STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115643	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Post Acute and Rehabilitation	3000 Lenora Church Drive Snellville, GA 30078

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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 0580

Level of Harm - Actual harm

Residents Affected - Few

Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47146

Based on record review, interviews, and review of policies titled Notification of Resident's Change in Condition, and Laboratory Testing, the facility failed to notify the physician and responsible party (RP) for a change in condition for one of 44 sampled residents (R) (R660). Specifically, facility staff failed to report critical urinalysis lab results for R660, who experienced actual harm on 12/16/2023, resulting in the resident being hospitalized for 11 days with urosepsis (sepsis caused by urinary tract infection) and acute renal failure.

Findings include:

Review of the policy titled Notification of Resident's Change in Condition revised 9/1/2019 indicated the policy statement as the facility will promptly notify the resident, his or her attending physician, and responsible party of changes in the patient's medical/mental condition and/or status (changes in level of care, billing/payments, resident rights, etc.). Practice Guidelines: Quality of Care - notification of changes - required notifications to Medical Doctor, legal representative, interested family, and resident of injurious accident, significant change in condition-treatment, transfer or discharge, change in room or roommate, or change in legal rights.

Step 1. The Nurse Supervisor/Charge Nurse will notify the resident's attending physician when there has been:

d. A significant change in the patient's physical/emotional/mental condition

e. A need to alter the patient's medical treatment significantly

f. A need to transfer the patient to a hospital/treatment center

i. Instructions to notify the physician of changes in the patient's condition

Step 2. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the family/responsible party

b. There is a significant change in the patient's physical, mental, or psychosocial status

e. It is necessary to transfer the patient to a hospital/treatment center

(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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F 0580 Level of Harm - Actual harm Residents Affected - Few	Step 4. Regardless of the resident's current mental or physical condition, the Nursing Supervisor/Charge Nurse will inform the resident, family, or responsible party of any changes in his/her medical care or nursing treatments. Step 5. The Nurse Supervisor/Charge Nurse will record in the resident's clinical record information relative to changes in the patient's medical/mental condition or status. The Nurse Supervisor/Charge Nurse will document the name of the responsible party that was notified of the change, date, time and response in the electronic health record (EHR). Review of the policy titled Laboratory Testing dated 9/1/2018, indicated the policy was that diagnostic testing will be completed according to the facility's routine laboratory schedule and/or as ordered by the primary care physician, physician assistant, nurse practitioner, or clinical specialist. The Standard of Practice section indicated when lab results are received, the Charge Nurse will indicate this on the lab log. The ordering clinician is to be promptly notified of the laboratory results that fall outside the desired clinical reference ranges. Critical lab results will be phoned to the ordering clinician when received with supporting documentation placed in a Nurse Progress Note. Non-critical abnormal laboratory results will be faxed to the ordering clinician when received. Indicate on the lab log/lab results: date the ordering clinician was notified; date of the ordering clinician's response; indicate if new orders were obtained; family notification; signature of nurse providing notification. Review of the clinical record revealed R660 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (MS), muscle weakness, and unspecified lack of coordination. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14, which indicated no cognitive impairment. Section H documented that R660 had occasional urinary incontinence. Section I documented she had not had a urinary tract infection (UTI) 30 days prior to the assessment. Review of the Progress Note dated 12/9/2023, written by Nurse Practitioner (NP) GG, documented that R660 complained of painful urination and stated, I think my UTI has returned. Current diagnoses documented hypertension, rheumatoid arthritis, and urinary tract infection. The plan included urinalysis (UA) with a culture and sensitivity (C/S) for dysuria (painful urination). Review of the lab [company name] revealed urinalysis was collected on 12/11/2023 and the results reported on 12/14/2023 documented abnormal results of blood 2+, white blood cells (WBC) too numerous to count (TNTC), culture source - urine, culture organism listed klebsiella pneumoniae greater than (>) 100,000. The report included a sensitivity report. Review of the electronic medical record (EMR) did not reveal evidence that R660's physician was notified of the lab result and there was no evidence that orders related to the lab result were received from the ordering physician for treatment of R660's UTI. Review of the Progress Note dated 12/16/2023 at 5:52 am, written by Licensed Practical Nurse (LPN) PP, documented Resident running temperature at 8:30 pm 101.7 F, gave Tylenol. At 5:40 am her temperature was 101.4 F. At 7:36 am, NP GG called, awaiting a return call. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Note dated 12/17/2023 at 3:58 am, written by LPN QQ, documented Resident was transferred to [hospital] as per her son's request. She was administered Tylenol by the outgoing nurse for a low-grade temp. She was diaphoretic at the time she left the facility. Review of [hospital] Emergency Department (ED) records dated 12/16/2023 documented Resident resides in a nursing home and family came to visit her today. The family wanted her transported to the emergency department for evaluation as she has had similar symptoms to UTI's in the past. Admitting diagnoses include sepsis-urinary tract infection and acute renal failure. Interview on 3/23/2024 at 9:05 am, Director of Nursing (DON) revealed the process for laboratory results was when lab results are reported, they show up in the EMR under the results tab. She stated the staff who receives the lab report is responsible for notifying the provider of the results. She stated labs are reviewed and discussed daily including lab orders, labs collected, and lab results, with any actions taken or needed to be taken related to the lab results. During further interview, she stated she was not employed at the facility at the time R660 was a resident, and she cannot state the reason the Physician, NP, or responsible party were not notified of R660's abnormal lab results. Interview on 3/23/2024 at 9:48 am, LPN AA stated when lab results are returned, the nurse taking care of the resident is responsible for notifying the physician of the abnormal results and then should document the notification in the progress notes. During further interview, she stated the nurse notifies the unit manager (UM) of the results and actions taken. She stated the nurse's documentation should include the lab results, the call to the physician and family of results, and the notification of the UM. Interview on 3/23/2024 at 3:16 pm, DON verified the results for the urinalysis collected on 12/11/2023 for R660 were reported to the facility on [DATE] as abnormal. She stated she would have to look in the medical records department for documentation of notification given to the provider and orders received related to the laboratory results from 12/14/2023. Interview on 3/24/2024 at 8:45 am, the DON revealed she had not been able to locate any documentation related to physician notification or orders/instructions related to R660's UA results from 12/14/2023. During continued interview, she stated they are still reviewing audits that were conducted in December of 2023. Interview on 3/24/2024 at 9:55 am, the Administrator was asked for documentation related to notifying the Physician of R660's abnormal lab results. She replied that the facility identified an issue with its previous laboratory provider and changed to its current provider in October 2023. She stated they identified issues related to laboratory results and have a Process Improvement Plan (PIP) in place that was started after they changed laboratory providers in October 2023. She did not address the issue related to the Physician and responsible party not being notified of R660's abnormal lab results, when the lab results were reported to the facility on [DATE]. Interview on 3/24/2024 at 10:35 am, the Medical Director stated he did not remember if the facility had contacted him regarding R660's urinalysis result, but he would have the NP contact the surveyor regarding the resident. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Interview on 3/24/2024 at 11:55 am, NP GG stated she could not remember if the facility had notified her of R660's abnormal UA with C&S lab results from 12/14/2023. She stated she did not keep records of when staff notified her about resident lab results, but revealed if she had been notified, she would have given the nurse orders for the treatment for R660's UTI. During further interview, she stated if a resident had an elevated temperature, she would have sent the resident to the emergency room to prevent any delay in treatment. Three requests were made to facility staff for documentation of Physician notification and orders related to the lab results received and were not provided during the survey. Cross Refer F690

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F 0656

Level of Harm - Minimal harm or potential for actual harm

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 35180

Based on observations, record review, staff interview, and review of the policies titled Care Plan Policy and Smoking Policy for Residents, the facility failed to develop a care plan for three of 44 sampled residents (R) R108 for Post-Traumatic Stress Disorder (PTSD), R116 for dementia, and R126 for smoking.

Findings include:

Review of the facility's Care Plan Policy, reviewed 10/25/2022, revealed the policy is that each resident would have a plan of care to identify problems, needs, and strengths that would identify how the facility staff would provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Standards of Practice: Number 2. A care plan to identify past trauma would be developed through input of the resident and/or resident representative to prevent re-traumatization to the resident. Number 10. Areas of concern or potential concern and residents' strengths would be addressed with measurable goals and specific person-centered approaches to promote attainment or maintenance of the goal(s).

1. Review of the clinical record revealed R108 was admitted to the facility on [DATE] with diagnoses including anxiety disorder, schizoaffective disorder, and post-traumatic stress disorder (PTSD).

Review of a Mental Health Note dated 6/8/2023 documented the resident was displaying symptoms indicative of PTSD, including agitation, irritability, hostility, hypervigilance, emotional detachment, and intrusive thoughts. Further review revealed R108 reported two men raped the resident on two occasions. Additionally, the resident reported a history of domestic violence, physical abuse, emotional abuse, kidnapping, and being forced to play Russian [NAME]. The clinician diagnosed the resident with acute PTSD.

Review of quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed R108 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Section revealed no moods exhibited; Section E behaviors revealed resident displayed rejection of care four - six days during look back period; Section I revealed a diagnosis of PTSD.

Review of the current care plan revealed there was no comprehensive plan of care developed to address R108's diagnosis of PTSD.

2. Review of clinical record revealed R116 was admitted to the facility on [DATE] with a diagnosis of dementia with other behavioral disturbances and adjustment anxiety disorder.

Review of the Significant Change MDS assessment, dated 12/15/2023, revealed R116 had a documented BIMS score of 10, indicating moderate cognitive impairment. Section D revealed the resident reported feeling down and depressed for two - six days of the look back period. Section I revealed a diagnosis of dementia.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of R108's MD orders revealed an initial order for psych services on 6/6/2023, Seroquel (a medication used to treat mental health conditions) 23 milligrams (mg) by mouth daily at bedtime and Aricept (a medication used to treat symptoms of Alzheimer's disease) 10 mg by mouth daily at bedtime.

Review of the current care plan for R116 revealed there was no comprehensive plan of care developed to address R116's diagnosis of dementia.

Interview on 3/23/2024 at 8:32 am, Assistant MDS Coordinator (AMDS) revealed that she developed resident care plans by reviewing the resident's diagnoses and MDS assessments. She explained that staff discuss additional resident information during clinical meetings, and any changes to the care plans were added based on that information. During further interview, she stated that any behavioral or psych components of the care plan, including interventions, were handled by the Social Worker (SW). The AMDS did not know why there was no comprehensive care plan developed for R108 for PTSD. The AMDS acknowledged that R116 had no care plan for dementia and stated he did not know why one had not been developed.

Interview on 3/23/2024 at 8:41 am, Social Worker (SW) stated based the residents' psych notes and recommendations and other clinical information, she tailored the residents' care plan to reflect any interventions or special needs the residents might have based on their diagnoses and symptoms. She stated she did not know the reason why R108 had PTSD and stated she had not reviewed the 6/8/2023 mental health notes. She indicated that if she had reviewed the notes, she would have personalized R108's care plan to reflect her symptoms and interventions. During further interview she acknowledged that R116 had a diagnosis of dementia, and verified there was no care plan developed. She stated R116 should have had a care plan for dementia developed but could not answer why one was not developed and added that it may have been overlooked.

33548

3. Review of the facility policy titled Smoking Policy for Residents dated 9/1/2018, revealed the policy of the facility is to establish and maintain safe resident smoking policies in accordance with resident rights and preferences. Standards of Practice: Number 2. Residents who smoke will have a plan of care related to this activity.

Review of the clinical record revealed R126 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder, anxiety disorder, and convulsions. Further review revealed a smoking assessment was completed on 12/28/2023 indicating resident was safe to smoke and he signed a smoking contract on 12/29/2023 indicating that he understood the smoking policy and the rules.

Review of the current care plan revealed there was no care plan developed to address R126 smoking.

Interview on 3/23/2024 at 10:50 am, MDS Coordinator revealed that she is not responsible for developing and entering resident care plan for smoking. The MDS Coordinator stated that the activities department is responsible for developing resident care plans for smoking. The MDS coordinator confirmed that no smoking care plan had been developed for R126. The MDS Coordinator revealed that each department that is responsible for a certain section of the MDS assessment and there is no oversight to ensure all aspects of the residents care plan have been addressed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/23/2024 at 10:55 am, Activities Director (AD) revealed that the activities department is responsible for the development of care plans for residents who smoke. The AD confirmed that there was no care plan for R126 smoking, and stated it should have been, it was an oversite. Interview on 3/23/2024 at 12:35 pm, DON stated that she expects a care plan for smoking to have been developed for R126. The DON revealed that she expects each department to develop care plans for their assigned sections. During further interview, she indicated there is not a specific staff member to ensure all necessary areas are addressed in a resident care plan,

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on observations, record review, interviews, and review of the facility's Holiday Newsletter, policy titled Cleaning and Disinfecting Residents' Rooms, and the Material Safety Data Sheet (MSDS) for Rapid Multi Surface Disinfectant Cleaner, the facility failed to ensure the environment was free from potential accident hazards. Specifically, R2 had an electrical power strip lying in the bed with her, providing electrical to multiple devices. In addition, the facility failed to ensure a chemical spray bottle with cleaning solution was properly stored while not in use placing R82 at risk for exposure to the chemical. The sample size was 44. Findings include: Review of the facility's Holiday Newsletter Volume 5 Edition 12 dated December 2022, indicated extension cords are NEVER allowed in the facility. Extension cords are prohibited, except when used on a portable appliance, such as a vacuum cleaner. NFPA 70 440.8; IFC 605.4. Review of the policy titled Cleaning and Disinfecting Residents' Rooms reviewed November 2020 revealed General Guidelines: Number 3. Manufacturer's instructions will be followed for proper use of disinfecting products. c. Storage. Number 8. Use heavy-duty gloves (and other PPE as indicated) for housekeeping tasks. a. Gloves, protective eyewear and masks may be indicated to reduce exposure levels to disinfectant chemicals. Review of the MSDS for Rapid Multi Surface Disinfectant Cleaner revealed in Section 7. Handling and Storage - Advice on safe handling: Do not ingest. Do not get in eyes, on skin, or on clothing. Do not breathe dust/fume/gas/mist/vapors/spray. Use only with adequate ventilation. Wash hands thoroughly after handling. Conditions for safe storage: Keep away from strong bases. Keep out of reach of children. Store in suitable labeled containers. 1. Review of the clinical record revealed R2 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis (MS), hypertension, muscle weakness, pulmonary embolism (PE) without acute cor pulmonale, and chronic pain. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status Score (BIMS) of 14 indicating little or no cognitive impairment. Section GG indicated R2 was dependent on staff for transfers and mobility with functional limitations in range of motion with impairments on both sides of lower extremities. Observation on 3/22/2024 at 9:41 am and at 11:19 am, revealed an electrical power strip lying in the bed with R2. The power strip was plugged into a wall outlet and the red light was illuminated indicating the power strip had power. The power strip had 3 cords plugged into it. Observation on 3/23/2024 at 9:48 am, revealed R2 was lying in bed. An electrical power strip was lying in the bed and positioned at the top left side of the bed, with the red indicator light illuminated, indicating the power was on. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/23/2024 at 9:38 am, R2 informed surveyor that the power strip was placed on her bed approximately two weeks ago, and stated when it is on the floor, the cords plugged into the power strip come out and she was unable to use them. Interview on 3/23/2024 at 9:52 am, Certified Nursing Assistant (CNA) NN revealed she provided care for R2 on 3/22/2024 and today and was aware the electric power strip was on the bed. During further interview, CNA NN stated that she was aware the power stirp should not be on the bed due to the potential risk for fire. She stated she had entered a work order into the electronic system on 3/18/2024 but had not reported the issue to a supervisor. Review of the facility's electronic work order record dated 3/17/2024 through 3/22/2024 revealed no evidence of a work order for the maintenance department related to the power strip in use by R2. Interview on 3/23/2024 at 9:57 am, Assistant Director of Nursing (ADON) revealed during compliance rounds this morning, she assisted R2 her with her breakfast. She stated she did not notice the power strip in her bed at the time. During further interview, the ADON confirmed that the power strip should not be placed on R2's bed, and stated whoever knew it was there, should have removed it immediately. Interview on 3/23/2024 at 10:10 am, Director of Nursing (DON) revealed a resident should never have a power strip in the bed. She further stated the power strip should have been removed immediately and the supervisor informed. Interview on 3/23/2024 at 11:17 am, Assistant Maintenance Director MM revealed he checks the electronic maintenance system several times a day for repair issues needed in the facility. He stated he had not seen anything in the electronic system related to a power strip being used in a resident's room, until today. The Maintenance Assistant reviewed all work orders entered into the electronic system from 3/17/2024 through 3/22/2024 and verified a work order had not been previously entered into the system. 2. Review of clinical record revealed R82 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, chronic systolic congestive heart failure, chronic obstructive pulmonary disease (COPD), dementia with behavioral disturbances, and generalized anxiety disorder. Review of the Admission MDS assessment dated [DATE] revealed a BIMS of 12 indicating moderate cognitive impairment. Section GG revealed the resident is independent with ambulation. Observation on 3/23/2023 at 8:48 am in room C12, R82 was ambulating from the bathroom using a rolling walker. The surveyor observed an unlabeled spray bottle of cleaning solution sitting in front of the television. Certified Nursing Assistant (CNA) KK was observed to pick up the bottle of cleaning solution and place it behind the television. This action was verified by Licensed Practical Nurse (LPN) Unit Manager (UM) BB, who removed the cleaning solution from the room and stated it should not be there. Interview on 3/23/2024 at 8:59 am, CNA KK stated she should have removed the cleaning solution from the room. During continued interview, she stated she was aware that it was not supposed to be there, which was why she placed it behind the television when she saw a surveyor standing in the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/23/2024 at 10:22 am, Housekeeper LL stated she was asked to clean the sticky floor in room C12. She revealed she was rushing to clean the floor because the breakfast trays were on the unit to be delivered, and she knew she was not allowed to clean during meal service. She stated she was aware that cleaning solutions/chemicals should never be left in residents' room, and stated it was left there by mistake. During further interview, she identified the contents of the spray bottle cleaning solution as Rapid Multi-Surface Disinfectant Cleaner. Interview on 3/23/2024 at 10:43 am, Director of Environmental Services revealed the bottle of cleaning solution left in R82's room contained Rapid Multi-Surface Disinfectant Cleaner and verified it should not have been left in the room. She stated the housekeeping staff are trained to not put chemicals/cleaning solutions down in resident's rooms, but to return it to the cleaning cart immediately after each use. Interview on 3/23/2024 at 11:21 am, Administrator revealed that cleaning chemicals should never be left in a resident's room unattended. She stated the CNA was aware that the cleaning chemical should have been removed, and stated she became nervous when she saw a surveyor in the room. During further interview, the Administrator revealed residents should not have a power strip lying in the bed at any time. She stated the facility did not have a policy related to electrical power strips or a policy that addressed accidents and hazards. She provided a newsletter addressing extension cords, which was given to residents and their families.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47146 Based on record review and staff interviews, the facility failed to provide appropriate treatment and care for one resident (R) (R660) with a severe urinary tract infection (UTI). Abnormal urinalysis (UA) and culture and sensitivity (C&S) results were reported to the facility on [DATE] and the facility failed to seek medication for treatment. Actual Harm occurred on 12/16/2023 when R660 was admitted to the hospital for 11 days with a urinary tract infection and acute renal failure. The sample size was 44. Findings include: Review of the electronic medical record (EMR) revealed R660 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (MS), muscle weakness, and lack of coordination. She was discharged on [DATE]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed R660 was occasionally incontinent of urine and no urinary tract infections 30 days prior to the assessment. Review of the EMR revealed a Progress Note dated 12/9/2023 documented resident complained of painful urination and stating, I think my UTI has returned. Nurse Practitioner (NP) GG indicated her plan to obtain a urinalysis (UA) with culture and sensitivity (C/S) if indicated for dysuria (painful urination). Review of the EMR revealed a physician's order for urinalysis (UA) with culture and sensitivity (C/S) dated 12/10/2023. Medication order for telmisartan-hydrochlorothiazide (a diuretic medication used to treat high blood pressure) 40 milligrams (mg) one tablet by mouth two times a day for hypertension dated 12/6/2023. Review of EMR revealed the dietitian documented on 12/11/2023 that the diuretic medication telmisartan-hydrochlorothiazide may cause fluid shifts. Review of the December 2023 Physician Orders revealed an order dated 12/10/2023 for urinalysis (UA) with culture and sensitivity (C/S) if indicated. Review of the EMR revealed the UA was collected on 12/11/2023 with results returned to facility on 12/14/2023 as abnormal for 2+ blood, white blood cell (WBC) - too numerous to count (TNTC) with culture resulted as: Source - Urine, organism - greater than (>) 100,000 Klebsiella pneumoniae. Continued review revealed there was no evidence documenting that the facility staff informed the physician of the laboratory results nor any documentation of orders related for treatment of the UTI. Review of the December 2023 Weights and Vitals Summary documented R660's body temperature was trending upwards, beginning 12/13/2023 with temperature recorded as 100.9 degrees Fahrenheit (F), and 12/15/2023 temperature was recorded at 101.7 F. There was no recorded temperature for 12/14/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115643	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Post Acute and Rehabilitation	3000 Lenora Church Drive Snellville, GA 30078

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 0690

Level of Harm - Actual harm

Residents Affected - Few

Review of EMR revealed nursing note dated 12/16/2023 at 5:52 am, documented R660 was running a temperature of 101.7, gave Tylenol, at 5:40 am temperature was 101.4 and at 7:36 am, Physician/NP (MD/NP) called and awaiting return call.

Review of EMR revealed a Progress Note - Change of Condition documented on 12/16/2023 at 11:00 pm with the situation documented as evaluation - urinary continence (new or worsening). There was no provider response or feedback documented on the form.

Review of EMR revealed a Progress Note dated 12/17/2023 at 3:58 am documenting R660 was transferred to the hospital per her son's request.

Review of the hospital records with admitted [DATE] and discharge date of [DATE] documented the following:

*12/16/2023 - Chief Complaint: generalized weakness - family wanted resident transported to the emergency department (ED) for evaluation - she has had similar symptoms with UTI's in the past

*12/16/2023 - Vital signs: blood pressure 110/62, pulse 92, temperature 100.1 Fahrenheit (rectal)

*12/17/2023 - low-grade temperature - treated with antibiotics, attempts to straight cath resident as she was receiving IV fluids but unable to obtain urine, lab values revealed acute renal failure

*12/17/2023 - History & Physical - labs on 12/16/2023 - white blood cell count (WBC) was high (11.6), with relative neutrophils high (88.6) and absolute neutrophils high (10.3), sodium (Na) level was low (128), blood urea nitrogen (BUN) was high (80), and Creatinine was high (6.10). The plan of care (POC) was documented as empiric intravenous (IV) antimicrobial treatment in the emergency department (ED)

*12/17/2023 - Nephrology was consulted for acute kidney injury (AKI). Labs - Creatinine 6.1 improved to 4.9, WBC 12.56 (high), Na 130 (low), BUN 82 (high). The plan of care was to continue IV fluids and IV antibiotics, monitor renal function and urine output daily.

*12/20/2023 - Nephrology progress note revealed the AKI likely secondary to hypovolemia and UTI. The assessment and plan documented - sepsis UTI - patient currently on Rocephin, urine culture growing gram negative rods and positive for klebsiella pneumonia, needs an appointment as an outpatient with Nephrology.

*12/27/2023 - Discharge summary - resident was admitted to the hospital on 12/16/2023 at 9:27 pm and was discharged on [DATE]. Brief Hospital Course documented care was managed for Sepsis - UTI. The principal discharge diagnosis was acute renal failure. The physician documented R660 was currently on Rocephin, had a temperature max of 102.7 F, and urine culture was positive for klebsiella pneumonia.

Interview on 3/23/2024 at 3:16 pm, the DON confirmed documentation that R660 stated she had painful urination and thought her UTI was back and that a urine specimen was collected on 12/11/2023 for the UA and C&S ordered by NP GG. During further interview, she verified the results from the UA and C&S were reported to facility on 12/14/2023. She verified R660 was sent to the hospital on 12/16/2023 for change in condition related to elevated body temperature.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115643	A. Building B. Wing	03/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Post Acute and Rehabilitation	3000 Lenora Church Drive Snellville, GA 30078

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 0690 Level of Harm - Actual harm Residents Affected - Few	Interview on 3/24/2024 at 11:55 am, NP GG revealed if the facility notified her of R660's abnormal UA & C/S results from 12/14/2023, she would have given the nurse orders for treatment. She stated she would expect the nursing staff to relay their nursing assessment at the time of the phone call and if there was anything going on such as elevated temperature, she would have sent the resident to the emergency room for treatment to prevent any delay in treatment. Cross Refer F580