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	08/07/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff and resident interviews, record review, and review of the facility's policies titled, Food Storage: Cold Foods and Labeling and Dating, the facility failed to ensure frozen food wrappers were intact and that food items were not expired. This deficient practice had the potential to cause cross contamination of unwrapped meat and foodborne illness affecting 135 of 142 residents receiving meals prepared in the kitchen.Findings include:Review of the facility's policy titled Food Storage: Cold Foods revised February 2023 revealed under Procedures: .5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.Review of the undated facility policy titled Labeling and Dating revealed under Importance of Labeling and Dating: Proper labeling and dating ensures that all foods are stored, rotated, and utilized in a First In First Out (FIFO) manner. This will minimize waste and ensure that items that are passed their due date are discarded. Under Guidelines for Labeling and Dating: Direct food labels must include the food item name, date of preparation, receipt, removal from freezer and use by date. Under Use By Dating Guidelines revealed: The manufacture's expiration date, when available, is the use by for unopened items.Observation made on 8/4/2025 at 10:00 am in the dry food pantry revealed a case of name of product mustard was identified with an expiration date of 7/30/2025. Also identified was double baking powder with an expiration date of 5/29/2025. The following seasonings/spices located on a shelf outside the pantry had illegible labels on the ground nutmeg, dill weed, and ground ginger. Expiration dates could not be identified. One bottle of apple cider vinegar with a use by date written on it of 7/8/2025 was observed.An interview with the Kitchen Manager on 8/4/2025 at 10:45 am confirmed there were spices and seasonings in the food preparation area that were expired or did not have an expiration date that was legible on the packaging. In the dry pantry, there was a case of mustard that had an expiration date of 7/30/2025. There were also packages of double acting baking powder that had an expiration date of 5/29/2025. The Kitchen Manager confirmed the dates of all expired and illegibly labeled items. Also, the Kitchen Manager confirmed there was an open box of meat in the freezer that was not closed/sealed properly. The Kitchen Manager stated expectations were for expired foods to be thrown out as soon as possible and expiration dates were checked daily, ensuring there were no out of date foods and opened items were closed/sealed properly.An interview on 8/4/2025 at 10:04 am with the Dietary District Manager confirmed the list of expired items that were identified, as well as the items that did not properly display expirations dates. Stated expectations were for staff to ensure that items are disposed of once expiration dates have passed and to ensure that items received into the kitchen were properly dated and stored. All staff were expected to check dates on food items regularly.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, staff interviews, and review of the facility's policy titled, Heating, Ventilation, and Air Conditioning (HVAC), (Packaged Terminal Air Conditioner (PTAC)): Clean Air Filters, the facility failed to maintain a clean, homelike environment by not ensuring that the PTAC unit filters were free of debris in 2 of 48 rooms (A9, A8 located in A Hall) and failed to ensure PTAC unit grills were free of debris in 1 of 48 rooms (A8 located in A Hall) . The deficient practice had the potential to affect resident comfort, air quality, and infection control.Findings include: Review of the facility policy titled, Heating, Ventilation, and Air Conditioning (HVAC), (Packaged Terminal Air Conditioner (PTAC)): Clean Air Filters”, documented under section titled, Steps, 1. Remove or open access cover. 2. Remove air filter and inspect for cleanliness. If filter is dirty, either wash or replace depending on type of filter. If clean, reinstall filter. 3. Re-install access cover. 4. Clean grill on cover. 5. Close and make sure it is secure. 6. At a minimum, air filters are to be replaced or thoroughly cleaned depending on type of filter every three months. Observation on 8/4/2025 at 11:36 am and 8/25/2025 at 2:03 pm in Room A9 revealed gray, fuzzy debris on the PTAC filters. Observation on 8/4/2025 at 11:23 am and 8/5/2025 at 2:02 pm in Room A8 revealed gray, fuzzy debris on the PTAC filters and additional debris on the unit’s grill. Interview and observation on 8/7/2025 at 10:30 a.m. with the Maintenance Director (MD) revealed he is solely responsible for the inspection, cleaning, and upkeep of all PTAC units throughout the facility. He confirmed that the PTAC filters in Room A9 contained gray, fuzzy debris and that the PTAC filters and grill in Room A8 also contained debris. He emphasized that proper PTAC maintenance was critical for resident comfort, air quality, and infection control. He stated his expectation is that all PTAC units remain clean, fully functional, and resident-ready at all times, with routine cleaning and inspections conducted on a schedule. Interview on 8/7/2025 at 11:41 am with the Administrator revealed PTAC filters were to be cleaned monthly and whenever a resident was admitted or discharged . She stated that a possible negative outcome of unclean filters was compromised air quality, which could affect residents with respiratory issues in a healthcare setting. During an interview and observation on 8/7/2025 at 12:55 pm with the MD, he outlined the current efforts and plans in place to address ongoing facility repair needs and environmental improvements. Any unit reported to be malfunctioning or excessively dirty was addressed immediately.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, staff interviews, record review and review of facility's policy titled, Water Temperature Policy, the facility failed to keep the residents free of accident hazards as evidenced by water temperatures above 110 degrees Fahrenheit (F) in 8 of 138 resident rooms (A2, A4, E31, E19, E16, E3, B10 and B12 located in A, B, and E Halls) and in 1 of 3 showers (B Hall). The deficient practice had the potential to cause injury to residents residing in these rooms.Findings include: Review of the facility provided document titled Water Temperature Policy revealed under Policy Statement: Hot water temperature at all resident-use fixtures shall not exceed 110- degrees Fahrenheit per Georgia Administrative Code Rule 111-8-56.18. Physical Plant Standards. Review of the facility's TELS system (maintenance reporting system) and water temperature logs from 1/27/2025 to 8/4/2025 revealed temperatures consistently ranging from 107 degrees F to 108 degrees F in most areas, with the kitchen water temperature recorded at 120 degrees F. Review of resident skin assessments and shower documentation dated 8/4/2025 revealed no evidence of burns or skin injuries related to hot water exposure. Observations on 8/4/2025 from 11:58 am to 12:04 pm of water temperature checks in resident shared bathrooms revealed the following readings exceeding the 110 degree F threshold: Rooms A13 and A15 at 114.9 F, Rooms A12 and A10 at 118.6 degrees F. Interview on 8/4/2025 at 2:53 pm with the Maintenance Director (MD) revealed he had been employed at the facility for five years and checked water temperatures daily. He stated water temperatures were supposed to be below 110 degrees F and typically range between 107 degrees F and 111 degrees F. He reported new hot water boilers were installed last year, replacing 10 older units, after residents complained of cold water. He stated water temperatures tend to be cooler in rooms farther from the water tanks. Observations on 8/4/2025 from 2:54 pm to 3:04 pm with the MD of water temperature checks in resident shared bathrooms revealed the following readings exceeding the 110 degrees F threshold: Rooms A2 and A4: 114 degrees F. The MD stated the water temperatures were going to be corrected immediately and the Administrator was made aware. Follow-up observations on 8/4/2025 at 5:40 pm conducted with the MD and Administrator showed corrected water temperature readings as follows: Rooms A2 and A4, 106 degrees F. Additional observations on 8/4/2025 from 6:37 pm to 6:41 pm conducted with the MD and Administrator revealed the following corrected water temperature readings: Room E3,106.3 degrees F; Room E19,103.0 degrees F; Room E31, 103.3 degrees F. Interview on 8/7/2025 at 11:41 am with the Administrator confirmed that water temperatures were expected to be maintained at or below 110 degrees F and that a possible negative outcome of noncompliance was that residents could be burned.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled, Infection Prevention and Control Program, the facility failed to maintain appropriate infection control practices by not using sterile procedure during tracheostomy care for one of 60 sampled residents (R) (R120), not storing respiratory equipment in an approved container for two of 60 sampled R's (R2 and R5), not protecting shared medical supplies from contamination during wound care for one of 60 sampled R's (R10), by storing personal items on clean linen carts, and by staff not adhering to contact precautions by entering a room with a sign for contact precautions without proper PPE (personal protective equipment). The deficient practices had the potential to contribute to the transmission of infectious organisms among residents, staff, and visitors.Findings include: A review of the facility's policy titled Infection Prevention and Control Program, dated June 2025 revealed under Policy Statement: Facility’s infection prevention and control policies/practices are intended to facilitate in maintaining a safe, sanitary, and comfortable environment and to prevent and manage transmissions of disease and infections. Under Standards of Practice: 1. The objectives of our infection control policies and practices are to: Prevent, detect, investigate, and control infections in the facility. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. Establish guidelines for the availability and accessibility of supplies and equipment necessary for standard precautions. Maintain records of incidents and corrective actions related to infections. Provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment. Under PRECAUTION GUIDELINES…Use disposable or dedicated patient-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient. Review of the facility’s policy titled “Tracheostomy Care” revised 4/5/2024 revealed under Policy Statement: revealed under Purpose: Residents who have a tracheostomy will have trach care done as ordered by a physician or as needed to keep the airway clean and unobstructed. Under Procedure Guidelines: Clean The Removable Inner Cannula: … 2. Put on sterile gloves. 3. Set up supplies on a sterile field. … 9. Keep one hand sterile and one hand dirty. 1. Review of the electronic medical record (EMR) revealed resident R120 was admitted to the facility with pertinent diagnoses including but not limited to chronic respiratory failure with hypoxia (low oxygen levels in the blood), and hemiplegia and hemiparalysis following cerebral vascular accident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R120’s five-day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated R120 was identified having severe cognitive impairment. Section GG, Functional Status, revealed R120 required extensive assistance for activities of daily living (ADLs) with one/two or more-person assistance. Section O, Special Treatments, Procedures, and Programs, revealed R120 receives continuous oxygen via tracheostomy. Review of R120 care plan dated 6/24/2025 indicated a problem of has a tracheostomy. Goals included but not limited to no signs and symptoms of infection through the review date. Interventions included but not limited to give humidified oxygen as prescribed, suction as necessary, use universal precautions. assist with coughing as needed. Review of the “Physician’s Orders” for R120 included but was not limited to: Order dated 7/9/2025 for Tracheostomy care every shift and prn using aseptic technique. Remove the inner cannula, clean with half strength H2O2 (peroxide) and sterile H20 (water), dry with sterile gauze and cotton swab. Re-insert the inner cannula, turn to lock. Clean outer cannula/stoma with sterile H20, rinse with sterile H20, pat dry with sterile gauze. May use split sterile gauze PRN (as needed). Observation on 8/6/2025 at 8:19 am Respiratory Therapist (RT) SS donned (put on) non-sterile exam gloves, opened sterile suction catheter and proceeded to suction R120’s tracheostomy. Interview on 8/6/2025 at 8:21 am with RT SS confirmed suctioning was a sterile procedure and sterile gloves should have been worn. RT SS also shared that the suction valve was only held while removing the suction catheter and R120 was suctioned about every three hours. An interview with the Director of Nurses on 8/7/2025 at 2:00 pm revealed using non-sterile exam gloves during suctioning of a trach was an unacceptable practice. 2. Review of R10’s quarterly MDS assessment dated [DATE] revealed a BIMS score of 10, indicating moderate cognitive decline, Section I, Active Diagnoses, revealed pertinent diagnoses including but not limited hypertension, renal insufficiency, and depression. Immediately after wound care observation on 8/6/2025 at 10:16 am on R10, RN GG placed the hand sanitizer back into the plastic bag without sanitizing the outside of the bottle or the clear plastic bag, transported the clear plastic bag into the hallway and placed the clear plastic bag onto the wound care dressing cart located in the hallway outside of the resident's room door. RN GG verbalized that her plan was to bring it out of the room and clean it with bleach wipe. 3. Review of R2’s quarterly MDS assessment dated [DATE] revealed a BIMS score of 0, indicating R2 was not able to complete, Section I, Active Diagnoses, revealed pertinent diagnoses including but not limited to heart failure, hypertension, non-Alzheimer’s dementia, and respiratory failure. Review of R5’s quarterly MDS assessment dated [DATE] revealed a BIMS score of 5, indicating severe cognitive decline, Section I, Active Diagnoses, revealed pertinent diagnoses including but not limited to hypertension, diabetes mellitus, and cerebral vascular accident (CVA). Observation on 8/4/2025 and 8/5/2025 revealed R2’s CPAP (continuous positive airway pressure) mask stored inside a cluttered nightstand drawer with miscellaneous personal items, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	including papers, coins, and loose debris. The mask was not in a clean, dry, dust-free container as per manufacturer guidelines and facility policy. Observation on 8/4/2025 and 8/5/2025 revealed R5’s CPAP mask placed on the seat of a bedside chair without protective covering. The surface contained visible dust and lint. Interview on 8/6/2025 at 3:45 pm with DON confirmed that CPAP masks should be stored in a clean, dry, dust-free container or designated storage bag to prevent contamination. The DON acknowledged the observed storage methods did not meet facility expectations. 4. Observation on 8/5/2025 at 12:43 pm revealed a linen cart containing a personal staff cell phone. Interview with laundry aide MM on 8/5/2025 at 12:43 pm confirmed that only linens should be stored inside the linen cart. However, she acknowledged storing her personal cell phone inside the cart, stating it was so her supervisor could reach her if needed. Interview with Certified Nursing Assistant (CNA) EE on 8/5/2025 at 12:48 pm revealed that she was not aware of any policy restricting items other than linen inside the linen carts and had not received any training specific to linen cart contents. Interview with LPN KK on 8/5/2025 at 12:56 pm revealed that she was unsure about any linen policy and stated that when deciding what items could be stored in the linen cart, “it depends on where it came from.” 5. Observation on 8/6/25 at 12:26 pm revealed Licensed Practical Nurse (LPN) BB enter room C6-P, which had signage for Contact Precautions related to Pneumonia- Methicillin-Resistant Staphylococcus aureus (MRSA), wearing only gloves and no gown, in violation of the facility's infection control expectations and signage instructions. Interview with LPN BB on 8/6/2025 at 12:30 pm confirmed she entered the isolation room without donning (putting on) a gown and acknowledged failure to follow Contact Precautions and further recognized the importance of PPE use and acknowledged the potential for spreading infection. Interview with Staff Development Coordinator (SDC) on 8/5/2025 at 2:46 pm and on 8/6/2025 at 5:20 pm revealed that she had not provided any training to staff on proper linen cart use and contents. Additionally, confirmed that for isolation precautions, staff should wear gowns, gloves, and goggles. Interview with Director of Nursing (DON) on 8/5/2025 at 3:20 pm and on 8/6/2025 at 5:05 pm confirmed that staff were expected to wear gown and gloves when entering Contact Precaution rooms and stated that the SDC is responsible for training clinical staff while the Director of Environmental Services trained laundry aides on clean linen carts. Additionally, they do not have a clean linen cart policy.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policy titled, Preadmission Screening and Annual Resident Review (PASARR) Policy, the facility failed to obtain a level II PASARR screening for one of 60 sampled residents (R) (R41). The deficient practice had the potential to prevent R41 of achieving the highest practicable mental, physical, and psychosocial well-being.Findings include:Review of the facility's policy titled Preadmission Screening and Annual Resident Review (PASARR) Policy revised 5/15/2025 revealed in the section titled Policy Statement: It is the policy of this facility to screen all potential admissions on an individualized basis. As part of the preadmission process, this facility participates in the Preadmission Screening and Resident Review (PASARR) screening process (Level ll (follow your state recommended guidelines or specific state criteria for PASARR) for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. Based upon the Level I screen, the facility will not admit an individual with a mental disorder or intellectual disability until the Level ll screening process has been completed and the recommendations allow for a nursing facility admission and the facility's ability to provide the specialized services determined in the Level I screen. Annually and with any significant change of status, the facility will complete the PASARR Level I screen for those individuals identified per the Level ll screen requiring specialized services. The facility will report any changes as identified via the screen to the state mental health authority or state intellectual disability authority promptly.Review of the electronic medical record (EMR) for R41 revealed she was admitted to the facility with diagnoses that included, but were not limited to, chronic kidney disease, stage 3; dementia with behavioral disturbance; generalized anxiety disorder; major depressive disorder, recurrent moderate; delusional disorder; auditory hallucinations and cognitive communication deficit.Review of R41's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicates severe cognitive impairment. Section E, Behaviors, revealed physical and verbal behavioral symptoms directed towards others occurred 1-3 days per week and wandering was noted. Section GG, Functional Abilities and Goals, revealed functional limitations including substantial/maximal assistance with toileting, dependent with bathing and dressing, and setup or supervision for eating. Section I confirmed the primary condition as dementia with behavioral disturbance.Review of R41's care plan dated 6/4/2025 included the following focus areas: R41 has a diagnosis of delusional disorder. R41has impaired cognitive function related to dementia with behavioral disturbances. R41is a part of the Adventure Group due to elopement risk related to wandering aimlessly due to dementia. R41has demonstrated physical and verbal behaviors towards staff when trying to assist with Activities of Daily Living (ADL) care related to dementia, including: 5/18/2025 - Resident was kicking another resident on the leg. 10/1/2024 - Resident grabbed another resident's wheelchair. 10/1/2024 - Resident hit another resident on her ear while in the dining room.10/1/2024 - Resident noted arguing with another resident in hallway. 8/22/2024 - Resident hit another resident on the leg when asked to leave the resident's room. 1/16/2024 - Resident demonstrated physical aggressive behaviors by trying to kick staff when trying to redirect. Interventions in the care plan included reality orientation, psych consults, supervision for ADL tasks, safety interventions to prevent falls, and maintaining dignity and privacy during personal care.Interview on 8/6/2025 at 11:50 a.m. with Social Worker (SW) VV revealed when residents were admitted , their diagnoses were reviewed to determine if a PASARR Level 2 was required. For residents with mental health diagnoses, a Level 2 was initiated if they were expected to stay long-term but not for short-term residents unless they knew they were expected to stay long term. SW VV stated diagnoses such as generalized anxiety disorder, developmental disabilities, paranoia, or suicidal ideation may trigger Level 2. SW VV verified that Level 2 PASARR had not been completed for R41, only Level 1. She verified and provided a copy of a Level 1 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	application that was resubmitted on 3/25/2025. She explained that when the resident initially came in, a different social worker handled the case, and a Level 2 PASSARR should have been submitted. SW VV stated the resident transferred to long-term care on 2/1/2024 and she was currently auditing records to ensure all eligible residents have PASARR Level 2 submitted. SW VV noted a potential negative outcome from not obtaining a Level 2 PASARR would be missing specialized care, such as psychotherapy.Interview on 8/7/2025 at 10:52 am with the MDS Director (MDSD) revealed R41's primary diagnosis was chronic kidney disease, stage 3 effective on 11/2/2024, and secondary diagnosis of dementia with behavioral disturbance effective 11/2/2023. The MDSD further confirmed anxiety, depression, and delusional disorders were also noted and confirmed they were considered mental health diagnoses.Interview on 8/7/2025 at 11:15 am with the Director of Nursing (DON) confirmed that all residents meeting eligibility criteria based on mental health or intellectual disability diagnoses should have a Level II PASARR submitted immediately, regardless of short-term or long-term status. The DON confirmed that R41 met criteria and should have had a Level II PASARR.Interview on 8/7/2025 at 11:41 am with the Administrator confirmed that PASARR screenings must follow federal regulations and should be initiated for eligible residents regardless of the expected length of stay.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, and review of the facility policy titled, Administration of Medications, the facility failed to follow physician orders for two of 60 sampled residents (R). Specifically, the facility failed to follow physician orders related to colostomy care for R90 and administration of medications for R122. The deficient practice had the potential to compromise the residents' health and safety.Findings include: Review of the facility policy titled Administration of Medications dated June 2025 documented under Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Under section Procedure: .3. Medications must be administered in accordance with the orders, including any required time frame. 1. Review of R90's electronic medical record (EMR) revealed he was admitted to the facility with diagnoses including but not limited to hypertensive heart disease with heart failure, acute systolic (congestive) heart failure, need for assistance with personal care, dysphagia (swallowing problems), and colostomy status. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for R90 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicated intact cognition. Section GG, Functional Abilities and Goals, revealed resident is dependent on staff for toileting and personal hygiene. On 8/4/2025 at 10:40 am during initial interview with R90, she stated that her colostomy bag had not been changed or emptied for five days. R90 displayed the colostomy bag which appeared to be full of bowel but not distended. She continued that the nursing staff did not change the bag routinely and only changed it when it began leaking. Review of physician's orders for R90 revealed the physician's orders stated, Clean around ostomy with soap and water every shift for maintenance, added 7/8/2025 at 19:00. Review of Treatment Administration Record (TAR) for July 2025 showed gaps in colostomy care July 12025, through July 8, 2025; and July 24, 2025 and July 25, 2025. An interview with Certified Nursing Assistant (CNA) AA on 8/7/2025 at 2:05 pm further confirmed that CNAs were instructed to empty colostomy bags and clean up any leakage but were not authorized to remove bags or cleanse the stoma. ^ CNA AA stated her understanding that physician orders require stoma cleaning by nursing staff each shift. ^ An interview on 8/6/2025 at 2:30 pm with LPN BB revealed that the stoma for R90 was not being cleaned daily with soap and water as ordered by the physician. ^ LPN BB stated that the CNA observed the site and bag during morning dressing and notified her if cleaning or changes were needed. ^ She continued that she checked off the CNA observation as a cleaning if nothing needed or if there was no leak or issue with the bag. On 8/6/2025 at 2:35 pm, LPN BB had marked the cleaning as complete for the day but stated she did not perform a cleaning of the stoma. Physician orders require nursing staff to clean the stoma each shift. Interview on 8/7/2025 at 1:50 pm with the Director of Nursing (DON) confirmed that nursing staff were responsible for cleaning the stoma with soap and water every shift. ^ It was noted that LPN BB (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	marked the task as completed on 8/6/2025 but later admitted that the cleaning was performed by the CNA, which was inconsistent with facility policy and physician orders. ^ The DON clarified that CNAs were only permitted to empty colostomy bags and report measurements, while stoma cleaning and bag replacement were nursing responsibilities. ^ 2. Review of R122's EMR revealed he was admitted to the facility with diagnoses including but not limited to cellulitis of right lower limb, muscle weakness, need for assistance with personal care, and adhesive capsulitis of right and left shoulder. Review of R122's quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 14, which indicates R122 was cognitively intact. Review of R122's care plan initiated 2/10/2025 indicated a focus of the resident having the potential for pain related to cellulitis of the right lower extremity (RLE), impaired mobility, capsulitis of the left and right shoulders. Interventions included but were not limited to administer analgesic per physician (MD) orders. Review of R122's Physician's Orders included but was not limited to an order dated 1/24/2025 for tramadol HCl oral tablet 60 milligrams (mg) give one tablet by mouth every eight hours as needed for pain. Review of R122's 8/2025 medication administration record (MAR) printed on 8/7/2025 revealed that on 8/4/2025, tramadol was documented as administered at 1814 (6:14 pm) and 2148 (9:48 pm). During an interview on 8/6/2025 at 2:28 pm with R122, when asked if he was given two doses of tramadol, R122 stated that he told a CNA that he was in pain so the CNA went to a nurse different from who had already administered his tramadol, and that nurse came to his room to offer it. He stated that he told the nurse to take it back and confirmed he only had the first dose. During an interview on 8/7/2025 at 11:50 am, Licensed Practical Nurse (LPN) TT confirmed the documentation of two doses of tramadol on 8/4/2025 and confirmed that the second dose was not administered in the appropriate time window. She stated that if it was an error, the nurse would have had to cross it off in the narcotic book as an error and if the resident didn't take it, then it should have been destroyed and there should be evidence of it being destroyed on the comments section of the narcotics sheet. She confirmed that the tramadol was signed out on the narcotic sign out sheet but was not marked as an error. When asked if the nurse should have attempted to administer the second tramadol at that time, she stated that if it was not according to the 8-hour window, then no. She further stated that she did not know why the nurse offered it at that time, but according to the times documented in the system, she should not have. When asked what could be a potential negative outcome if the resident had taken the second dose, she stated that the resident could have gotten sick or overdose. In an interview on 8/7/2025 at 3:00 pm, the Director of Nursing (DON) stated that she expected nursing staff to follow physician orders. She confirmed from the MAR that the as needed (PRN) tramadol was administered at 1848 and 2148 based on the documentation. She stated that the second nurse could only have administered the dose if there was an additional doctor order. Without the order, that would not have been appropriate to administer it in that time window. If it was an error, the nurse should have gotten another nurse to waste it with her and it would have been documented on the narcotic sheet as wasted. The DON further stated that a potential negative outcome could be a possibility of overdose.

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F 0690 Level of Harm - Minimal harm or potential for 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** Based on observations, staff and resident interviews, record review, and review of facility policies titled Urinary Catheter Care, Anchoring and Changing, the facility failed to provide proper catheter care and positioning for one of 16 residents (R) (R71). Specifically, staff failed to provide correct cleaning and failed to ensure the catheter drainage bag was properly positioned. The deficient practice had the potential to cause pain, trauma to the urethra, catheter-associated urinary tract infections (CAUTIs), and impaired drainage.Findings include:Review of the facility policy titled Urinary Catheter Care, Anchoring and Changing revised March 2024 revealed under section 10: .10. For the male resident, .cleanse the meatus outward., and section 16 revealed: .16. Secure foley catheter drainage bag below level of bladder and above the floor. Catheter drainage bags will be covered when residents are in a public area.Review of the electronic medical record (EMR) revealed R71 was admitted to the facility with pertinent diagnoses including but were not limited to benign prostatic hyperplasia (BPH), type 1 diabetes mellitus, stage 3 chronic kidney disease, atrial fibrillation, hypertension, chronic obstructive pulmonary disease (COPD), and anemia.Review of R71's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Section GG, Functional Abilities and Goals, indicated that R71 was dependent requiring Substantial/Max Assistance.Review of R71's care plan dated 7/9/2025 included a problem of foley catheter use related to BPH (benign prostatic hyperplasia), with goals to prevent Urinary Tract Infection (UTI) and maintain comfort. Interventions included: provide catheter care per protocol, monitor for signs of infection, and ensure drainage bag is below level of bladder.Review of Physician Orders included but were not limited to:Order dated 6/29/2025 for Foley catheter monthly change due to BPH.Order dated 4/9/2025 for Catheter care and output every shift.Order dated 8/7/2025 for Urinalysis (UA) with culture for hematuria.Order dated 2/17/2025 for Enhanced Barrier Precautions (EBP).Review of nursing notes dated 8/3/2025 revealed R71 was transferred to the local hospital after bleeding was observed in the foley catheter. The note documented the catheter had been changed the previous day, the Nurse Practitioner (NP) was notified and gave the order to send the resident to the hospital for further evaluation. A follow-up nursing note on 8/4/2025 documented R71 returned from the hospital.Observation on 8/5/2025 at 2:57 pm with Certified Nursing Assistant (CNA) LL and CNA NN revealed staff performed catheter care for R71. During care, CNA LL supported the penis at the corona, not the meatus, as required for best practice. The catheter tubing was taut and not detached from the bed. When the resident was turned for peri care, the catheter pulled taut, and CNA NN was asked to unhook it by CNA LL, indicating it was not managed properly. Blood was visible in the catheter tubing during this observation.Interview on 8/5/2025 at 3:17 pm with CNA LL revealed she believed she had supported the catheter at the meatus and stated that she did notice the blood in the catheter tubing and collection bag.Interview on 8/5/2025 at 3:00 pm with Licensed Practical Nurse (LPN) JJ reported that the catheter bleeding may have been caused by improper handling of the catheter tugging during transfers or care. He stated he had flushed the catheter and notified the physician.Observation and interview on 8/6/2025 at 1:35 pm with R71 revealed the catheter drainage bag was not visible on either side of the bed. When questioned, LPN JJ discovered the catheter bag was under the resident, who had recently been transferred from his wheelchair to the bed. The resident complained of pain and discomfort. LPN JJ removed R71's pants, retrieved the catheter bag, hung it beside the bed, and returned the call light to the resident as it was found out of reach on the floor.Interview on 8/6/2025 at 1:50 pm with CNAs QQ and RR, who performed the transfer, confirmed the resident had been left with the catheter under him and pants around his knees under the covers. CNA RR stated it was CNA QQ's responsibility to hang the catheter. CNA QQ provided no rationale for the improper catheter positioning.Interview on (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/6/2025 at 5:20 pm with the Staff Development Coordinator (SDC) revealed that staff were trained to transfer a resident with a urinary Foley catheter by securing the catheter and drainage bag to the resident during the transfer to prevent pulling and kinking of the tubing. Once the resident was positioned in bed, the drainage bag should be secured to the bed and kept below the level of the resident. She further explained that when providing catheter care for a male resident, staff were instructed to hold the shaft of the penis with one hand while using the other hand containing a washcloth to clean outward along the catheter tubing. She provided the facility's catheter care policy, but it did not specify where to hold the catheter during care. Based on this, she trained staff to hold the shaft of the penis, as the policy lacks direction on catheter stabilization. When asked whether this method reflected best practice and ensured resident safety, particularly considering the potential for trauma due to a lack of support at the meatus, the SCD acknowledged that this was not best practice and agreed that not supporting the catheter at the meatus could cause trauma to the resident.Interview on 8/6/2025 at 5:05 pm with the Director of Nursing (DON) confirmed that staff were expected to hook Foley catheter drainage bags below the level of the bed. She further explained that during catheter care for a male, staff should use one hand to hold the tip of the penis and, with the other hand, wrap a towel and cleanse downward along the catheter. When asked whether this technique aligns with best nursing practice and whether it was safe in terms of preventing potential trauma, specifically, whether or not supporting the catheter at the meatus could lead to pulling or injury. The DON reviewed the facility's policy. She stated that the policy did not address holding the catheter at the meatus during care.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility policy titled, Oxygen Therapy Policy, the facility failed to obtain a physician's order for oxygen (O2) for one of 12 residents (R) (R165) and failed to ensure that O2 was administered as ordered for one of 12 Rs (R120) who use O2. This deficient practice had the potential to cause respiratory complications and inadequate oxygenation.Findings include: Review of the policy titled Oxygen Therapy Policy revised 4/1/2025 revealed under Standard of Practice: 1. Oxygen therapy is to be used with a written order by a physician. 1. Review of the electronic medical record (EMR) revealed R165 was admitted to the facility with diagnoses including but not limited to malignant neoplasm of the glottis, tracheostomy, chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD). There was no completed Minimum Data Set (MDS) assessment for R165 at time of survey. The care plan for R165 did not include any problem statements regarding respiratory, tracheostomy care, or O2 needs. Review of the Physician's Orders for R165 included but was not limited to: Order dated for 8/4/2025 documented OXYGEN 2 LITERS/28% TRACH COLLAR RT MAY TITRATE TO KEEP O2 SATS GREATER THAN 88%-92%. Observation and interview on 8/4/2025 at 12:50 pm revealed R165 was lying in bed in an approximately 45 degree angle. R165 was alert and oriented, receiving O2 via tracheostomy. R165 was unable to clearly verbally communicate, she was able to understand and write to communicate. The O2 concentrator was set at 3.5 liters per minute (LPM) with humidifier, filter had a small amount of debris. R165 did not know what her O2 level should be set to on the machine. R165 indicated (by writing) that she had been in the facility since 7/22/2025. Observation of R165 on 8/5/2025 at 1:00 pm revealed her sitting up in bed eating from a lunch tray. She gave a thumbs up when asked how she was doing today. The O2 concentrator was observed to be set on 2 LPM. Observation of R165 on 8/6/2025 revealed her sitting in her wheelchair by her bed eating lunch, smiling and did not appear to be in distress. The O2 was set to 2 LPM. Observation of R165 on 8/7/2025 revealed her sitting up in her bed watching TV and eating. She indicated with a thumbs up that she was doing well. When asked if she had any issues or concerns, she shook her head no. O2 was set to 2 LPM. Interview on 8/4/2025 at 3:32 pm with Licensed Practical Nurse Unit Manager (LPN UM) II revealed she was notified by one of the Respiratory Therapists (RT) HH that R165 had no order for her O2. EMR review with LPN UM II confirmed R165 was admitted on [DATE] and had been on O2 since admission and an initial RT note was documented on 7/24/2025. LPN UM II further reviewed the nursing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission note which stated O2 on at 3 liters per minute (l/m) with no order and no notation of R165 have a tracheostomy. LPN UM II stated clinical staff made O2 rounds every Monday and between nursing and respiratory staff should be monitoring and ensuring orders were present, and if not, action should be taken immediately to contact her or the provider directly for assistance and orders. Interview on 8/4/2025 at 3:42 with RT HH revealed he rounded on R165 this morning and her oxygen was on by way of trach collar at 2 LPM. RT HH also shared he was not surprised upon observation that O2 flow was at 3.5 LPM. RT HH revealed upon receiving order, he did adjust her O2 flow to 2 LPM. RT HH further shared respiratory therapy was on site from 7:00 am to 7:00 pm every day and after-hours nurses were responsible for monitoring and care of tracheostomy residents. Interview with the Director of Nursing (DON) on 8/7/2025 at 1:57 pm revealed that any resident that came into the facility with a tracheostomy was assessed by the respiratory therapist (RT). RT initially set up the resident's room and initially assessed the resident as that was one of their main responsibilities. Orders for O2 were checked the next day at the morning meeting with department leadership to ensure they were in place and accurate. O2 was monitored by nursing and RT. The DON stated that her expectation was that O2 orders were in place for residents that required them and not having an order for O2would mean they were administering it without orders, which should not be done. The DON was informed that R165 had been admitted on [DATE] and did not have any O2 order in the medical record until 8/4/2025, which she stated should not be the case since those orders should be in the chart and accurate. Additionally, the resident's O2 was initially observed to be on 3.5 LPM and later the order in the EMR was for 2 LPM. The DON stated that orders in the EMR should be followed as written. 2. Review of the electronic medical record (EMR) revealed R120 was admitted to the facility with diagnoses including but not limited to chronic respiratory failure with hypoxia (tracheostomy in place), congestive heart failure, paroxysmal atrial fibrillation, hemiplegia following cerebral infarction, moderate malnutrition, pressure ulcers, generalized muscle weakness, dysphagia with gastrostomy tube, and advanced dementia without behavioral disturbances. Review of R120's 5-Day MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment and section GG, Functional Abilities, indicated that R120 required total assistance with all activities of daily living (ADLs). Review of the Physician's Orders for R120 included but was not limited to: Order dated 8/5/2025 for Oxygen 5L (liters) via trach (tracheostomy) collar with instructions that respiratory therapy may titrate to maintain oxygen saturation above 92% (percent); frequency noted as every shift for shortness of breath (SOB). Order dated 6/24/2025 for Humidified oxygen at 28% to trach collar continuously. Order dated 7/13/2025 to change and date all respiratory supplies and tubing weekly and clean the oxygen concentrator filter if present; frequency: every Sunday, day shift. Order dated 7/9/2025 for Ipratropium-Albuterol nebulizer treatment, 3 mL (milliliters) via trach twice a day, for SOB/wheezing. Order dated 7/9/2025 for tracheostomy suction every 4 hours and as needed (PRN). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R120's Respiratory Progress notes included but was not limited to: Pulmonary Function Note dated 8/4/2025 revealed that the resident's oxygen flow rate was documented as set to 2 liters per minute (LPM). Pulmonary Function Note dated 8/5/2025 revealed that the resident's oxygen flow rate was documented as set to 2 LPM. Pulmonary Function Note dated 8/7/2025 revealed that the resident's oxygen flow rate was documented as set to 2 LPM. Observation on 8/4/2025 at 1:00 pm of R120 O2 concentrator revealed that the O2 was set at 1 LPM. Interview with Licensed Practical Nurse (LPN) JJ on 8/4/2025 at 1:00 pm confirmed the 1 LPM setting and stated, I don't touch the oxygen. That's the RT's job. I just change the tubing when ordered. Interview on 8/4/2025 at 1:10 pm with Respiratory Therapist (RT) HH revealed,the resident should be at 2 liters to meet the prescribed 28%. He referenced previous notes indicating a recommendation of 1.5 liters and acknowledged that 1 liter is insufficient and should be adjusted to 2 liters. Interview on 8/4/2025 at 2:46 pm with Staff Development Coordinator (SDC) revealed that she does not provide tracheostomy care training and deferred responsibility to the DON. Interviews on 8/5/2025 at 4:55 pm and 8/7/2025 at 3:42 pm with the DON confirmed that RT staff were contracted and receive training via name of online education. The DON further stated, RTs must follow the physician orders as written and notify the Unit Manager or DON if the order needs to be changed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, and review of the facility policies titled, Storage of Medications and Biologicals and Administration of Medications, the facility failed to ensure the secure storage of medications by not locking medication carts when unattended for one of six medication carts. The deficient practice had the potential to allow residents, unauthorized staff, or visitors to access medications and biologicals, or to tamper with items stored on the cart.Findings include: Review of the facility's policy titled Storage of Medications and Biologicals reviewed April 2025, revealed under Policy Statement: The facility shall ensure medications and biologicals are stored appropriately and securely at any given time. Review of the facility's policy titled Administration of Medications reviewed June 2025 revealed under Procedure: .16. The medication cart should be locked at all times. 1. Observation and interview on 8/6/2025 at 11:19 am revealed a medication cart was left open and unattended in Hallway AI with no nurse in sight. When a staff member was asked who the cart belonged to, she identified it as belonging to Licensed Practical Nurse (LPN) Charge Nurse BBB, who was in Room A2 with a resident. Upon exiting the room, LPN BBB confirmed she was using the cart and stated she had been providing nail care for the resident. She explained that she left the cart open when she quickly grabbed alcohol from it to clean the resident's nails, stating she wanted to complete the task before the resident changed his mind. She estimated she had been in the room for approximately two minutes. The LPN BBB acknowledged the cart was open and confirmed medication carts were not supposed to be left unlocked when unattended. LPN BBB stated a possible negative outcome of leaving a cart unlocked was that someone could access and take medications. Interview on 8/7/2025 at 11:15 am with the Director of Nursing (DON) revealed she was aware of the incident and had discussed it with LPN BBB. The DON stated the nurse acknowledged the error and understood it was against expectations. The DON confirmed that the expectation was that unattended medication carts must remain locked at all times. She stated possible negative outcomes include medications going missing or being taken by someone for whom they were not prescribed. Interview on 8/7/2025 at 11:41 am with the Administrator confirmed that medication carts were required to remain locked when unattended. She stated that a possible negative outcome of an unlocked cart was that someone could take medications, which could result in harm. 2. An observation on 8/6/2025 at 8:30 am revealed LPN ZZ walked away from a medication cart on the A hall and entered a resident room leaving the medication cart unattended. Observation on 8/6/2025 at 8:30 am of LPN ZZ during medication administration was noted to leave a medication storage card that still contained medication on top of the cart unattended. The medication was Ranolazine Extended Release (ER) which was for treatment of chronic chest pain. An interview on 8/6/2025 at 8:31 am with LPN ZZ confirmed that she left the Ranolazine Extended-Release Tablets on top the medication cart. LPN ZZ also confirmed that she should not have left this medication unattended and that she should have locked the medication away in the medication storage cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 8/7/2025 at 2:00 pm with the DON confirmed that nurses should not leave anything on top of the medication cart unattended, and that the facility's policy and practice was to store this medication inside of the medication cart and lock the cart.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and review of the facility policy titled, Administration of Medications, the facility failed to document medication administration for 2 of 60 sampled residents (R) (R122 and R102. This deficient practice created an inaccurate record of care and services provided to the residents which had the potential to affect continuity of care.Findings include:1. Review of the facility policy titled Administration of Medications dated June 2025 documented under Procedure: .5. Each time you administer a medication, you need to be sure to have the right documentation. Under Procedure: .10. The individual administering the medication must initial the resident's electronic medication administration on the appropriate line entry after giving each medication and before administering the next ones, or document in wet ink the administration of medication.11. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document in space provided for that drug and dose.Review of R122's electronic medical record (EMR) revealed he was admitted to the facility with diagnoses including but not limited to cellulitis of right lower limb, muscle weakness, need for assistance with personal care, adhesive capsulitis of right and left shoulder, major depressive disorder, and gastroesophageal reflux disorder (GERD).Review of R122's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicates R122 was cognitively intact.Review of R122's Physician's Orders included but was not limited to an order dated 4/28/2025 for Lexapro oral tablet 5 milligrams (mg) give one tablet by mouth one time a day related to major depressive disorder, an order dated 1/24/2025 for omeprazole 20 mg capsule give 1 tablet by mouth one time a day for GERD, an order dated 1/24/2025 for lactobacillus capsule give 1 capsule by mouth one time a day for probiotic, an order dated 1/27/2025 for a weekly skin assessment, perform one time a day every 8 days for monitoring, an order dated 1/25/2025 for thiamine hcl (hydrochloride) oral tablet 100 mg give 1 tablet by mouth one time a day for supplement, an order dated 1/25/2025 to observe the resident closely for significant side effect monitoring related to anti-depressant medication use, an order dated 1/24/2025 to assess pain levels every shift, an order dated 7/15/2025 for behavior monitoring every shift, and an order dated 1/29/2025 to check for abnormal bruising related to anticoagulant (blood thinner) use.Review of R122's July 2025 Medication Administration Record (MAR) revealed no documentation on 7/15/2025 for administration or refusal of R122's Lexapro and omeprazole, yet other medications to be administered that morning were documented as given. Further review revealed no documentation on 7/22/2025 for administration or refusal of R122's lactobacillus capsule, thiamine tablet, weekly skin assessment, anti-depressant medication use monitoring, pain level assessment, behavior monitoring, checking for abnormal bruising or bleeding related to anticoagulant use, or psych (psychiatric) meds (medications) monitoring, yet other medications for that shift were documented as administered.In an interview on 8/7/2025 at 11:50 am, Licensed Practical Nurse (LPN) TT confirmed the lack of documentation for administration or refusal on 7/15/2025 and 7/22/2025. She confirmed that it didn't give an accurate representation of resident care and stated that anytime a medication was given, it should be documented.In an interview on 8/7/2025 at 3:00 pm, the Director of Nursing (DON) stated that she expected there to not be any holes in the MAR and stated that potential negative outcomes could affect continuity of care.2. Review of R102's EMR revealed he was admitted to the facility with diagnoses including but not limited to need for assistance with personal care, fracture of right lower leg, chronic diastolic (congestive) heart failure, major depressive disorder, and generalized anxiety disorder.Review of R102's significant change MDS assessment dated [DATE] revealed a BIMS score of 15, which indicates R102 was cognitively intact.Review of R102's Physician's Orders included but was not limited to an order dated 7/1/2025 for aspirin give one tablet by mouth one time a day for (continued on next page)

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	08/07/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heart disease, an order dated 7/1/2025 for duloxetine give 1 capsule by mouth one time a day for depression, an order dated 7/1/2025 for magnesium oxide give 1 tablet by mouth one time a day for supplement, an order dated 7/1/2025 for potassium chloride give 1 tablet by mouth one time a day for heart disease, an order dated 7/1/2025 for spironolactone give 1 tablet by mouth in the morning for hypertension, an order dated 7/1/2025 to observe the resident closely for significant side effect monitoring related to anti-anxiety medication use, an order dated 7/1/2025 to observe the resident for significant side effects related to anti-depressant medication use, an order dated 7/1/2025 to assess pain level, an order dated 7/1/2025 for docusate sodium to give 1 capsule by mouth two times a day for constipation, an order dated 7/1/2025 for furosemide give 1 tablet by mouth two times a day for heart failure, an order dated 7/14/2025 to monitor for any discomfort or change in condition every 12 hours for foot fracture, and an order dated 7/1/2025 for sacubitril-valsartan oral tablet give 1 tablet by mouth two times a day for heart failure.Review of R102's July 2025 MAR revealed no documentation on 7/22/2025 for administration or refusal of R102's morning medications and monitoring, yet an as needed (prn) tramadol was documented as administered on 7/22/2025 at 0800 (8:00 am).