STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115571	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cartersville Center for Nursing and Healing	78 Opal Street Cartersville, GA 30120

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility policy titled, Catheter Care, the facility failed to ensure residents were provided with privacy bags for the urinary drainage bag on the Foley catheter for two of eight Residents (R) (R119 and R128) with catheters. The deficient practice had the potential for infection for R119 and R128.Findings include:Review of Policy titled Catheter Care dated October 2025 revealed that the catheter should have a Privacy bag available and catheter drainage bags will be covered at all times while in use. Privacy bags will be changed out when soiled, with a catheter change or as needed. Review of the clinical record for R119 revealed a [AGE] year-old male admitted with diagnosis included but not limited to: urinary retention, chronic kidney failure, congestive heart failure.Review of the care plan dated 12/16/2025 revealed that R119 has an indwelling catheter related to urinary retention.Observation on 12/16/2025 at revealed R119 up in his wheelchair in the therapy room for rehab with his Foley catheter attached to the lower part of the wheelchair without a privacy bag.Observation on 12/17/2025 revealed R119 in activities in the dining room without a privacy cover to his drainage bag.Observation on 12/18/2025 when surveyor passed room of R128 and observed resident in bed with a Foley catheter to the bedside without a privacy cover.Interview on 12/18/2025 at 11:15 am with Licensed Practical Nurse (LPN) JJ revealed that all catheters should have a privacy bag, and this should be checked by the nurses and the Certified Nursing Assistants (CNA) working on the hall.Interview on 12/18/2025 at 11:25 am with LPN LL revealed that all residents who have a catheter are expected to have a privacy bag and should be checked by the nurse. Interview on 12/18/2025 with Director of Nursing revealed that she expected all nursing staff to perform correct catheter care and follow the policy on privacy bags. She revealed that privacy bags should be put in place on admission to the facility if they were admitted without one.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility policy titled, MDS 3.0 Completion, the facility failed to properly code a resident for discharge furthermore there was no correction transmittal sent to Center for Medicaid Services (CMS) for one of two residents (R) (R116) reviewed for discharge. Findings include:A review of the facility policy titled, MDS 3.0 Completion dated October 2025 documented, Definitions: ARD, or Assessment Reference Date, refers to the specific endpoint in the MDS (Minimum Data Set) assessment process (last day of MDS observation period). 2. Type of OBRA (Omnibus Budget Reconciliation Act) Assessments: f. Discharge Assessment - completed using the discharge date as the ARD. Must be completed within 14 days of the discharge date /ARD. 5. Correction of Errors on the Assessment: . d. i. An inactivation request is used when a record has been accepted into IQIES (CMS on line system) but the corresponding event did not occur. ii. An inactivation must be completed when specific items on the MDS are inaccurate.Review of the electronic medical record (EMR) revealed R116 was admitted to the facility with pertinent diagnoses including but was not limited to chronic obstructive pulmonary disease with (acute) exacerbation, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, other specified arthritis, unspecified site, gastro-esophageal reflux disease without esophagitis, chronic kidney disease, unspecified, hypertensive heart disease with heart failure, transient cerebral ischemic attack, unspecified. Review of the EMR in the section labeled Progress Notes documented a note dated 10/6/2025 by the Occupational Therapist stating R116 scheduled for ST (speech therapy) and OT (occupational therapy) evaluations today but requested discharge from facility. No therapy evaluations completed due to DC from facility. Review of the EMR in the section labeled Progress Notes/nurse note dated 10/6/2025 documented R116 and granddaughter packed all of resident's personal belongings and removed them from the facility. All medications and paperwork were explained to both resident and granddaughter, both verbalized understanding. Resident left facility at 1503 (3:03 pm).Review of the EMR in the section labeled MDS - Section A documented Discharge MDS dated [DATE] Section A: unplanned discharge - return anticipated; discharge status short term general hospital (acute hospital, IPPS).R112 did not have a baseline care plan in the system. R116 had a base line care plan in the system, was able to find when the Director of Nursing (DON) explained the process of the assessment and showed how the baseline was in the system. Interview on 12/17/2025 at 4:13 pm with the Minimum Data Set (MDS) Coordinator revealed she completed section A of the MDS and she would get her information from the morning meetings and would run reports when she checked her dashboard. If there was a discharge from the facility, she would typically know. For those residents who were unplanned, she would search her dashboard then it would be discussed in the morning meeting. For those who were discharged to the hospital, it depended on insurance as to when she would code them as a discharge. If there was a mistake, she would ask for assistance to correct the code. As far as R116, she was unsure of what happened with her discharge and why it was coded as hospitalization when she discharged home. Interview on 12/17/2025 at 4:49 pm with the Remote MDS Coordinator revealed R116 should have been coded as discharge return not anticipated and not sure as to why it was not. She further stated it was unplanned and should have done a correction and she could do that right now, this was purely an oversight.Interview on 12/17/2025 at 4:58 pm with the DON revealed if anything was coded wrong she expected for MDS to check and triple check the process to make sure the correct transmittals are sent to CMS.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policy titled, Pharmacy Services, the facility failed to provide routine and emergency drugs and biologicals to the facility residents for one of four halls sampled, and specifically for resident (R) (R82). This deficient practice had the potential to cause serious complications with resident health.Findings include:Review of the facility's policy titled Pharmacy Services revised June 2023, revealed under Compliance Guidelines: 1.The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. Section 8 subsection f. states Strive to assure that medications are requested, received, and administered on time as ordered by the authorized prescriber.Review of the electronic medical record (EMR) revealed resident R82 was admitted to the facility with pertinent diagnoses, including but not limited to chronic kidney disease, chronic obstructive pulmonary disease, diabetes mellitus with diabetic neuropathy, obstructive sleep apnea, paroxysmal atrial fibrillation, pain in right foot, syncope and collapse, bradycardia, chronic diastolic heart failure, sick sinus syndrome, cardiac pacemaker, malignant neoplasm of skin on face, atherosclerosis of native arteries of extremities with rest pain.Review of R82's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated R82 was cognitively intact. Section GG, functional status, revealed R82 required minimum assistance with meals and oral hygiene, dependent on staff for toileting hygiene and personal hygiene, was independent for dressing upper and lower body, and independent for footwear. R82 was independent for transfer from bed to wheelchair. Review of the Physician's Orders for R82 included, but was not limited to:Order dated 5/30/2025 Spiriva HandiHaler Inhalation Capsule 18 MCG (Tiotropium Bromide Monohydrate)Order dated 12/14/2025 Eliquis Oral Tablet 5 MG (Apixaban)Observation on 12/17/2025 at 9:53 am revealed on the medication pass on 200 hall with Licensed Practical Nurse (LPN) OO observing medication pass for R82. Two medications were missing: apixaban 5mg oral tablet, nine am dose, and Spiriva inhaler 18mcg capsule for inhalation. At 10:15 am LPN OO went to pull the apixaban from the emergency stock. 10:30 am LPN OO was still trying to find apixaban, and a Certified Nursing Assistant (CNA) came to the medication cart to report that another resident needed pain medication. At 10:43 am, LPN OO came back to the medication cart after calling the Nurse Practitioner (NP) and receiving orders to hold the apixaban, Spiriva, due to drugs being unavailable. At 10:49 am, LPN OO went to find R82 to give him his 9:00 am medication, but he had left his room and was in therapy. At 10:52 am, LPN OO came back to the medication cart with R82 and administered his 9:00 am medication that was available.An interview with LPN KK on 12/18/2025 at 8:10 am revealed that on the 200-hall medication cart, R82's apixaban did come in the night before, and he did receive his nine pm dose of apixaban last night, but the Spiriva did not come in, and the resident will not get it today at the 9:00 am medication pass.An Interview with Pharmacist MM from the providing pharmacy on 12/18/2025 at 8:37 am revealed that R82's apixaban was ordered on 12/14/2025 and was delivered last night on 12/17/2025. R82's Spiriva was ordered according to Pharmacist MM, on 12/14/2025, and for reasons that he could not explain, it had not been filled yet, and the resident did not have any available. Pharmacist MM also stated that they had been short-staffed but that in a perfect world, the medication turnaround was 24 hours from ordering to delivery.An interview with LPN KK on 12/18/2025 at 11:30 am revealed that the pharmacy called her and said that R82's insurance denied the Spiriva claim, and they were working on it.An interview with an unnamed pharmacist from the pharmacy provider on 12/18/2025 at 12:24 pm after multiple attempts to contact the pharmacy concerning the insurance denial for R82's Spiriva. She revealed that she was not going to give me her name because she didn't know anything, she was a PRN (as needed) pharmacist, and that I should call the insurance specialist, and she would be in at 1:00 pm.An interview on 12/18/2025 at 1:17 pm call conducted with the providing pharmacy, and a message was left on the insurance specialist's voicemail concerning the insurance denial on R82's Spiriva. An interview with LPN NN Unit Manager on 12/18/2025 at 10:29 am revealed that she expected the reordering of medications should be done a week before they are out. If medication was not available, they called the pharmacy, and if we couldn't get it, we would call the MD (Doctor of Medicine) and put the medication on hold until it was available. An interview with the Director of Nursing (DON) on 12/18/2025 at 10:40 am revealed that her expectation for pharmacy

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, staff and resident interviews, record review, and review of the facility's policies titled, Medication Administration, the facility failed to maintain a medication error rate below 5% (percent). The observed medication administration error rate was 17.24% with 5 errors of 29 opportunities for four residents (R) (R50, R15, R23, and R82) during medication administration. This deficient practice had the potential to cause health complications for residents on B hall.Findings include:Review of the facility's policy titled Medication Administration, revised 4/2/2025, section 10. revealed Ensure that the six rights of medication administration are followed. Right time Section 12b Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.Review of the facility's policy titled Pharmacy Services, revised June 2023, section 8. f. states Strive to assure that medications are requested, received, and administered promptly as ordered by the authorized prescriber (in accordance with state requirements), including physicians, advanced practice nurses, pharmacists, and physician assistants.Observation on 12/17/2025 at 8:49 am of a medication pass with Licensed Practical Nurse (LPN) JJ revealed one omitted medication for R50, polyethylene glycol 3350 17000MG (milligrams) powder for oral solution, one packet daily mixed with 8 ounces of water or juice. Observation made on 12/17/2025 at 9:02 am of medication administration with LPN JJ revealed LPN JJ did not assist or instruct R15 to rinse his mouth after the use of fluticasone propionate and salmeterol inhaler 100 mcg/50mcg daily.Observation made on 12/17/2025, started at 9:19 am, of a medication administration with LPN OO revealed that LPN OO omitted R23's Nepro supplement that was scheduled at 7:30 am due to unavailability.An observation made on 12/17/2025, starting at 9:53 am and ending at 10:56 am with LPN OO revealed that at 10:08 am, while preparing medications for R82, she realized that R82's Blood Pressure was 101/57 and heart rate of 66. R82 had no visible signs of hypotension, and there were no parameters set for R82's lisinopril. She held the medication and continued to prepare the rest of R82's medications. At 10:15 am, OOLPN discovered that R82 was out of apixaban, and she left the medication cart to pull apixaban from emergency stock. At 10:43 am, OOLPN returned to the medication cart and stated that apixaban was not in the emergency stock, and she spoke with the provider, and who ordered to hold the lisinopril for low blood pressure and hold the apixaban and the Spiriva for one day due to unavailability of the medication. At 10:49 am, LPN OO had finished preparing R82's medication, but the resident had left and gone to therapy. LPN OO then labeled the cup of medications and locked them up in the top drawer of the medication cart and went to find R82. At 10:52 am, OOLPN returned to the medication cart with R82 in his wheelchair and proceeded to give the resident his medication in the hall and rubbed Naprosyn cream on his knees. LPN OO omitted the nystatin external powder 100000 units/GM (units per gram).An interview with LPN OO on 12/17/2025 at 10:47 am revealed that she usually gets through her 9:00 am medication pass at 10:30 am. She confirmed that she has more than half of the residents on B hall left to give 9:00 am medications too, and that she is more than an hour late with those medications. LPN OO confirmed that in the case of twice a day, three times a day, and every 8 and 12-hour timed medications, the residents could have complications due to these medications being given too close together or a drop in blood levels when too far apart. An interview with LPN KK on 12/18/2025 at 8:10 am revealed that LPN KK was working on the 200 hall today. She looked to see if R82 had his apixaban and Spiriva on the 200-hall medication cart, and R82 did have a full card of apixaban that came in last night, and his bedtime dose was administered. R82's Spiriva was not on the cart.An interview via telephone with the pharmacy provider on 12/18/2025 at 8:37 am, and spoke with Pharmacist MM who revealed that Apixaban was ordered 12/14/20205 and was delivered last night, and the resident did get his bedtime dose. The Spiriva was ordered according to Pharmacist MM, 12/14/20205, and has not been filled yet, and the resident did not have any available. He stated that there was no drug shortage associated with apixaban or Spiriva. An interview on 12/18/2025 at 10:12 am with Registered Nurse (RN) GG, Unit Manager, revealed his expectations for appropriate time limits on medication passes were an hour before and an hour after the ordered time. He also expected that the residents get their medications on time and the correct medications. He also revealed that there were about 20-25 residents on each cart and that the 9:00 am med pass was the heaviest medication administration pass. An interview with LPN NN Unit Manager on 12/18/2025 at 10:29 am revealed that she expected medications to be given within an hour before and an hour after the rule. She also had about 25 residents per cart.An interview with the Director of Nursing (DON) on 12/18/2025 at 10:40 am revealed that her expectation was for the medication passes should be completed an hour before and an

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facilities policies titled, Food Preparation and Service, Food Brought by Family/Visitors, and Sanitization, the facility failed to ensure food was labeled, stored and prepared under sanitary conditions. In addition, the facility failed to ensure cleanliness of the kitchen and that equipment was working properly. The deficient practices created an unsanitary environment that increased the potential for cross contamination and food borne illness for the 109 of 112 residents receiving meals prepared in the kitchen.Findings include:Review of the undated policy titled Food Preparation and Service documented Food service employees shall prepare and serve food in a manner that complies with safe food handling practices. Review of the policy titled Food Brought by Family/Visitors undated, documented Liberalized diets will be permitted as much as possible. Staff must be aware of, and approve, food(s) brought to a resident by family members. Section titled Guidelines number 6. documented Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and received date. Review of the policy titled Sanitization undated, documented The food service area shall be maintained in a clean and sanitary manner. The section titled Policy Interpretation and Implementation number 2. documented . Seals, hinges and fasteners will be kept in good repair. The food storage policy was requested but was not provided by the facility. During the initial observation tour of the kitchen, dry storage, walk-in freezer on 12/16/2025 beginning at 9:04 am with the Administrator, the following concerns were identified and confirmed:- Four pans on the steam table were covered in plastic wrap. Each pan was labeled (1) Item: Soup prepared 12/15; (2) Item: Beef Pot Roast Prepared Date 12/15/2025; (3) Item Ham prepared 12/15; and (4) Pureed Meat Prepared 12/16. -25-pound box of Powered Sugar was observed to be open and not sealed or labeled. During the tour, Administrator confirmed and verified all identified concerns and revealed he was unaware of why the four pans were on the steam table and confirmed the staff should have sealed the box of sugar and labeled it with date and time of opening. During observation and interview with the Registered Dietician (RD) on 12/16/2025 at 9:28 am in the walk-in refrigerator, a 32-ounce carton of Liquid Whole Eggs with Citric Acid was observed unlabeled without an open date. The RD confirmed the observation. During observation and interview with the RD on 12/16/2025 at 9:32 am, the walk-in freezer had ice build-up on the step and threshold strip and the horizontal air curtains. Inside the freezer a large package of meat wrapped in plastic wrap was unlabeled or dated. The RD confirmed the observation. Observation and interview with the Certified Dietary Manager (CDM) on 12/16/2025 at 9:32 am revealed the door handle to the walk-in freezer did not latch securely. CDM confirmed the observation of ice buildup on the step, threshold strip, and horizonal air curtains. Observation and interview with the CDM on 12/17/2025 at 12:10 pm revealed a tray of white and burgundy colored coffee cups turned face down. The CDM described the cups as clean and ready for use. After his assessment of the coffee cups on the tray with a gloved hand it was revealed the burgundy coffee cups had an unidentified, orange-colored film in ten of ten cups. He stated these cups should not have any film or residue inside. Observation and interview with the CDM on 12/17/2025 at 2:39 pm revealed a ceiling fan centrally located above the dishwasher and clean and soiled dish location. The ceiling fan blades had a buildup and accumulation of fuzzy grey matter. The CDM confirmed and verified the blades were covered with grey and fuzzy matter. Observation and interview with Certified Nursing Assistant (CNA) EE on 12/17/2025 at 5:05 pm on the 200 Hall Pantry revealed a box of take-out chicken on the top shelf of the refrigerator with a hand-written notation room [ROOM NUMBER] on the top of the box. CNA EE confirmed there was no date or name on the box. The CNA stated all resident food brought in from family/friends should be labeled with the resident's name and the date it was placed in the refrigerator. CNA EE further revealed items three days old or greater should be discarded. Review of Maintenance Work Reports for the Walk-In Freezer reveals there were no work orders created for the walk-in freezer, since a repair was made in February 2025. There was no record of Maintenance being notified of equipment repair needs for the walk-in freezer from February 2025 to December 2025 when the loose latch was identified during the Kitchen Tour. During Interview with Administrator, CDM and RD on 12/18/2025 at 1:18 pm the CDM revealed the [NAME] pulled [items] from the cooler on Tuesday 12/16/2025 and placed them on the steam table for the lunch meal. CDM stated it is not normal to pull food that early. He stated the soup, ham and roast beef were on the lunch menu for Wednesday, 12/17/2025. He further added, the [NAME] should have returned the food items to the oven to