STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115626	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hazelhurst Court Care and Rehabilitation Center	180 Burkett Ferry Road Hazlehurst, GA 31539

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to ensure that the Advanced Directive care plan was implemented for one of 11 sampled residents (R)(R1). This failure resulted in CPR not being provided for R1, whose Advanced Directive care plan specified she was a Full Code. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy (IJ) on [DATE], at 2:15 pm. The noncompliance related to the IJ was identified to have existed on [DATE].An acceptable Removal Plan was received on [DATE]. Based on the validation of the Removal Plan, the State Survey Agency determined that the corrective plans and the immediacy of the deficient practice were removed on [DATE]. Findings included:A review of the electronic medical record (EMR) revealed that R1 was admitted to the facility on [DATE] and had diagnoses that included cerebral atherosclerosis, dysphagia, gastro-esophageal reflux disease, anemia, constipation, hypertension, and hyperlipidemia. A review of R1's clinical record revealed a [DATE] Advanced Directive physician's order. The physician's order specified that R1 was a Full Code and to attempt CPR.A review of R1's care plan revealed a [DATE] Advanced Directive care plan that documented R1 was a Full Code. The care plan included an intervention, dated [DATE], to attempt resuscitation (CPR). A review of the Facility Notification of Hospice Admission/Change form revealed that R1 was admitted to hospice services on [DATE]. The admitting diagnosis was cerebral atherosclerosis. Further review of R1's care plan revealed an [DATE] care plan which R1 was under the care of hospice services. Following R1's admission to hospice services, an updated Physician Orders for Life Sustaining Treatment (POLST) form, dated [DATE], was completed. The POLST form specifies attempting CPR. Therefore, R1 remained a Full Code. During an interview on [DATE] at 4:11 pm, Registered Nurse (RN) Unit Manager GG confirmed that R1's Responsible Party wanted R1's Advanced Directives to remain a full code status. A review of progress notes revealed a [DATE] 6:55 pm nurse's note entry by Licensed Practical Nurse (LPN) HH, that staff alerted her that R1 was deceased . A subsequent nurse's note entry on [DATE] at 7:00 pm documented that R1 was assessed and noted to have no pulse or respirations, and skin was cool to the touch. The note further documented that the Director of Nursing, Administrator, RN unit manager, Nurse Practitioner, and hospice nurse were notified. A review of hospice documentation revealed a [DATE] Visit Note Report that documented the hospice RN pronounced R1's death on [DATE] at 7:31 pm. However, there was no evidence that facility nursing staff attempted CPR on R1 when she was noted to have no pulse or respirations, as specified in her Advanced Directives care plan.During an interview on [DATE] at 1:52 pm, the DON confirmed that CPR was not attempted on R1 on [DATE]. She stated that R1 was fairly new, being on hospice services, and what she gathered through interviews was that the night and day shift nurses thought that once a resident was receiving hospice services, they were a Do Not Resuscitate (DNR). The DON stated that R1's death occurred during the shift change (7:00 am-7:00 pm nursing staff going off shift and 7:00 pm-7:00 am nursing staff coming on shift). Cross-reference to F678

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of facility policies titled Emergency Response Management and Cardiopulmonary Resuscitation (CPR), the facility failed to assess and implement life-sustaining measures for one of 11 sampled residents (R)(1). This failure resulted in CPR not being provided for R1, who was found unresponsive, and whose Advanced Directives specified attempting CPR. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on [DATE], at 2:15 pm. The noncompliance related to the IJ was identified to have existed on [DATE]. An acceptable Removal Plan was received on [DATE]. Based on the validation of the Removal Plan, the State Survey Agency determined that the corrective plans and the immediacy of the deficient practice were removed on [DATE]. Findings included:The facility had an Emergency Response Management policy, dated [DATE]. Section d of the General Policy and Procedure included that in the event of cardiac/respiratory arrest, initiate CPR if the resident is a full code and notify Emergency Management Services (EMS), and the physician for further orders. The facility had a Cardiopulmonary Resuscitation (CPR) policy, dated [DATE]. Section 3 of the Procedure portion of the policy includes delegating a specific individual to check physician orders; CPR order/Do Not Resuscitate (DNR) status. R1 was admitted to the facility on [DATE] and had diagnoses that included cerebral atherosclerosis, dysphagia, gastro-esophageal reflux disease, anemia, constipation, hypertension, and hyperlipidemia. A review of R1's clinical record revealed a [DATE] Advanced Directive physician's order. The physician's order specified that R1 was a Full Code and to attempt CPR.A review of the Facility Notification of Hospice Admission/Change form revealed that R1 was admitted to hospice services on [DATE]. The admitting diagnosis was cerebral atherosclerosis. Following R1's admission to hospice services, an updated Physician Orders for Life Sustaining Treatment (POLST) form, dated [DATE], was completed. The POLST form specifies attempting CPR. Therefore, R1 remained a Full Code. During an interview on [DATE] at 4:11 pm, Registered Nurse (RN) Unit Manager GG confirmed that R1's Responsible Party wanted R1's Advanced Directives to remain a full code status. A review of progress notes revealed a [DATE] 6:55 pm nurse's note entry by Licensed Practical Nurse (LPN) HH, who staff alerted her that R1 was deceased . A subsequent nurse's note entry on [DATE] at 7:00 pm documented that R1 was assessed and noted to have no pulse or respirations, and skin was cool to the touch. The note further documented that the Director of Nursing, Administrator, RN unit manager, Nurse Practitioner, and hospice nurse were notified. A review of hospice documentation revealed a [DATE] Visit Note Report that documented the hospice RN pronounced R1's death on [DATE] at 7:31 pm. However, there was no evidence that facility nursing staff attempted CPR on R1 when she was noted to have no pulse or respirations, as specified in her Advanced Directives.During an interview on [DATE] at 1:52 pm, the DON confirmed that CPR was not attempted on R1 on [DATE]. She stated that R1 was fairly new, being on hospice services, and what she gathered through interviews was that the night and day shift nurses thought that once a resident was receiving hospice services, they were a Do Not Resuscitate (DNR). The DON stated that R1's death occurred during the shift change (7:00 am-7:00 pm nursing staff going off shift and 7:00 pm-7:00 am nursing staff coming on shift). The DON stated there were six nurses at the facility, including herself. The DON stated that it was about an hour and a half after hospice had left the facility when hospice staff called the facility and notified them that R1 was a Full Code.A review of the Daily Clinical Assignment sheet, dated [DATE], revealed that the nurses assigned to R1 were LPN BB for the day shift (7:00 am-7:00 pm) and LPN HH for the night shift (7:00 pm-7:00 am). Certified Nursing Assistant (CNA) AA was listed as R1's day shift CNA. During an interview on [DATE] at 3:09 pm, LPN BB confirmed she worked on [DATE]. She stated that she had last checked on R1 when she gave R1 her evening medications, that R1 was a little more tired at that time, but alert and accepted her medications. When LPN BB was questioned about how she became aware that R1 had passed away, LPN BB stated she found out after the fact (on [DATE], while still at the facility); one of the nurses came to the nurses' station, and she overheard them talking about it. LPN BB stated that around 6:30 pm (on [DATE]), she had already counted (controlled) medications with the on-coming night shift nurse (LPN HH) and handed her the (medication cart) keys. When LPN BB was questioned about whether CNA AA had asked for assistance in R1's room prior to it becoming known that R1 had passed. LPN BB

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record reviews, and the Director of Nursing (DON) job description, facility nursing administration failed to provide effective oversight to ensure that facility nursing staff assessed and implemented the correct Advance Directive for one of 11 sampled residents (R)(1) reviewed for Advanced Directives. This failure resulted in CPR not being provided for R1, whose Advanced Directive care plan specified she was a Full Code.On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment, or death to residents.The facility's Administrator and DON were informed of the Immediate Jeopardy (IJ) on [DATE], at 2:15 pm. The noncompliance related to the IJ was identified to have existed on [DATE].An acceptable Removal Plan was received on [DATE]. Based on the validation of the Removal Plan, the State Survey Agency determined that the corrective plans and the immediacy of the deficient practice were removed on [DATE]. Findings included:The facility had a job description for the Director of Nursing. The job duties and responsibilities sections included care plan and assessment functions. The care plan and assessment functions included a responsibility to ensure that medical and nursing care is administered in accordance with the resident's wishes, including the implementation of advance directives.R1 was admitted to the facility on [DATE] and had diagnoses that included cerebral atherosclerosis, dysphagia, gastro-esophageal reflux disease, anemia, constipation, hypertension, and hyperlipidemia. A review of R1's clinical record revealed a [DATE] Advanced Directive physician's order. The physician's order specified that R1 was a Full Code and to attempt CPR.A review of the Facility Notification of Hospice Admission/Change form revealed that R1 was admitted to hospice services on [DATE]. The admitting diagnosis was cerebral atherosclerosis. Following R1's admission to hospice services, an updated Physician Orders for Life Sustaining Treatment (POLST) form, dated [DATE], was completed. The POLST form specifies attempting CPR. Therefore, R1 remained a Full Code. During an interview on [DATE] at 4:11 pm, Registered Nurse (RN) Unit Manager GG confirmed that R1's Responsible Party wanted R1's Advanced Directives to remain a full code status. A review of progress notes revealed a [DATE] 6:55 pm nurse's note entry by Licensed Practical Nurse (LPN) HH, that staff alerted her that R1 was deceased . A subsequent nurse's note entry on [DATE] at 7:00 pm documented that R1 was assessed and is noted to have no pulse or respirations, and skin is cool to the touch. The note further documented that the Director of Nursing, Administrator, RN unit manager, Nurse Practitioner, and hospice nurse were notified. A review of hospice documentation revealed a [DATE] Visit Note Report that documented the hospice RN pronounced R1's death on [DATE] at 7:31 pm. However, there was no evidence that facility nursing staff attempted CPR on R1 when she was noted to have no pulse or respirations, as specified in her Advanced Directives.During an interview on [DATE] at 1:52 pm, the DON confirmed that CPR was not attempted on R1 on [DATE]. She stated that R1 was fairly new, being on hospice services, and what she gathered through interviews was that the night and day shift nurses thought that once a resident was receiving hospice services, they were a Do Not Resuscitate (DNR). The DON stated that R1's death occurred during the shift change (7:00 am-7:00 pm nursing staff going off shift and 7:00 pm-7:00 am nursing staff coming on shift). The DON stated there were six nurses at the facility, including herself. The DON stated that it was an hour and a half after the hospice nurse had left the facility, and that hospice staff then called the facility to inform them that R1 was a Full Code. During a subsequent interview on [DATE] at 3:10 pm, the DON stated that she was still at the facility, in the parking lot, with RN Unit Manager EE when they were notified that R1 was deceased , and they re-entered the facility. The DON stated that night shift nurses (LPN DD and LPN HH) were in R1's room, and the day shift nurses (LPN BB and LPN CC) were at the nursing station charting. The DON went to R1's room and observed R1 to have fixed pupils and to be cold. The DON stated that nursing staff were already on the phone notifying hospice. The DON stated that after she got home, later in the evening, she received a phone call from LPN HH, letting her know that R1 had been a Full Code.Cross-reference to F678