STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115565	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Mountain Run of Journey LLC	5160 Spring View Avenue Stone Mountain, GA 30083

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690 Based on observation, record review, interviews, and policy review, the facility failed to determine if one of one resident (Resident (R) 33) was assessed as clinically appropriate to self-administer medications out of 41 sampled residents. The failure of the facility to leave medications at the bedside unattended prior to an assessment, created the potential that if R33 did not take the medication, the physician and nurses would not be aware. Findings include: Review of the facility's policy dated 02/01/24 and titled, Resident Self Administration of Medication revealed It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely .Each resident is offered the opportunity to self-administer medication during the routine assessment by the facility's interdisciplinary team. Review of R33's electronic medical record (EMR) Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE]. R33 had a diagnosis that included major depressive disorder, schizoaffective disorder, and generalized anxiety disorder. Review of R33's EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/01/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of four out of 15 which revealed the resident was severely cognitively impaired. The assessment did identify the resident had a depression, anxiety, psychotic, and schizophrenia diagnoses. Review of R33's EMR Administration Record revealed R33 received Lactulose Encephalopathy Oral Solution 10GM (gram)/15ML (milliliters) (Lactulose (Encephalopathy)) Give 30 ml by mouth every morning and at bedtime for Encephalopathy -Start Date- 09/01/2023 Review of R33's EMR revealed no assessments were conducted related to self-administration of medications. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/17/25 at 10:35 AM, R33 was sitting up on her bed. She was eating breakfast. To the left side of her plate she had a small medication cup, filled with a yellowish liquid. She stated she did not know what the liquid was but she stated she took it every morning and evening. The Director of Nursing (DON) entered the room and stated she did not know what the medication was and asked R33 if she could take it away. R33 started screaming at her and told her not to take it. During an interview on 03/17/25 at 11:16 AM, the DON stated she was not sure if the facility had completed a medication self-administration assessment. During an interview on 03/19/25 at 2:06 PM, Licensed Practical Nurse (LPN) 3 and Unit Manager (UM) both stated they had received education related to not leaving mediations at the bedside unless the resident has had a self-administration assessment. During an interview on 03/20/25 at 1:03 PM, the DON stated medications should not be left at any residents' bedside unless a self-administration assessment had been completed. She stated an assessment had been completed for R33 and she was not capable of self-administration.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, and policy review, the facility failed to ensure facility staff reported an allegation of potential sexual abuse for one out of seven residents (Resident (R) 103 against R113) immediately to the Administrator who was the abuse coordinator for the facility. This had the potential to delay the investigation conducted by the facility to determine whether abuse occurred or not. Findings include: Review of a facility policy titled Abuse, Neglect and Exploitation dated 11/01/24 indicated .It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident properly.Reporting of all alleged violations to the Administrator, state agency, adult protection services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes.Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Review of R103's electronic medical record titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R103's EMR titled quarterly Minimum Data Set with an Assessment Reference Date of 06/06/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of seven out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident had no previous behaviors directed towards others. Review of R103's EMR titled Health Status Note located under the Prog (Progress) Note tab dated 08/18/24 at 10:38 PM, indicated a nurse approached R103 and informed the resident that R113 had alleged R103 went to R113's bed and asked her for sex. The progress note indicated R103 denied the allegation. Review of R103's EMR titled Care Plan located under the Care Plan tab dated 08/20/24 indicated the resident was hypersexual at times and would pleasure herself. The goals of the care plan were to administer the resident's medications as physician ordered and to attempt to redirect her. There was no additional evidence of R103 acting out sexually after medical intervention. Review of R113's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R113's EMR titled admission MDS with an ARD of 08/05/24 indicated the resident had a BIMS score of eight out of 15 which revealed the resident was moderately cognitively impaired. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R113's EMR titled Health Status Note located under the Prog Note dated 08/18/24 which revealed R113 approached the charge nurse and informed the nurse that her roommate R103 asked her to have sex with her. R113 denied being scared and the nurse moved R103 to another room. Review of R113's EMR titled Care Plan located under the Care Plan tab dated 10/03/24 indicated the resident had a history of confabulation about things with staff and other residents. Review of a document provided by the facility titled Final Report with Investigation on Incident Report, dated 08/23/24, indicated the incident occurred on 08/19/24. The author of the document was the Administrator who was the facility's abuse coordinator and stated that she was notified on 08/19/24 at 10:00 AM that R113 alleged R103 wanted to have sex with her. There was evidence that the State Survey Agency (SSA) was notified at this time. During the investigation, R113 was interviewed and claimed R103 touched her breast and then, her buttocks. R113 stated she initially thought that this was an accident but then R103 came over to her side of the room, touched her breast and asked her for sex. The investigation indicated R113 voiced that she was upset and did not support those behaviors. The facility then interviewed R103 who denied the allegation. During an interview on 03/18/25 at 2:48 PM R113 stated she felt safe and has never been asked by another resident to have sex with her. During an interview on 03/20/25 at 9:21 AM, the Director of Nursing (DON) stated the allegation that R113 made against R103 should have been reported immediately. During an interview on 03/20/25 at 2:54 PM, the Administrator stated after the allegation was made a room change was made to make sure the residents felt comfortable. During an interview on 03/20/25 at 12:38 PM the Administrator, [NAME] President of Clinical Operations and the DON were present. The Administrator was asked why the delay in reporting to the SSA, and she stated that R113 claimed that she was asked by R103 to have sex and it was not until the next day that the allegation was reported to her then R113's story changed. The Administrator stated she would not report based on a statement made by R113 when R103 asked for sex. The Administrator stated the story changed from R113 and this was when she then alleged R103 had touched her and that was when the resident-to-resident was reported to the SSA.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on observation, interview, record review, and policy review, the facility did not ensure one of one resident (Resident (R)338) bed frame was not bigger than the air mattress. Failure to do so had the potential for R338's leg(s) and/or arm(s) to get caught in the bed frame and cause injury. Findings include: 1.Review of R338s EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Further review of the medical record revealed their was no bed assessments completed for the resident. Observation on 03/18/25 at 10:05 AM revealed R338's air mattress was smaller than the bed frame. There was approximately 12 inches of the bed frame exposed making it a potential hazard. Licensed Practical Nurse/Wound Nurse (LPN/WN) and Certified Nursing Assistant (CNA)13 confirmed the above observation. LPN/WN said she would inform maintenance to switch out the bed frame. Observation on 03/19/25 at 11:00 AM revealed R338's air mattress was still smaller than the bed frame with approximately 12 inches of the bed frame exposed. Observation on 03/20/25 at 11:09 AM revealed R338's bed frame had still not been changed to ensure R338's legs or arms did not become trapped during care. Physical Therapist (PT) who was doing range-of-motion (ROM) exercises for R338 confirmed the mattress was too small for the bed frame. She said when he was repositioned from side-to-side one of his arms or legs could become trapped in the bed frame. Interview on 03/20/25 at 11:15 AM with the Director of Nursing (DON) revealed she had not been made aware R338's air mattress was too small for the bed frame. She agreed there was potential for injury to the resident while staff repositioned him if he had a leg/arm caught in the frame. Interview on 03/20/25 at 11:30 AM with LPN/WN said she had informed maintenance that the bed frame was too big for the air mattress on 03/18/25. She was not aware it had not changed. Review of the facility's policy titled Environmental Services Inspection implemented on 11/01/24 showed All opportunities will be corrected immediately by environmental services personnel. Review of the facility's policy titled, Resident Environmental Quality implemented on 02/01/24 showed Identify areas of possible entrapment by conducting regular inspections on all bed frames, mattresses, and bed rails. These inspections will be part of the facility's routine maintenance program. All facility personnel are responsible for reporting broken, defective or malfunctioning equipment or furnishings immediately upon identification of the issue.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to ensure one of five residents (Resident (R) 1) for pneumococcal vaccines had accurate consents signed, including the risks and benefits explained to the resident and/or representative prior to the administration of the vaccine. The failure for not providing an accurate consent and providing education to the resident and/or representative prior to administering the pneumococcal vaccine did not give the resident and/or representative the ability to make an informed decision prior to the vaccine being administered. Findings include: Review of the CDC website titled Pneumococcal Disease, effective 10/26/24, indicated . Based on shared clinical decision-making, adults [AGE] years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. Review of a facility policy titled Pneumococcal Vaccine dated 11/01/24 indicated .It is our policy to offer residents and staff immunizations against pneumococcal disease in accordance with current CDC guidelines and recommendation.Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization with the education documented in the clinical record. Review of R1's electronic medical records (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of his admission. Review of R1's EMR titled Immunizations located under the Immun (Immunizations) tab failed to include evidence that the resident received the PCV20 or PCV21 vaccination. Review of R1's document provided by the facility titled Initial Influenza & Pneumococcal Vaccine Administration Acceptance & Declination undated indicated the resident's representative (RR) consented to receive the Prevnar13 (pneumococcal conjugate vaccine) or the Pneurnovax23 (pneumococcal polysaccharide vaccine). The form asked the author to circle a vaccine. Neither of the vaccines were circled. There was no evidence the resident and/or her representative was provided the opportunity to be provided with education regarding the PCV20 or PCV21 vaccines. During an interview on 03/20/25 at 8:51 AM, the Director of Nursing (DON) who was also the facility's Infection Preventionist (IP) confirmed that the facility completed an audit for vaccinations and called and provided education to the RR but was unaware that the consents were inaccurate and did not follow current CDC recommendations.