

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115576	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/10/2024
NAME OF PROVIDER OR SUPPLIER  Oak View Home, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  119 Oakview Street Waverly Hall, GA 31831	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38517</p> <p>Based on observations, resident and staff interviews, record review, and review of the facility policy titled A Comprehensive Patients' Rights Program, the facility failed to ensure staff interacted with a resident in a courteous manner and allowed them access to their room for one of four residents (R) (R33) reviewed for choices out of a sample of 19 residents. This failure placed R33 at risk of their rights being violated and not upheld.</p> <p>Findings include:</p> <p>Review of the facility's policy titled A Comprehensive Patients' Rights Program, reviewed 12/29/2023 reads in part, .We believe that all staff should understand the importance of treating patients with care and respect, and honoring patients' rights to make personals choices .</p> <p>Review of R33's undated Admission Record, located in the resident's Electronic Medical Record (EMR) under the Resident Summary tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, type 2 diabetes, and major depressive disorder.</p> <p>Review of R33's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/5/2024 located in the resident's EMR under the MDS tab revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated the resident was moderately cognitively impaired.</p> <p>Observation on 5/7/2024 at 11:03 am revealed that R33 knocked on his room's door and asked to go inside the room. Nurse Aide Trainee (NAT) 1 opened the door and stated to R33, Go to activities, you need to go to activities and closed the door. R33's facial expression revealed he was visibly upset. Continued observation revealed that R33 waited in front of his room's door until it was opened at 11:08 am. NAT1 then stated to R33, Hurry up and get in here and get what you need. R33 then proceeded into his room.</p> <p>During an interview on 5/7/2024 at 11:09 am, Certified Nursing Assistant (CNA) 1 stated that she, NAT1, and CNA2 were providing care to R33's roommate when R33 knocked on the door. CNA1 stated they had been trained to tell residents they were providing patient care and to ask them to wait. CNA1 stated residents were more than welcome to come in but NAT1 just hollered for R33 to go to activities instead.</p> <p>(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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/7/2024 at 11:11 am, CNA2 stated she, CNA1, and NAT1 were providing care to R33's roommate when R33 knocked on the door. CNA2 stated when R33 knocked on the door NAT1 instructed R33 to go to activities. CNA2 stated after they finished providing care, NAT1 also was the one that instructed R33 to come into the room and get what he needed. CNA2 stated she did not feel NAT1's statements and tone were appropriate. CNA2 stated they had been trained to open the door and explain they were providing care. CNA2 stated if it is a resident wanting to come into their room then they just pull the curtain and allow the resident to come in.</p> <p>During an interview on 5/7/2024 at 11:43 am, NAT1 stated this was the first time she had experienced a resident knocking and wanting to come into their room while care was being provided to another resident. NAT1 stated when R33 knocked on their door, she opened the door and asked R33 what he needed, then instructed R33 to go to activities, and closed the door back. NAT1 stated after she was finished providing care, she opened the door and told R33 to come in. NAT1 stated she did not recall stating, Hurry up and get in here and get what you need. NAT1 also stated that CNA2 spoke to her after the interaction and told her that R33 had the right to come into the room.</p> <p>During an interview on 5/7/2024 at 2:01 pm, R33 stated he was trying to get into his room to get some money for the soda machine. R33 stated that was the first time he had been denied access to his room. R33 confirmed he had become frustrated at having to wait outside the door.</p> <p>During an interview on 5/8/2024 at 12:57 pm, the Director of Nursing (DON) stated it was her expectation the staff would have allowed R33 in his room when he wanted to go in. The DON stated there was a privacy curtain in the room that could have been pulled to allow privacy if needed. The DON also stated it was the resident's right to go in and out of their room as they please.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38517</p> <p>Based on resident and staff interviews and record reviews, the facility failed to ensure residents were as free from accidents and hazards as possible for one of 19 sampled residents (R) (R35). R35 sustained an injury when his scrotum was caught in between the toilet seat and the toilet. However, the facility did not address the resident's toilet to ensure another injury would not occur. This failure placed the resident at risk of sustaining another injury.</p> <p>Finding include:</p> <p>Review of R35's undated Admission Record, located in the resident's Electronic Medical Record (EMR) under the Resident Summary tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included absence of right leg above knee.</p> <p>Review of R35's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/2024, located in the resident's EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact.</p> <p>Review of R35's Event-Initial Note v3.0 dated 4/25/2024 and located in the resident's EMR under the Data Collection tab documented, [R35's Name] was transferring from the wheelchair to the toilet and got their scrotum caught on a rusty screw and squashed from the toilet lid causing a skin tear to bottom of scrotum.</p> <p>Review of R35's Nurses Note dated 4/25/2024 and located in the resident's EMR under the Progress Notes tab documented at 10:20 pm [R35's Name] came to the nursing station and stated he went to the restroom and when transferring from the wheelchair to the toilet he got his scrotum caught on a rusty screw and the toilet lid squashed his scrotum. [R35's Name] has an abrasion noted to bottom of scrotum area cleaned with normal saline. Nurse Practitioner notified and R35 is his own responsible party.</p> <p>Review of R35's Nurses Note dated 5/8/2024 documented that R35 reported, Got my scrotum pinched between the toilet lid and the toilet seat. Open area noted to scrotum. Treatment Nurse and Physician made aware. The area was cleaned and dressed by a treatment nurse. The toilet was looked at by maintenance and the Director of Nursing (DON). There was no rust noted. No visible screws or nails protruding. The raised seat was removed and replaced by maintenance.</p> <p>During an interview on 5/7/2024 at 10:40 am, R35 stated his testicles had gotten caught and scraped by the toilet seat a couple of weeks ago, and the facility had not done anything about it. R35 stated he had a skin tear on his testicles from the incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/10/2024 at 1:13 pm, the DON stated R35 reported to nursing that he cut or scratched himself on something when he independently transferred from his wheelchair to the toilet. The DON stated nursing examined the toilet and did not see anything that could have injured R35. However, they did replace the raised toilet seat (after the surveyor had brought it to the facility's attention). The DON also stated the toilet seat should have been examined and replaced following the initial incident on 4/25/2024. The DON stated it was her expectation the nurse who completed the nursing note dated 4/25/2024 would have investigated the cause of the injury.</p>		