

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115615	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Baptist Village, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 2650 Carswell Ave Waycross, GA 31502	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675</p> <p>Based on observations, staff interviews, record review, and review of the facility policy titled Urinary Catheter Care, the facility failed to ensure urinary catheter drainage bags were covered to protect the dignity of two of four sampled residents (R) (R71 and R94) with indwelling urinary catheters. This failure had the potential to diminish R71 and R94's quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life.</p> <p>Findings include:</p> <p>A review of the facility's policy titled Urinary Catheter Care, revised 12/27/2023, revealed 2. Catheter tubing and bag: d. Use a catheter bag cover to protect the resident's dignity.</p> <p>1. A review of R71's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed section H (Bladder and Bowel) documented the resident did not have an indwelling urinary catheter.</p> <p>A review of the Physician's Orders revealed an order dated 9/14/2024 for a urinary catheter and catheter care every shift.</p> <p>A review of the comprehensive care plan revealed a focus area for an indwelling urinary catheter with a diagnosis of neuromuscular dysfunction of the bladder.</p> <p>An observation on 9/17/2024 at 11:49 am revealed R71 lying in bed with a catheter drainage bag uncovered, exposing R71's urine to other residents and visitors</p> <p>During an interview and observation on 9/19/2024 at 10:10 am, Licensed Practical Nurse (LPN) BB confirmed that R71's urinary catheter drainage bag was not in a privacy bag.</p> <p>2. A review of R94's Quarterly MDS dated [DATE] revealed section H (Bladder and Bowel) documented that R94 had an indwelling urinary catheter.</p> <p>A review of the Physician's Orders revealed an order dated 9/9/2024 to change the urinary catheter every month.</p> <p>A review of the comprehensive care plan revealed a focus area for an indwelling urinary catheter with diagnoses of benign prostatic hyperplasia and obstructive and reflux uropathy.</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>Observations on 9/17/2024 at 11:21 am and 9/18/2024 at 8:52 am revealed R94 lying in bed with a urinary catheter drainage bag uncovered, exposing R94's urine to other residents and visitors.</p> <p>During an interview and observation on 9/19/2024 at 10:10 am, LPN BB confirmed that a privacy bag was not on R94's urinary catheter drainage bag on 9/17/2024 or 9/18/2024 and revealed she placed the privacy cover over the catheter drainage sometime on 9/18/2024. LPN BB stated urinary catheter drainage bags should be in a privacy bag.</p> <p>In an interview on 9/19/2024 at 10:30 am, the Assistant Director of Nursing (ADON) AA revealed that all residents with urinary catheters should have the drainage bag in a privacy bag.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675</p> <p>Based on observations, staff interviews, and record review, the facility failed to implement care plan interventions for two of 48 sampled residents (R) (R94 and R66). This failure had the potential for R94 and R66 to not receive treatment and/or care according to their needs.</p> <p>Findings include:</p> <p>1. A review of R94's medical record revealed diagnoses included but was not limited to, pulmonary disease.</p> <p>A review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section O (Special Treatments, Procedures, and Programs) documented that R94 received oxygen while a resident.</p> <p>A review of the care plan revealed that R94 received oxygen therapy and had diagnoses of chronic obstructive pulmonary disease (COPD) and asthma. Interventions included oxygen as ordered.</p> <p>A review of the Physician Orders revealed an order dated 9/9/2024 to check oxygen saturation and apply oxygen at 2 liters per minute (LPM) via nasal cannula (NC) for oxygen saturation below 92 percent.</p> <p>Observation on 9/17/2024 at 12:05 pm and 9/18/2024 at 8:52 am revealed R94 was receiving oxygen at 3 LPM.</p> <p>In an interview on 9/19/2024 at 10:10 am, Licensed Practical Nurse (LPN) BB verified R94's physician's order for oxygen at 2 LPM and verified the oxygen was set on the wrong flow rate. She confirmed that R94's care plan included administering oxygen as ordered by the physician and that if the oxygen was not administered as ordered, staff were not following the resident's care plan.</p> <p>2. A review of R66's medical record revealed diagnoses included but was not limited to, hypertension.</p> <p>A review of the Quarterly MDS dated [DATE] revealed Section O (Special Treatments, Procedures, and Programs) documented that R66 received oxygen while a resident.</p> <p>A review of the care plan revealed the resident had hypertension. Interventions included administering oxygen as ordered.</p> <p>A review of R66's Physician's Orders revealed an order dated 3/25/2024 for oxygen at 2 LPM via NC as needed for shortness of breath.</p> <p>Observations on 9/17/2024 at 3:00 pm, 9/18/2024 at 10:41 am, and 9/19/2024 at 8:49 am revealed that R66 was receiving oxygen with the flow rate set above 3 LPM.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 9/19/2024 at 10:24 am, LPN CC verified R66's physician's order for oxygen at a rate of 2 LPM. She confirmed that R66's oxygen flow rate was above 3 LPM. She confirmed that R94's care plan included administering oxygen as ordered by the physician and that if the oxygen was not administered as ordered, staff were not following the resident's care plan.</p> <p>In an interview on 9/19/2024 at 3:40 pm, MDS Coordinator FF stated nursing staff was responsible for ensuring resident care plans were followed.</p> <p>Cross-Reference F695</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675</p> <p>Based on observations, staff interviews, record review, and review of the facility policy titled Oxygen Therapy, the facility failed to ensure that two of 48 sampled residents (R) (R94 and R66) were administered oxygen therapy in accordance with the physician orders. This failure had the potential to affect the necessary respiratory care and services that are in accordance with professional standards of practice.</p> <p>Findings include:</p> <p>A review of the facility policy titled Oxygen Therapy, dated 12/28/2023, revealed the Purpose section included 1. There must be a physician's order for oxygen use which includes the route and liter flow or specific oxygen concentration and how long the oxygen is to be administered. 5. The Unit Nurse must instruct staff members that they must not . c. change the flow rate of the oxygen.</p> <p>1. A review of R94's medical record revealed diagnoses included but was not limited to, pulmonary disease.</p> <p>A review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section O (Special Treatments and Programs) documented that R94 received oxygen while a resident.</p> <p>A review of the Physician Orders revealed an order dated 9/9/2024 to check oxygen saturation and apply oxygen at 2 liters per minute (LPM) via nasal cannula (NC) for oxygen saturation below 92 percent.</p> <p>Observation on 9/17/2024 at 12:05 pm and 9/18/2024 at 8:52 am revealed R94 was receiving oxygen at 3 LPM.</p> <p>In an interview on 9/19/2024 at 10:10 am, Licensed Practical Nurse (LPN) BB verified R94's physician's order for oxygen at 2 LPM and verified the oxygen was set on the wrong flow rate. She stated the medication nurses were responsible for checking the oxygen flow rates daily to ensure the flow rate was correct.</p> <p>2. A review of R66's medical record revealed diagnoses included but was not limited to, hypertension.</p> <p>A review of the Quarterly MDS dated [DATE] revealed Section O (Special Treatments and Programs) documented that R66 received oxygen while a resident.</p> <p>A review of R66's Physician's Orders revealed an order dated 3/25/2024 for oxygen at 2 LPM via NC as needed for shortness of breath.</p> <p>Observations on 9/17/2024 at 3:00 pm, 9/18/2024 at 10:41 am, and 9/19/2024 at 8:49 am revealed that R66 was receiving oxygen with the flow rate set above 3 LPM.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 9/19/2024 at 10:24 am, LPN CC verified R66's physician's order for oxygen at a rate of 2 LPM. She confirmed that R66's oxygen flow rate was above 3 LPM and adjusted the rate to 2 LPM. She stated risks to the resident when receiving the wrong oxygen flow rate included breathing and heart rate problems.</p> <p>In an interview on 9/19/2024 at 10:30 am, Assistant Director of Nursing (ADON) AA revealed that she expected nursing staff to check oxygen rates frequently. She further stated she expected all oxygen flow meters to be set at the rate prescribed by the physician.</p>