

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Harmony Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 176 Lincoln Ave Fitzgerald, GA 31750	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's Standard and Task List titled, Elopement Management, the facility failed to ensure that the physician and responsible party were notified of an elopement of one resident (R) (R1) from a total sample of 24 residents. This deficient practice had the potential to place R1 at risk of unmet needs and a diminished quality of life.</p> <p>Findings included:</p> <p>Review of the facility's Elopement Standard and Task List titled, Elopement Management, dated 2023, defined elopement, Elopement occurs when a resident leaves the facility or a safe area without authorization. If a resident is off facility property, then an elopement has occurred. If a resident is on facility property but not under supervision as need identifies; then an elopement has occurred. The standard and task list also included that post elopement, a progress note (in the clinical record) was to be completed at the time of the elopement with an accurate timeline of events, and MD/RP (Medical Doctor/Responsible Party) notification with documentation.</p> <p>Review of the clinical record revealed R1 was admitted to the facility with diagnoses of but not limited to schizoaffective disorder, traumatic brain injury, post-traumatic stress disorder, and unsteadiness on feet.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed R1 was assessed as exhibiting wandering behavior and being independent for mobility and ambulation.</p> <p>Review of R1's care plan, initiated on 9/20/2023, revealed R1 was at risk for elopement with a history of elopement and wandering behavior. The care plan included that R1 resided on a secure unit.</p> <p>Review of R1's physician's orders revealed an order dated 9/20/2023 to admit to secure unit for diagnosis of schizophrenia.</p> <p>Review of R1's clinical record revealed no documented evidence that R1's responsible party or physician was notified of an elopement occurrence.</p> <p>Review of a Maintenance Request form dated 10/17/2024, completed by the Maintenance Director, revealed that R1 got out of the side door exit on the North Hall.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 115654
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/4/2024 at 11:50 am with Licensed Practical Nurse (LPN) EE revealed that she found R1 outside of the facility several weeks prior but could not recall the exact date. LPN EE revealed she returned R1 to the North Hall secure unit because that was the hall he resided on.</p> <p>Interview on 12/9/2024 at 11:29 am, with Certified Nursing Assistant (CNA) FF revealed she thought R1 got out of the facility on 10/17/2024.</p> <p>Interview on 12/9/2024 at 1:30 pm with LPN GG confirmed that she was working on the North Hall secure unit when LPN EE brought R1 back to the North Hall but could not recall the date. Interview further revealed that when asked if she notified R1's responsible party or the physician after R1 eloped, LPN GG responded that she was on a break and unaware of what happened.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's Elopement Standard and Task List titled, Elopement Management, the facility failed to ensure the care plan was revised for one of 24 sampled residents (R) (R1). Specifically, the facility failed to revise and update R1's care plan following an elopement on 10/17/2024. This deficient practice had the potential to place R1 at risk of not receiving treatment and/or care according to their needs.</p> <p>Findings included:</p> <p>Review of the facility's Elopement Standard and Task List titled, Elopement Management, dated 2023, defined elopement, Elopement occurs when a resident leaves the facility or a safe area without authorization. If a resident is off facility property, then an elopement has occurred. If a resident is on facility property but not under supervision as need identifies; then an elopement has occurred. The standard and task list also included that post elopement, the care plan was to be updated.</p> <p>Review of the clinical record revealed R1 was admitted to the facility with diagnoses including, but not limited to, schizoaffective disorder, traumatic brain injury, post-traumatic stress disorder, and unsteadiness on feet.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed R1 was assessed as exhibiting wandering behavior and being independent for mobility and ambulation.</p> <p>Review of R1's care plan, initiated on 9/20/2023, revealed R1 was at risk for elopement with a history of elopement and wandering behavior. The care plan included that R1 resided on a secure unit. Further review revealed no evidence that the care plan had been revised to include R1's elopement on 10/17/2024.</p> <p>Review of a Maintenance Request form dated 10/17/2024, completed by the Maintenance Director, revealed that R1 got out of the side door exit on the North Hall (which was not the secured unit R1 resided on at the time).</p> <p>Interview on 12/4/2024 at 11:50 am with Licensed Practical Nurse (LPN) EE revealed that she found R1 outside of the facility several weeks prior but could not recall the exact date.</p> <p>Interview on 12/9/2024 at 11:29 am with Certified Nursing Assistant (CNA) FF revealed she thought R1 got out of the facility on 10/17/2024.</p> <p>Interview on 12/9/2024 at 1:30 pm with LPN GG confirmed that she was working on the North Hall secure unit when LPN EE brought R1 back to the North Hall but could not recall the date.</p> <p>Interview on 12/17/2024 at 12:30 pm with the MDS Coordinator confirmed that she was unaware R1 had eloped from the facility when it occurred in October, which was why his care plan was not updated.</p> <p>Cross-Reference F689</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's Elopement Standard and Task List titled, Elopement Management, the facility failed to ensure one of 24 sampled residents (R) (R1) was adequately supervised to prevent elopement. In addition, the facility failed to ensure a door leading to the outside was secured to prevent elopement by residents. This deficient practice had the potential to place R1 at risk of avoidable injury and a diminished quality of life.</p> <p>Findings included:</p> <p>Review of the facility's Elopement Standard and Task List titled, Elopement Management, dated 2023, defined elopement, Elopement occurs when a resident leaves the facility or a safe area without authorization. If a resident is off facility property, then an elopement has occurred. If a resident is on facility property but not under supervision as need identifies; then an elopement has occurred. The standard and task list also included that post elopement, a progress note (in the clinical record) was to be completed at the time of the elopement with an accurate timeline of events.</p> <p>Review of the clinical record revealed R1 was admitted to the facility with diagnoses including, but not limited to, schizoaffective disorder, traumatic brain injury, post-traumatic stress disorder, and unsteadiness on feet.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] assessed R1 with a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment. R1 was also assessed as exhibiting wandering behavior and being independent in mobility and ambulation.</p> <p>Review of R1's care plan, initiated on 9/20/2023, revealed R1 was at risk for elopement with a history of elopement and wandering behavior. The care plan included that R1 resided on a secure unit.</p> <p>Review of R1's physician's orders revealed an order dated 9/20/2023 to admit to secure unit for diagnosis of schizophrenia.</p> <p>Review of an Elopement Evaluation completed on 9/19/2024 documented that R1 wandered aimlessly.</p> <p>Review of census information revealed R1 resided on the [NAME] Hall secure unit from 9/20/2023 until he was transferred to the North Hall secure unit on 10/28/2024.</p> <p>Review of a Maintenance Request form dated 10/17/2024, completed by the Maintenance Director, revealed that R1 got out of the side door exit on the North Hall (which was not the secured unit R1 resided on at the time). The form further documented that the Maintenance Director was called in at 6:10 pm because a resident had gotten out of the North Hall side exit door. When the Maintenance Director arrived at the facility, staff had already gotten R1 back to his room, and the side door was closed and locked.</p> <p>Review of Logbook Documentation, completed by the Maintenance Director, revealed that prior to 10/17/2024, the North side exit door was checked on 10/16/2024 and 10/17/2024 and documented as passed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 12/5/2024 at 10:30 am revealed there was a locked door at the end of North Hall secure unit, that when unlocked (by staff), opened up into the [NAME] Hall secured unit activity area.</p> <p>Interview on 12/4/2024 at 11:50 am with Licensed Practical Nurse (LPN) EE indicated that she found R1 outside of the facility several weeks prior but could not recall the exact date. LPN EE said she was on-call that day, returned to the facility after 4:00 pm to do something, and R1 was sitting on the bench outside of the front door entrance. She stated she did not know how he got there. She further stated R1 walked inside the building with her, and she returned him to North Hall secured unit and let LPN GG know. LPN EE also revealed she notified the Director of Nursing (DON) BB. LPN EE revealed she returned R1 to the North Hall secured unit because that was the hall he resided on.</p> <p>Interview on 12/4/2024 at 1:00 pm with the Maintenance Director revealed he checked the doors and keypads daily to make sure they were working and locked. He revealed that he was called and came back to the facility (on 10/17/2024). He was informed that R1 got out of the side door on the North Hall, which exits out the front of the building. He revealed the door was closed and locked when he checked it, and he changed the keypad code on the outside and inside of the door.</p> <p>Interview on 12/9/2024 at 11:29 am with Certified Nursing Assistant (CNA) FF (who worked on the North Hall secured unit during the 3:00 pm to 11:00 pm shift on 10/17/2024) revealed she thought R1 got out of the facility on 10/17/2024. CNA FF recalled that R1 was at the back door lined up with other residents, waiting to go out to smoke. She stated R1 did not smoke, so he went back up the hallway, and she went out with the residents for smoke break. CNA FF stated she took the residents who smoke outside at 6:10 pm, and while she was still outside with them, the DON BB called her on the phone and informed her that R1 got out the side door. She further revealed that R1 resided on North Hall when this occurred, which conflicted with the census information that documented R1 resided on the [NAME] Hall secure unit on 10/17/2024.</p> <p>Interview on 12/9/2024 at 1:30 pm with LPN GG confirmed that she was working on the North Hall secure unit when LPN EE brought R1 back to the North Hall but could not recall the date. LPN GG revealed she was getting ready to go on break and she saw LPN EE bring R1 back to the North Hall unit and asked LPN GG if she was missing a resident. LPN GG revealed she could not recall the last time she had seen R1 prior to LPN EE bringing him back, but it did not seem like he was missing. LPN GG confirmed that CNA FF worked with her that shift and was out on smoke break when R1 was brought back to the unit. She confirmed that R1 resided on the North Hall when the incident occurred.</p>		