

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Bonterra Transitional Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 Felton Drive East Point, GA 30344	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**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, Enhanced Barrier Precautions Policy, the facility failed to ensure nursing staff used appropriate personal protective equipment (PPE) during catheter care and a bed bath for one of 20 residents (R) (R90) on EBP (enhanced barrier precautions). R90 had a suprapubic catheter, colostomy, and sacral wound, placing them at increased risk for infection. Findings include: Review of the facility's policy titled, Enhanced Barrier Precautions Policy, updated February 2025, revealed: Practice Guidelines: .3. EBP are indicated for residents with any of the following: b. Wounds and/or indwelling medical devices, even if the resident is not known to be infected or colonized with a MDRO. d. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. e. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Dressing Bathing/showering Transferring Providing hygiene (oral care/feeding) Changing linens Changing briefs or assisting with toileting. 4. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. R90 was admitted to the facility on [DATE] with diagnoses including cervical spinal cord injury with incomplete quadriplegia (C1-C4 and C5-C7), intracranial injury with loss of consciousness, neurogenic bladder and bowel, colostomy status, and urinary tract infection (UTI). Review of the physician's orders revealed nursing and treatment orders that included catheter care: change Foley/suprapubic catheter with occlusion or removal, clean around the Foley/suprapubic catheter with soap and water every shift and change the Foley catheter monthly and as needed (PRN). Other nursing orders included skin care with a hydrocolloid dressing to the buttocks every 7 days until resolved and implementation of Enhanced Barrier Precautions (EBP) per facility policy. Review of R90's care plan related to the suprapubic catheter revealed the resident had a suprapubic catheter due to neurogenic bladder, with goals to remain free from catheter-related trauma and signs/symptoms of urinary tract infection. Interventions included maintaining proper catheter positioning, providing peri-care, and implementing Enhanced Barrier Precautions. Staff were to monitor for pain and signs/symptoms of urinary tract infection, with prompt reporting to the physician as indicated. Review of the quarterly Minimum Data Set (MDS) for R90 dated 03/30/2026 revealed a BIMS score of 15, indicating intact cognition. Section GG documented impairment in both upper and lower extremities; the resident requires partial assistance with eating and oral hygiene and is dependent for toileting, bathing, dressing, hygiene, bed mobility, and transfers. The resident uses a wheelchair. Section H documented the use of an indwelling catheter and ostomy. Observation on 04/29/2026 at 9:45 AM revealed Certified Nursing Assistant (CNA) HH providing suprapubic catheter care and a bed bath to R90. EBP signage was posted on the resident's door, and PPE supplies were available outside the room. CNA HH gathered necessary supplies, performed hand hygiene, and donned (put on) gloves; no additional PPE, such as a gown, was used. No concerns were noted with bathing technique or catheter care. During a post-observation interview, the surveyor asked CNA HH whether any additional actions should have been taken prior to providing care; the CNA was unable to (continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>identify any. When asked about the EBP signage posted on the resident's door and its meaning, CNA HH acknowledged he should have worn a gown during care but forgot to do so. He stated that residents identified with a star on the door have wounds or external devices and require appropriate PPE during close-contact care and admitted he failed to follow this precaution. In a joint interview conducted on 04/29/2026 at 11:30 AM, the Infection Preventionist (IP) nurse and Director of Nursing (DON) were present. The IP nurse stated that staff were educated on the use of gowns during high-contact care, including care involving catheters, colostomies, and central lines. She explained that a star was also posted on the resident's door next to the name, along with EBP signage, to alert staff to the need for enhanced PPE use. The DON confirmed this information and stated that nursing staff were expected to utilize appropriate PPE when providing high-contact care.</p>		