date, The resident will show no signs and symptoms (s/sx) of Urinary infection through review date, Catheter: The resident has foley catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door; Monitor/document for pain/discomfort due to catheter; Monitor/record/report to MD (medical doctor) for s/sx UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp; Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Observation on 3/25/2025 at 10:20 am revealed R93 in her room lying in bed. A foley catheter was observed on the side of the bed and the foley catheter bag was in a drainage bag holder. Observation on 3/26/2025 at 11:25 am revealed R93 in her room sitting up in bed. A foley catheter was observed on the side of the bed and the foley catheter bag was in a drainage bag holder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/27/2025 at 12:50 pm revealed R93 in her room sitting in a chair beside her bed eating lunch. R93 had a leg bag attached to the foley catheter. Review of the EMR for R93's After Visit Summary from [name of hospital] dated 12/10/2024 -12/18/2024 documented included but not limited to PLAN: Bladder outlet obstruction: continue foley catheter, F/U (follow up) with Urology. Interview on 3/25/2025 at 10:30 am with R93 revealed she stated she was admitted to the facility from the hospital with the foley catheter. Interview on 3/27/2025 at 10:55 am with Unit manager (UM) CC, she confirmed and verified there were no physician orders for R93's foley catheter care. She stated there was usually an admission and discharge nurse who would write the initial orders for the residents who were admitted , but she did not. She stated she would also review the admission information and write the orders. She stated she did not write the orders for the foley catheter for R93, and she should have checked to ensure the orders were there, but she did not. UM CC stated if there were no physician's orders, the outcome would be the staff may not be aware that R93 had a foley catheter. She stated the orders should be there in the EMR so that everybody would be aware that R93 had a foley catheter in place. She further stated the staff would not be able to sign off on the orders to show that catheter care was done. Interview on 3/27/2025 at 11:00 am with Admission Nurse (AN) DD confirmed there were no physician orders for R93's foley catheter care. She stated she was familiar with R93, and she was aware she had a foley catheter. She stated she was responsible for writing the orders for the newly admitted residents and also for transcribing orders from the hospital notes. The AN stated she did not place the orders for R93's foley catheter in the EMR and she should have placed or transcribed the orders. She stated there should be orders for the foley catheter which included to be changed if needed, to notify the physician if there was leakage of the foley, and to empty the foley and document it. She stated an order should be there for the foley catheter and diagnosis to indicate the need for the foley catheter. She stated the outcome if there was no order for the foley catheter would be the staff would not know R93 had a foley catheter, they would not check it, and they would not change it if needed. AN DD stated the resident could be at risk for infection if catheter care was not done. Interview on 3/27/2025 at 11:31 am with the Director of Nursing (DON) revealed her expectations were for the nurses to ensure there were physician's orders and adhering to the physician's orders. She stated there should be physician's orders for the foley catheter and any licensed nurse was responsible for contacting the physician to put in the orders for the foley catheter or to transcribe the orders from the hospital discharge notes. The DON stated if there were no physician's orders, the outcome could be serious to the resident, such as obtaining a urinary tract infection or complications such as bleeding from the urinary tract. 44959 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the electronic medical record (EMR) revealed R53 was admitted to the facility with diagnoses of but not limited to type 2 diabetes mellitus without complications, peripheral vascular disease, unspecified, cardiovascular and coagulations, hereditary and idiopathic neuropathy, unspecified, acute neurologic, gastro-esophageal reflux disease without esophagitis, anemia, unspecified, acute embolism and thrombosis of right femoral vein cardiovascular and coagulations, unspecified, essential (primary) hypertension, major depressive disorder, single episode, unspecified, other chronic pain, unspecified. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R53 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of Section O (Special Treatments and Programs) indicated oxygen use. Review of the Physician's Orders revealed an order dated 3/27/2025 for oxygen at 2 L (liters) per minute via nasal cannula (NC) as needed for o2 sats oxygen in place for R53. Observation and interview during the initial screening on 3/25/2025 at 10:00 am revealed R53's O2 level was set at 3 LPM. R53 stated that it should be set at 2 LPM. Observation on 3/25/2025 at 03:28 pm revealed R53's O2 level remained set at 3 LPM. Observation on 3/26/2025 at 10:56 am revealed R53's O2 level was still set at 3 LPM. During an interview on 3/26/2025 at 3:52 pm with Licensed Practical Nurse (LPN) AA regarding R53's O2 setting, she stated that the order was for O2 to be set at 2 LPM. During an interview on 3/26/2025 at 5:40 pm with LPN BB, she confirmed that R53's O2 was set at 3 LPM. She went to the EMR and confirmed that the physician order was for O2 to be set at 2 LPM. During an interview on 3/27/2025 at 8:00 am with the Director of Nursing (DON), she revealed that she expected staff to follow and adhere to the physician order and to ensure that during rounds O2 was set at the ordered level.