

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Altamaha Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 West Cherry Street Jesup, GA 31545	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262</p> <p>Based on record review, interview, and policy review, the facility failed to provide written information to five residents (Resident (R) 48, R18, R12, R24, and R4) and/or their resident representative concerning the right to formulate an advance directive of 28 sample residents. The failure to discuss advance directive information with the resident and resident representative could potentially affect their ability to make informed decisions about their care.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Advance Directive, dated 08/09/22, indicated The facility must inform and provide written information to all adult residents concerning the right .to formulate an advance directive .Upon admission/readmission, the facility Social Service Director will inform and educate the resident, or POA [Power of Attorney] in writing about the right .to an advance directive . and upload to the resident's chart .</p> <p>1. Review of R48's electronic medical record (EMR) Profile tab, indicated R48 was admitted on [DATE]. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/26/24 in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderate cognitive impairment.</p> <p>Review of the EMR revealed no documentation that the resident was provided written information concerning the right to formulate an advance directive.</p> <p>2. Review of R18's EMR Profile tab, indicated R18 was admitted on [DATE] and that R18 was her own responsible party. Review of the annual MDS with an ARD of 06/18/24 in the EMR under the MDS tab indicated a BIMS score of 15 out of 15 which indicated R18's cognition was intact.</p> <p>Review of the EMR revealed no documentation that the resident was provided written information concerning the right to formulate an advance directive.</p> <p>During an interview on 07/30/24 at 4:04 PM, the Social Services Director (SSD) stated that she could not find any documentation that R48 and R18 were provided with written information about formulating an advance directive.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of R12's EMR Profile tab indicated R12 was admitted on [DATE]. Review of the quarterly MDS with an ARD of 07/08/24 in the EMR under the MDS tab indicated a BIMS score of one out of 15 which indicated cognition was severely impaired.</p> <p>During an interview on 07/30/24 at 4:10 PM, the SSD confirmed she was unable to locate any documentation that R12's responsible party was provided written information concerning the right to formulate an advance directive.</p> <p>4. Review of R24's undated Admission Record located in R24's EMR under the Profile tab revealed R24 was admitted to the facility on [DATE].</p> <p>Review of R24's EMR revealed no documentation that R24 had an advance directive or that the facility provided written information to the resident, or the resident representative concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.</p> <p>5. Review of R4's Admission Record from the EMR Profile tab showed a facility admitted [DATE] and readmission on 12/26/17, with medical diagnoses that included convulsions, osteoporosis, intracranial injury, and dizziness.</p> <p>Review of R4's electronic EMR Documents tab revealed no information regarding an advance directive or education regarding an advance directive. Review of the 2016 admission agreement for R4 showed no education regarding an advance directive.</p> <p>Review of R4's annual MDS with an ARD of 06/04/24 revealed R4 had a BIMS score of 15 out of 15 which indicated the resident was cognitively intact.</p> <p>During an interview on 07/31/24 at 11:30 AM, R4 confirmed he had been in the facility since 2016; that the SSD had provided the advance directive information the previous day and had not received this information prior to 07/30/24.</p> <p>During an interview on 07/31/24 at 11:48 AM, the SSD confirmed she had found nothing in the EMR that R4 had presented previously during his admission.</p> <p>26446</p> <p>28154</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>09262</p> <p>Based on personnel file review, interview, and policy review, the facility failed to follow their policy to obtain background and criminal checks at time of employment for four of nine employee files (Certified Nurse Aide (CNA) 1, CNA2, Licensed Practical Nurse (LPN) 2, and Dietary Aide (DA) 1) reviewed for background checks. The failure to obtain background and criminal checks had the potential to allow facility staff with criminal backgrounds to work with the residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Background and Criminal Checks, dated 12/21/23, indicated The facility . may investigate all statements contained in any documents, applications and/or resumes you have provided. A background check will be conducted . to include .criminal history .fingerprints .references .upon submitting an application of employment, you release the facility . from obtaining such information .</p> <p>Review of four of nine personnel files revealed the Administrator was unable to provide background and criminal checks information for the following staff:</p> <ul style="list-style-type: none"> -CNA1's file revealed hire date of 09/08/20. -CNA2's file revealed hire date of 04/17/24. -LPN2's file revealed hire date of 02/01/21. -DA1's file revealed hire date of 06/10/24. <p>During an interview on 07/31/24 at 1:45 PM, the Administrator confirmed she was unable to find the background and criminal history information for the above employees. She stated that the facility no longer had a Human Resource Director (HRD) who was responsible for uploading the information into the computer system.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262</p> <p>28154</p> <p>Based on record review, interview, and policy review, the facility failed to ensure seven of seven residents and their representatives (Resident (R) 27, R29, R38, R48, R116, R112, and R44) reviewed for facility initiated emergent hospital transfer, from a total sample of 28 residents, were provided with written transfer/discharge notice that stated the reason for transfer, the place of transfer, other information regarding the transfer, and information on the right to appeal the transfer. This failure had the potential to affect the resident and their Resident Representative (RR) by not having the knowledge of where and why a resident was transferred, and/or how to appeal the transfer, if desired.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Discharge Plan/Transfers, revised 10/20/23, showed it did not address a written notice of transfer, the required contents, or the provision of the notice to the Resident and RR.</p> <p>1. Review of R27's Admission Record from the electronic medical record (EMR) Profile tab, showed a facility admitted [DATE], readmission on 06/18/24, with medical diagnoses that included end stage renal disease, type II diabetes, seizures, atrial fibrillation, psychotic disorder, and Alzheimer's dementia.</p> <p>Review of R27's EMR Census tab showed hospital leave on 06/26/24. Review of R27's Progress Notes tab showed nothing about a hospital transfer but did show a readmit progress note, dated 06/29/24 at 11:47 AM, that revealed resident back from hospital.</p> <p>Further review of R27's EMR Progress Notes, Documents, and Assessments tabs did not reveal any evidence of the provision of a written transfer notice.</p> <p>During an interview on 07/30/24 at 5:52 PM regarding receipt of any written documentation regarding the hospital transfer from the facility that stated why and where he was transferred and information on his right to appeal the transfer, R27 stated, No.</p> <p>2. Review of R29's Admission Record from the EMR Profile tab showed a facility admitted [DATE], readmission on 05/29/24, with medical diagnoses that included toxic encephalopathy, congestive heart failure, chronic respiratory failure, end stage renal disease, chronic obstructive pulmonary disease, and anxiety disorder.</p> <p>Review of R29's Progress Notes showed on 07/16/24 at 7:15 PM, R29 was admitted to hospital, from dialysis.</p> <p>Further review of R29's EMR Progress Notes, Documents, and Assessments tabs did not reveal any evidence of the provision of a written transfer notice.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/30/24 at 11:40 AM, the Director of Nursing (DON) remarked she was unsure who did the transfer notices.</p> <p>3. Review of R38's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with medical diagnoses that included chronic kidney disease, atrial fibrillation, vascular dementia, glaucoma, history of cerebrovascular disease, type II diabetes, and Alzheimer's dementia.</p> <p>Review of R38's EMR Progress Notes tab showed on 04/14/24 at 3:12 PM that Resident transferred to hospital due to altered mental status. [Doctor name] notified. [R38's RR identified] notified and [name] DON notified as well.</p> <p>Further review of R38's EMR Progress Notes, Documents, and Assessments tabs did not reveal any evidence of the provision of a written transfer notice.</p> <p>During an interview on 07/30/24 at 5:42 PM regarding the facility process for an emergent transfer, Licensed Practical Nurse (LPN) 5 stated, When we find there is an issue, we call the doctor and let him know, get an order to transfer out. Call 911, let them know the issue, then call the hospital and give them report. Then, I print all the paperwork. [transfer/discharge record and medication administration record [MAR]. Then fill out all the paperwork on the computer, such as this E-transfer form [an E-Interact transfer form for the hospital] and do a change in condition, [an E-Interact form, both of which are saved in the EMR Assessment tab] call the family and let them know they are being or were transferred and why. Then write a progress note. When asked what was given to the Emergency Medical Services (EMS), LPN5 responded the E-transfer report and MAR. When queried if anything was provided to the resident or RR regarding the transfer, LPN5 stated, No.</p> <p>During an interview on 07/31/24 at 8:08 PM, the Administrator stated an expectation regarding the provision of written transfer notices that the document is sent, a signature that they are made aware and document that it went to family / POA [Power of Attorney or RR] is aware. When asked on her expectation as to when the notice should be provided, the Administrator responded, When they go to leave the facility on way out or as soon as possible.</p> <p>4. Review of R48's EMR Profile tab indicated R48 was admitted on [DATE]. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/26/24 in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderate cognitive impairment.</p> <p>Review of R48's EMR Progress Notes, dated 05/13/24 and 07/11/24, revealed R48 experienced a change in condition and was transferred to the hospital. There was no documentation in the EMR that the resident and the resident's responsible party were provided the transfer notice for either time R48 was transferred to the hospital.</p> <p>5. Review of R116's EMR Profile tab indicated R116 was admitted on [DATE]. Review of the quarterly MDS with an ARD of 06/21/24 in the EMR under the MDS tab indicated a BIMS score of seven out of 15 which indicated severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R116's EMR Progress Notes, dated 07/09/24, indicated R116 was experiencing behavioral issues and was sent to the behavioral hospital. There was no documentation in the EMR that the resident and the resident's responsible party were provided the transfer notice when R116 was transferred to the hospital on 07/09/24.</p> <p>6. Review of R112's EMR Profile tab indicated R112 was admitted on [DATE].</p> <p>Review of R112's EMR Progress Notes, dated 02/14/24, indicated R112 experienced a change of condition and was sent to the hospital. There was no documentation in the EMR that the resident and the resident's responsible party were provided the transfer notice when R112 was transferred to the hospital on 02/14/24.</p> <p>7. Review of the EMR Profile tab indicated R44 was admitted on [DATE]. Review of the quarterly MDS with an ARD of 07/10/24 in the EMR under the MDS tab indicated a BIMS score of one out of 15 which indicated severe cognitive impairment.</p> <p>Review of R44's EMR Progress Notes, dated 07/17/24, indicated R44 experienced a change in condition and was sent to the hospital. There was no documentation in the EMR that the resident's responsible party was provided the transfer notice when R44 was transferred to the hospital on 07/17/24.</p> <p>During an interview on 07/30/24 at 9:44 AM, the Social Service Director (SSD) stated that she would have to check with the Administrator to see who sent the transfer notices to the Ombudsman.</p> <p>During an interview on 07/30/24 at 12:33 PM, the Administrator stated that there was no documentation that the transfer notice was provided to the resident and their resident representative when the residents were transferred to the hospital. The Administrator also stated that since becoming the Administrator at the end of November 2023, the facility had not been sending the transfer notices to the Ombudsman.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262</p> <p>28154</p> <p>Based on record review, interview, and review of facility policy, the facility failed to ensure seven of seven residents (Resident (R) 27, R29, R38, R48, R116, R112, and R44) reviewed for facility initiated emergent transfer to the hospital and/or their Resident Representative (RR) received a written bed hold notice that included all required information of 28 sample residents. This failure had the potential to contribute to possible denial of re-admission and loss of the resident's room following a hospitalization for residents transferred to the hospital.</p> <p>Findings include:</p> <p>Review of the facility policy titled Discharge Plan/Transfers, revised 10/20/23, showed: Policy: All Residents are given the option of reserving their bed when leaving the facility with the intent to return. This temporary absence may be for hospitalization or therapeutic leave. All Residents or their Responsible party are informed in writing about the facility's bed-hold policy at the time of admission. A copy of the bed hold agreement is also provided to the Resident or Responsible party prior to a resident's transfer to a hospital or start of a therapeutic leave. The bed hold policy provides written information detailing bed hold regulations for specific payers including Medicare regulations, the duration of the bed-hold policy under the specific State's Medicaid plan, if any, and private bed hold rules.</p> <p>1. Review of R27's Admission Record from the electronic medical record (EMR) Profile tab, showed a facility admitted [DATE] with readmission on 06/18/24 and medical diagnoses that included end stage renal disease, type II diabetes, seizures, atrial fibrillation, psychotic disorder, and Alzheimer's dementia.</p> <p>Review of R27's EMR Census tab showed hospital leave on 06/26/24. Review of R27's Progress Notes tab revealed nothing about a hospital transfer but did show a readmit progress note, dated 06/29/24 at 11:47 AM, that revealed resident back from hospital.</p> <p>Further review of R27's EMR Progress Notes, Documents, and Assessments tabs did not reveal any evidence of the provision of a written bed hold notice.</p> <p>During an interview on 07/30/24 at 5:52 PM regarding receipt of any written documentation regarding bed hold, R27 responded, The government pays for my bed. Clarified, if he had received anything regarding how long the government would pay to hold his bed, R27 stated, No they don't give me anything in writing.</p> <p>2. Review of R29's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with readmission on 05/29/24 and medical diagnoses that included toxic encephalopathy, congestive heart failure, chronic respiratory failure, end stage renal disease, chronic obstructive pulmonary disease, and anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R29's Progress Notes revealed on 07/16/24 at 7:15 PM, R29 was admitted to hospital, from dialysis.</p> <p>Further review of R29's EMR Progress Notes, Documents, and Assessments tabs did not reveal any evidence of the provision of a written bed hold notice.</p> <p>During a request for the provision of a written transfer notice on 07/30/24 at 11:40 AM, the Director of Nursing (DON) remarked she was unsure of the bed hold, she had been in long term care many years and her nurses did not do it; she thought perhaps Admissions did the bed hold.</p> <p>3. Review of R38's Admission Record from the EMR Profile tab revealed a facility admitted [DATE] with medical diagnoses that included chronic kidney disease, atrial fibrillation, vascular dementia, glaucoma, history of cerebrovascular disease, type II diabetes, and Alzheimer's dementia.</p> <p>Review of R38's EMR Progress Notes tab revealed on 04/14/24 at 3:12 PM that Resident transferred to hospital due to altered mental status. [Doctor name] notified. [R38's RR identified] notified and [name] DON notified as well.</p> <p>Further review of R38's EMR Progress Notes, Documents, and Assessments tabs did not reveal any evidence of the provision of a written bed hold notice.</p> <p>During an interview on 07/30/24 at 5:42 PM regarding the facility process for an emergent transfer, Licensed Practical Nurse (LPN) 5 stated, When we find there is an issue, we call the doctor and let him know, get an order to transfer out. Call 911, let them know the issue, then call the hospital and give them report. Then, I print all the paperwork . call the family and let them know they are being or were transferred and why. Then write a progress note. When queried if anything was provided to the resident or RR regarding the bed hold policy, LPN5 stated, No, nothing in writing to the Resident or Representative.</p> <p>4. Review of R48's electronic medical record (EMR) Profile tab indicated R48 was admitted on [DATE]. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/26/24 in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated moderate cognitive impairment.</p> <p>Review of R48's EMR Progress Notes, dated 05/13/24 and 07/11/24, revealed R48 experienced a change in condition and was transferred to the hospital. There was no documentation in the EMR that the resident and the resident's responsible party were provided the bed hold policy for either time R48 was transferred to the hospital.</p> <p>5. Review of R116's EMR Profile tab indicated R116 was admitted on [DATE]. Review of the quarterly MDS with an ARD of 06/21/24 in the EMR under the MDS tab indicated a BIMS score of seven out of 15 which indicated severe cognitive impairment.</p> <p>Review of R116's EMR Progress Notes, dated 07/09/24, indicated R116 was experiencing behavioral issues and was sent to the behavioral hospital. There was no documentation in the EMR that the resident and the resident's responsible party were provided the bed hold policy when R116 was transferred to the hospital on 07/09/24.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262</p> <p>Based on observation, interview, record review, Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI) review, and policy review, the facility failed to revise the care plan to include fall interventions and ensure care conferences were held for one resident (Resident (R) 48) of 28 sample residents reviewed for care planning. The failure to revise the care plan could affect staff implementing interventions to prevent a future fall. Failure to conduct care plan conferences with the resident and/or their resident representatives could cause the resident to not be informed of care interventions as well as for the resident and/or the resident representative to ask questions about the resident's care.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, RAI/Care Plan Management, dated August 2021, indicated Care Conferences are held after the MDS [Minimum Data Set] is completed but before the care plan is due for all new admissions. Conferences are also held quarterly and annually with each review. In addition, care plan reviews are conducted when a resident has a change of condition. Invitations are mailed to the family/responsible party one week prior to the conference date. Social Services invites each resident to the care conference personally on the morning of the care conference .If for some reason the resident, family or responsible party cannot attend the conference, an alternate method of communicating the information should be implemented .</p> <p>Review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual RAI, dated 10/01/24, indicated, 4-7 . The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care .</p> <p>During an observation on 07/28/24 at 6:48 PM, R48 was in his room with his bed in a low position and a fall mat next to his bed.</p> <p>During an observation on 07/31/24 at 11:17 AM, R48 was seated in a geri chair in the hallway near the nurses' station.</p> <p>During an observation on 07/31/24 at 11:30 AM, R48's room revealed his bed against the wall and a fall mat was folded up next to the wall.</p> <p>During an observation and interview on 07/31/24 at 10:50 AM, R48 was seated in a geri chair in hallway. The Regional Consultant Nurse stated that the resident appeared to be more comfortable in the geri chair. She could not remember when they started using the geri chair.</p> <p>Review of R48's electronic medical record (EMR) Profile tab, indicated R48 was admitted on [DATE]. Further review of the EMR Progress Notes tab indicated that R48 returned from the hospital on 07/19/24. Review of the EMR MDS with an Assessment Reference Date (ARD) of 05/26/24 revealed R48's Brief Interview for Mental Status (BIMS) score was 12 out of 15 indicating R48's cognition was moderately impaired.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Altamaha Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 West Cherry Street Jesup, GA 31545	

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Fall assessment provided by the Regional Operations Manager (ROM) revealed that on 07/24/24 and 07/27/24, the resident was found on a floor mat next to his bed.</p> <p>During an interview on 07/31/24 at 10:53 AM, the Physical Therapist (PT) and the Certified Occupational Therapy Assistant (COTA) both stated that R48 started using the geri chair after he returned from the hospital on 07/19/24.</p> <p>Review of R48's Care Plan, dated 12/05/23 and located in the EMR under the Care Plan tab, failed to identify the intervention of a floor mat next to bed, low bed, or geri chair.</p> <p>During an interview on 07/31/24 at 11:51 AM, the MDS Coordinator (MDSC) reviewed R48's Care Plan and stated that she could not find that the care plan had been revised to include the interventions of low bed, geri chair, and fall mats.</p> <p>Review of the EMR Documents tab revealed no evidence of care plan conferences since R48's admission to the facility.</p> <p>During an interview on 07/30/24 at 9:33 AM, the MDSC confirmed R48 admission MDS was completed on 12/08/23 and he had a quarterly MDS on 03/09/24, 05/26/24, and 07/24/24.</p> <p>During an interview on 07/30/24 at 2:00 PM, the MDS Coordinator confirmed she was unable to find any documentation that a care plan conference was held R48 and who attended.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154</p> <p>Based on observation, record review, and interview, the facility failed to ensure that three of three residents (Resident (R) 5, R38, and R3) reviewed for bed rail use out of a total of 28 sampled residents had bed rail assessments and attempted alternatives with documented reasons for the failure of the alternative prior to the use of the bed rails. This failure increased the potential risks associated bed rail use and could put the residents at risk for injury, entrapment, and/or death.</p> <p>Findings include:</p> <p>1. During an observation on 07/29/24 at 10:42 AM, R5 was asleep in bed with bilateral assist bars in the up position; on 07/29/24 at 12:27 PM, and 07/30/24 at 9:45 AM, R5 was asleep in bed with bilateral assist bars. On 07/29/24 at 12:30 PM, R5 was observed in bed eating lunch and the bilateral assist bars were in the up position on the bed.</p> <p>Review of R5's Admission Record from the electronic medical record (EMR) showed a facility admitted [DATE] with medical diagnoses that included dementia, periprosthetic fracture around internal prosthetic left hip, peripheral vascular disease, generalized muscle weakness, and reduced mobility.</p> <p>Review of R5's EMR Assessments tab showed three Bed Rail Evaluation forms:</p> <p>a. effective date 12/12/23 at 3:51 PM that did not show any failed attempted alternatives to bed rails and recommended Side Rails/Assist Bar are indicated and serve as an enabler to promote independence.</p> <p>b. effective date 03/12/24 at 10:48 AM that did not show any failed attempted alternatives to bed rails and recommended Side Rails/Assist Bar are not indicated at this time.</p> <p>c. effective date 03/12/24 at 11:39 AM that did not show any failed attempted alternatives to bed rails and recommended Side Rails/Assist Bar are not indicated at this time.</p> <p>2. During an observation on 07/28/24 at 7:45 PM R38 was in bed with bilateral assist bars and when asked if she used them R38 responded no. Observation on 07/29/24 at 11:25 AM showed R38 in bed napping with bilateral assist bars; and on 07/30/24 at 9:43 AM, R38 was out of her room but the bed was noted to have bilateral assist bars in place.</p> <p>Review of R38's Admission Record from the EMR Profile tab showed a facility admitted [DATE] with medical diagnoses that included chronic kidney disease, atrial fibrillation, vascular dementia, glaucoma, history of cerebrovascular disease, type II diabetes, and Alzheimer's dementia.</p> <p>Review of R38's EMR Assessments tab showed two Bed Rail Evaluation forms:</p> <p>-Dated 10/15/21 at 5:07 PM showed no documented failed attempted alternatives and recommended Side Rails/Assist Bar are indicated and serve as an enabler to promote independence.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Dated 02/12/23 at 9:45 AM showed no documented failed attempted alternatives and recommended Side Rails/Assist Bar are indicated and serve as an enabler to promote independence and The Resident has expressed a desire to have Side Rails/Assist Bars.</p> <p>A request for alternatives attempted and the reason for failure was made to the Administrator on 07/30/24 at 5:45 PM and 07/31/24 at 10:00 AM with no documentation provided.</p> <p>A request for a facility bed rail policy was made on 07/31/24 at 3:34 PM from the Regional Operations Manager (ROM), however, no policy was received.</p> <p>During an interview on 07/31/24 at 7:45 PM, the Administrator confirmed no alternatives were attempted and stated that alternatives attempted to bed rails should have been documented prior to bed rail use; and an expectation that risk/benefits were advised and informed consents completed as part of the documentation for rail use.</p> <p>3. Observation on 07/28/24 at 6:39 PM revealed R3 was in his room in bed with half side rails on both sides of his bed.</p> <p>Review of R3's electronic medical record (EMR) Profile tab revealed admitted [DATE]. Review of the quarterly MDS with an ARD of 06/19/24 revealed a BIMS score of three out of 15 which indicated R3's cognition was severely impaired.</p> <p>Review of R3's bed rail assessment in the Assessment tab of the EMR, revealed there was no bed rail assessment, dated 07/03/24. Review of the bed rail assessment in the EMR Assessment tab, revealed the assessment, dated 04/03/24, was blank and the EMR indicated the assessment was in progress. The bed rail assessment, dated 01/22/24, indicated the family requested the side rails.</p> <p>During an interview on 07/31/24 at 11:31 AM, the Administrator stated that there are no recent bed rail assessments. The Administrator also confirmed that the 04/03/24 bed rail assessment was blank, the last bed rail assessment was dated 01/22/24 and the family requested the side rails.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>26446</p> <p>Based on observation and interview, the facility failed to ensure that the daily nurse staffing was posted to accurately reflect the actual staff hours to care for the 52 current residents for three of four survey days. This failure had the potential to inaccurately inform any resident, family member, or visitor of the available nursing staff caring for residents.</p> <p>Findings include:</p> <p>An observation throughout the facility on 07/28/24 at 6:43 PM revealed the daily nurse staffing was not posted.</p> <p>Observations throughout the facility on 07/29/24 at 9:30 AM and at 10:40 AM revealed the daily nurse staffing was not posted.</p> <p>An observation throughout the facility on 07/30/24 at 6:05 PM revealed the daily nurse staffing was not posted.</p> <p>During an interview on 07/31/24 at 8:15 AM, the Administrator stated that the daily nurse staff posting should have been posted in the glass display window near the front of the facility each day. She confirmed the staffing had not been posted for three of the four survey days.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure pharmacy provided medications timely and residents received medications as ordered by the physician for one of six residents (Residents (R) 113) reviewed for medication administration out of 28 sample residents. The failure of the facility to ensure medications were provided from the pharmacy had the potential to affect all residents requiring administration of medications.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Medication Administration Guide, dated July 2023, revealed If a medication is not administered because the medication is not available, make every effort to locate the medication. If the medication cannot be located, check the interim or emergency kit for the medication so that the medication pass can be completed .Document unavailable medications appropriately per facility policy. Contact the pharmacy and arrange for delivery of the medication.</p> <p>Review of R113's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease and diabetes mellitus.</p> <p>Review of R113's EMR under the Progress Notes tab revealed the resident was admitted on [DATE] at 1:03 PM with a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated intact cognition.</p> <p>Review of R113's EMR under the Orders tab revealed an order, dated 07/12/24, for Atorvastatin Calcium Oral Tablet 40mg [milligrams], Give one tablet by mouth at bedtime for hyperlipidemia.</p> <p>Review of the Medication Administration Record (MAR) revealed the medication was not administered on 07/12/24 at 9:00 PM. There was no follow-up documentation to indicate why the medication was not administered.</p> <p>Review of R113's EMR under the Orders tab revealed an order, dated 07/12/24, for Ondansetron HCl [hydrochloride] Oral Tablet 8mg, give one tablet by mouth every six hours for nausea.</p> <p>Review of the MAR revealed the medication was not administered on 07/12/24 at 11:00 PM, on 07/13/24 at 5:00 AM and 11:00 PM, on 07/16/24 at 11:00 PM, on 07/17/24 at 5:00 AM, on 07/18/24 at 11:00 PM, on 07/19/24 at 5:00 AM, on 07/22/24 at 11:00 PM, and on 07/23/24 at 5:00 AM. There was no follow-up documentation to indicate why the medication was not administered.</p> <p>Review of R113's EMR under the Orders tab revealed an order, dated 07/12/24, for Carvedilol Oral Tablet 12.5 mg, give one tablet by mouth three times a day related to essential hypertension.</p> <p>Review of the MAR revealed the medication was not administered on 07/12/24 at 9:00 PM. There was no follow-up documentation to indicate why the medication was not administered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R113's EMR under the Orders tab revealed an order, dated 07/12/24, for Metformin HCl Oral Tablet 1000 mg, give one tablet by mouth two times a day related to type 2 diabetes mellitus without complications.</p> <p>Review of the MAR revealed the medication was not administered on 07/12/24 at 9:00 PM. There was no follow-up documentation to indicate why the medication was not administered.</p> <p>Review of R113's EMR under the Orders tab revealed an order, dated 07/12/24, for Eliquis Oral Tablet 5 mg, give one tablet by mouth two times a day related to presence of aortocoronary bypass graft.</p> <p>Review of the MAR revealed the medication was not administered on 07/12/24 at 9:00 PM. There was no follow-up documentation to indicate why the medication was not administered.</p> <p>Review of R113's EMR under the Orders tab revealed an order, dated 07/13/24, for Levothyroxine Sodium Oral Tablet 50 mcg (microgram), Give one tablet by mouth in the morning related to hypothyroidism.</p> <p>Review of the MAR revealed the medication was not administered on 07/13/24 or 07/17/24 at 5:00 AM. There was no follow-up documentation to indicate why the medication was not administered.</p> <p>During an interview on 07/31/24 at 10:15 AM, Licensed Practical Nurse (LPN) 5 stated that when a new resident was admitted to the facility the admission staff, or the nurse would put the medication orders into the EMR. She stated that the medication orders were automatically sent to the pharmacy, and that the pharmacy delivered medications twice a day. LPN5 stated that the medications were usually delivered from the pharmacy early in the morning and late in the evening. She stated that if a resident was admitted in the afternoon or later, it was not uncommon for the pharmacy to not bring medications until the following morning. LPN5 stated that if a medication was not available, the nurse should pull medication from their emergency kit, if possible. She stated that if the MAR showed a 9 then look for a progress note, which should indicate a note in the EMR about why the medication was not given. She confirmed that only a checkmark on the MAR indicated the medication was given to the resident.</p> <p>During an interview on 07/31/24 at 1:45 PM, the Director of Nursing (DON) stated that when residents were admitted, the pharmacy was made aware of the medications needed. She stated that the pharmacy usually had a cut off time, approximately 3:00 PM, to arrive on the next delivery. She stated that if a medication was not available, the facility had an emergency drug kit that carried the basic medications. She stated if a nurse did not have the medication to administer to the resident, they would code a 9, which meant that the nurse was aware the medication was not available, and that a progress note would be documented in the EMR to indicate what steps the nurse had followed. The DON stated that pharmacy had been a problem, and that there were instances when the medications had not arrived for delivery, the facility had contacted the pharmacy, and been given excuses. She confirmed that pharmacy deliveries had been difficult.</p> <p>During an interview on 07/31/24 at 4:24 PM, the Medical Director stated that if a resident did not have their medications available on admission, the nursing staff should have called for the medication to be held until it arrived, or to use the local pharmacy to get the medications.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262</p> <p>Based on record review, interview, and policy review, the facility nurses failed to document the behaviors that were occurring and what nonpharmacological interventions were attempted prior to the administration of antipsychotic medication, Seroquel Intramuscularly (IM) for one of five residents (Resident (R) 48) reviewed for unnecessary medications of 28 sample residents. The failure could result in the resident receiving unnecessary medication.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Behavior Management Standard, dated September 2021, indicated . Goals for use of psychoactive .The Interdisciplinary Team (IDT) will ensure the following have been completed before a psychoactive medication is administered .targeted behavior is identified; behavior monitoring sheets are initiated .Appropriate nonpharmacological interventions have been identified prior and implemented based on an individual resident assessment .</p> <p>Review of R48's electronic medical record (EMR) Profile tab, indicated R48 was admitted on [DATE]. Further review of the EMR progress notes tab indicated that R48 returned from the hospital on 07/19/24. Review of the EMR Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/26/24 revealed R48's Brief Interview for Mental Status (BIMS) score was 12 out of 15 indicating R48's cognition was moderately impaired.</p> <p>Review of R48's EMR orders tab, dated 07/18/24, revealed, Haldol Injection Solution 5 MG/ML [milligrams/ milliliters] (Haloperidol Lactate), Inject 5 mg intramuscularly every 8 hours as needed for agitation.</p> <p>Review of R48's July 2024 Medication Administration Record (MAR) located under the Orders tab of the EMR revealed that since R48 returned from hospital on 07/19/24, the MAR indicated what behaviors to monitor. Further review of the MAR revealed that R48 received Haldol (antipsychotic medication) 5 mg IM on 07/21/24, 07/25/24, and on 07/29/24 he received two doses of the medication. The MAR did not indicate any behaviors R48 displayed prior to receiving the Haldol IM injections.</p> <p>During an interview on 07/31/24 at 4:46 PM, the Regional Operations Manager (ROM) reviewed R48's July 2024 MAR, the behaviors section of the MAR, and the Progress notes from 07/19/24 to 7/31/24. She was asked what behaviors R48 displayed and what nonpharmacological interventions were used prior to the administration of Haldol. The ROM confirmed there were no behaviors documented and that there was no documentation of nonpharmacological interventions. She stated, if it is not documented, then it wasn't done.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262</p> <p>Based on observation, interview, record review, and policy review, the facility nurse failed to follow the physician order and provide the resident his insulin per the sliding scale order for one of seven residents (Resident (R) 3) reviewed during medication administration of 28 sample residents. Specifically, the resident did not have the insulin available for medication administration. This failure caused a significant medication error which could affect the management of R3's diabetes and glucose levels.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Medication Administration Guidelines dated August 2021, indicated, General and Specific Guidelines on Administration of Medications by Routes .c. Staff will compare the MAR [Medication Administration Record] with the label of each medication for the following: Right person, Right medication .e. Staff will compare the label with the MAR for a second time. G. Staff will compare the label on the medication to the MAR for a third time before administering the medication .</p> <p>Review of R3's electronic medical record (EMR) Census tab indicated R3 was admitted on [DATE] with diagnosis of diabetes mellitus. Review of R3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/02/24 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R3's cognition was moderately impaired. The MDS indicated R3's active diagnosis of diabetes mellitus.</p> <p>Review of the EMR Orders tab revealed an order, dated 06/19/24, for Humulin R Injection Solution 100 UNIT/ML [unit/ milliliter] (Insulin Regular (Human)) Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS (E11.8) BS [blood sugars] greater than 401 call MD [Medical Doctor] for further instructions.</p> <p>During an observation and interview on 07/29/24 at 11:50 AM, Registered Nurse (RN) 1 obtained R3's glucose reading of 258 and returned to the medication cart. RN1 reviewed the MAR and determined that R3 required six units of Humulin R insulin. RN1 searched throughout the medication cart and was unable to find R3's insulin. RN1 went to the medication room to obtain R3's insulin. RN1 returned to the medication cart with the insulin box and vial inside and prepared a syringe of six units of Humulin R. RN1 proceeded to R3's room and was asked by the surveyor to return to the medication cart. When asked why she was administering six unit of Humulin R insulin to R3 when the box indicated four units of Humulin R insulin for a blood glucose of 258. RN1 reviewed the MAR and showed the surveyor that the MAR indicated that six units of Humulin R insulin were to be administered. RN1 then reviewed the insulin and insulin box and determined that the insulin belonged to R50. RN1 stated that she reported the failure to have R3's Humulin R insulin to the Regional Operations Manager (ROM) and that she will order the insulin. R3 did not receive the insulin as ordered.</p> <p>The Administrator provided documentation that the pharmacy sent the insulin on 07/29/24 at 10:44 PM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R3's July 2024 MAR revealed R3 did not receive any insulin on 07/29/24 at the 1100 (11:00 AM), 1600 (4:00 PM), and 2100 (9:00 PM) and on 07/30/24 at 0700 (7:00 AM) designated time periods. Review of the July MAR indicated that R3 routinely received sliding scale Humulin R insulin from 07/01/24 to 07/29/24 at the 7:00 AM Accu-Chek.</p> <p>Review of R3's MAR, dated 07/30/24, indicated at the 11:00 AM Accu-Chek, R3's glucose level was 239 and required four units of Humulin R insulin.</p> <p>During an interview on 07/31/24 at 1:40 PM, the Administrator stated that she was not aware of any delay in pharmacy providing the medications.</p> <p>During an interview on 07/31/24 at 4:26 PM, the Medical Director stated that if there was delay in getting the insulin, the facility should have called him, and he would have called the insulin order into a local pharmacy so that the resident could receive it much sooner. He further stated that while waiting for the insulin, the nurses still should have performed the Accu-Chek to assess the resident's glucose level and notify him of any elevated glucose levels.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Altamaha Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 West Cherry Street Jesup, GA 31545	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446</p> <p>Based on observations, interviews, and policy review, the facility failed to ensure food was not stored on the floor, expired foods were disposed of in a timely manner, ready-to-eat food was not touched with bare hands, and moldy food was not stored for use in accordance with professional standards for food service safety as required for 52 census residents who received meals from the facility kitchen. These failures had the potential to lead to food-borne illness among facility residents.</p> <p>Findings include:</p> <p>Review of a facility policy titled, Nutrition Services Manual, dated ,d+[DATE], revealed, The facility strives to promote good sanitation practices in order to protect its residents/patients and employees from foodborne illness. The facility sanitation system will ensure a clean, safe environment for its residents/patients and staff . The Nutrition Services staff follows infection control procedures including maintaining personal hygiene and handling foods to prevent contamination .Verify expiration dates are appropriate on individual cartons .Store delivered items immediately upon receipt.</p> <p>During an observation on [DATE] at 10:53 AM, sixteen boxes of canned foods and perishables were observed resting directly onto the pantry floor.</p> <p>During an interview on [DATE] at 10:54 AM, Cook1 stated that the food shipment had arrived the previous evening, but staff had not had time to properly store the food.</p> <p>During observation of a reach-in refrigerator on [DATE] at 11:00 AM, there was one 46-ounce (oz.) thickened orange juice carton, opened with [DATE] written on it. A second 46oz. thickened pomegranate berry juice, opened with [DATE] written on it. Both cartons documented, After opening, may be kept up to 7 days under refrigeration. Also, a large, opened container of turkey lunch meat with ,d+[DATE]-,d+[DATE] written on the side.</p> <p>During an interview on [DATE] at 11:05 AM, Cook2 stated she was not aware that the opened thickened juices had to be disposed of after seven days. Cook2 also confirmed the turkey lunch meat was dated past acceptable use by date.</p> <p>During lunch service observation on [DATE] from 12:00 PM through 12:15 PM, Cook1 was observed plating food from the steam table, touching the dinner rolls with her bare hands. Cook1 was observed to touch the meal trays, the tray rack, and again touched dinner rolls with her bare hands without handwashing.</p> <p>During an observation on [DATE] at 3:58 PM, one moldy 16oz. carton of strawberries was found in a refrigerated reach-in.</p> <p>During an interview on [DATE] at 3:58 PM, Dietary Aide (DA) 2 confirmed that there were moldy strawberries, and that staff had not always checked the produce when it arrived from the supplier to ensure it was still edible.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262</p> <p>Based on observation, interview, record review, personnel file review, and policy review, the facility failed to</p> <ol style="list-style-type: none"> 1. follow manufacturer's instructions regarding the cleaning and disinfecting of one of one glucometer between residents' use. 2. follow pre-employment and annual purified protein derivative (PPD) (skin test that determines if you have tuberculosis) guidelines of obtaining PPD 1st and 2nd step at the time of employment for six of nine personnel files (Administrator, Director of Nursing (DON), Certified Nurse Aide (CNA) 2, Licensed Practical Nurse (LPN) 2, Dietary Aide (DA) 1, and LPN3) reviewed, 3. obtain annual PPD test for two of nine personnel files (LPN1 and CNA1) reviewed, and 4. maintain a current infection surveillance program for 2024. Failure to follow infection control guidelines could result in the residents acquiring a blood-borne pathogen or infectious disease. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy titled, Diabetic Management. dated August 2021. indicated Guidelines .14. Clean and disinfect the glucometer per the facility's infection control protocol/manufacturer's instruction . <p>Review of the undated Evencare G3, Blood Glucose Monitoring System manufacturer's instructions for the glucometer and provided by the facility, revealed on page 11, The Evencare G3 Meter should be cleaned and disinfected between each patient .The following products have been approved for cleaning and disinfecting the Evencare G3 Meter .Medline Micro-Kill Bleach Germicidal Bleach Wipes . Further review of the manufacturer's instructions revealed on page 16, In-Service Training .Step6. Perform a blood glucose test 8. Clean and disinfect the meter .</p> <p>During an observation on 07/29/24 at 11:50 AM Registered Nurse (RN)1 stood at the medication cart on the 100 unit, removed the glucometer out of her uniform pocket. Without cleaning and disinfecting the glucometer, attached the Accu-Chek test strip into the glucometer and entered R3's room. After obtaining R3's glucose reading, returned to the medication cart and placed the glucometer directly on top of the cart without first placing a clean barrier between the glucometer and the cart. RN1 reviewed the Medication Administration Record (MAR) and determined that R3 required insulin. RN1 searched throughout the medication cart and was unable to find R3's insulin. Without cleaning and disinfecting the glucometer, RN1 placed the glucometer in the medication cart and locked the cart. RN1 went to the medication room to obtain R3's insulin. RN1 returned to the medication cart and prepared a syringe of six units of Humulin R. At this time, RN1 did not remove the glucometer to clean and disinfect it.</p> <p>During an interview on 07/29/24 at 12:28 PM, RN1 was asked what training she had received regarding the cleaning and disinfecting of the glucometer. RN1 stated at this time, I probably need to clean it. When asked what product she was to use, RN1 stated she was to use an alcohol wipe. RN1 removed the glucometer from the medication cart and cleaned it with an alcohol wipe. When asked what training the facility had provided regarding cleaning and disinfecting the glucometer between residents' use, RN1 stated that she had not received any training and just relied on her nursing knowledge.</p> <p>Review of the diagnosis list provided by the Regional Operations Manager (ROM) for all the residents in the facility revealed no evidence of a resident having a bloodborne pathogen diagnosis.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the list of residents with sliding scale orders per hallway and provided by the ROM revealed seven residents (R15, R48, R116, R18, R17, R30, and R3) on the 100 hallway.</p> <p>During an interview on 07/31/24 at 1:37 PM, the Administrator stated that it was her expectation that the nurses followed the manufacturer's instruction and to use the Micro Kill product, which was in each medication cart to disinfect the glucometer.</p> <p>During an interview on 07/31/24 at 4:35 PM, the ROM stated that they could not find any documentation that nurses, including RN1, had been trained on how to disinfect the glucometer prior to the incident on 07/29/24.</p> <p>2. Review of the facility's undated document titled, Pre-Employment and Annual TB [Tuberculosis] Test Results indicated, Pre-employment requires a 2-step TB. Employee may not start working on the floor until 1st step is completed. 2nd step must be completed no later than 14 days after the 1st step. Annual TB test are a 1-Step .</p> <p>Review of six of nine personnel files revealed the Administrator was unable to provide PPD information for the following staff:</p> <ul style="list-style-type: none"> -Administrator's file revealed hire date of 11/3/23 -Director of Nursing (DON) file revealed hire date of 07/08/24 -CNA2's file revealed hire date of 04/17/24 -LPN2's file revealed hire date of 07/02/24 -DA1's file revealed hire date of 06/10/24 -LPN3's file revealed hire date of 05/01/24 <p>3. Review of two of two personnel files revealed the facility was unable to provide yearly PPD information for the following staff:</p> <ul style="list-style-type: none"> -LPN1's file revealed hire date of 02/01/21 and the last documentation of the PPD was dated 02/23. -CNA1's file revealed hire date of 09/08/20 and the facility was unable to find documentation of the PPD for 09/23. <p>During an interview on 07/31/24 at 1:45 PM, the Administrator confirmed she was unable to find the PPD information for the above employees. She stated that the facility no longer had a Human Resource Director (HRD). She stated the HRD was responsible for uploading the information into the computer system.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>4. Review of the facility policy titled Infection Surveillance, dated 09/23, showed: Overview. The facility will use a systematic method of collecting, consolidating, and analyzing data concerning the distribution and determining factors of a given disease or event. An outbreak may be defined as an increase in the incidence of a disease, complication, or event above the background rate. The facility will have baseline surveillance data on the incidence of</p> <p>nosocomial infections in order to identify outbreaks. Following the collection and analysis of data, the information will be provided to the staff for educational purposes to strive to improve infection prevention/control outcomes. The facility will also use surveillance as follows . Procedure. 1. Gather information from each unit at least once per week. 2. Initiate a resident specific Infection Surveillance Worksheet if infection appears likely . 3. Summarize information from the Infection Surveillance Worksheet on the Monthly Line Listing Report .4. Tabulate infection data according to the following and document on the appropriate month on the Annual Infection Rate Summary .5. Calculate incidence rates and compare to previous rates within the facility. 6. Present the information at the next scheduled Infection Control/Prevention Team meeting .8. Implement an action plan as needed. Report to the Risk Management/ Quality Improvement Committee as needed. 9. Provide staff training as needed. 10. Review and revise action plan as needed.</p> <p>During the Infection Control review in response to a request for infection tracking and trending (surveillance) documentation for 2024, the Director of Nursing (DON) provided a binder with numerous tabs and blank schematics. On 07/31/24 at 6:46 PM, the DON stated it might be in another book that was taken out of here. I know I can do the schematic for the trends for cross contamination, and I can show you what I'm going to do. When the last six months was requested, the DON stated, I wasn't here. I can go through more boxes and books. At 6:54 PM, the DON was going through boxes in her office and related I feel sure she [prior DON] was doing that stuff, I don't know why she put things in such strange places before she left. On 07/31/24 at 7:05 PM, the DON stated, I can't provide any documentation about an infection control program before my arrival. I am putting my program [in place] but it's not up and running yet. I've been here about two weeks, maybe the 8th or 9th, and I worked on the floor for the first 13 or 14 days.</p> <p>During an interview on 07/31/24 at 7:08 PM, the Administrator [NAME] in a file for tracking and trending from 2023 but was unable to provide anything from 2024. The Administrator stated it was an expectation that the facility had an infection surveillance program.</p> <p>28154</p>		