STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115679	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Comfort Creek Nursing and Rehabilitation Center	10200 U.S. Hwy 1 South Wadley, GA 30477

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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 - Minimal harm or potential for 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** 40415 Based on staff interviews, family interview, record review, and review of the facility's policy titled, Change of Condition/Reporting, the facility failed to provide a timely notification of change in condition for a resident that became unresponsive, breathless, and Cardiopulmonary Resuscitation (CPR) was initiated for one of one resident (Resident (R) 385) reviewed for notification of change in condition of 28 sample residents. This failure had the potential to affect the families' grieving process. Findings include: Review of the facility's policy titled, Change of Condition/Reporting, dated [DATE], revealed when a resident exhibits a change in condition, action will be taken to coordinate appropriate care to meet resident needs and communicate condition change to physician . 3. If there is an actual change in condition, the resident's physician is notified promptly and validated as to information. Family/Responsible Party notified promptly. Review of R385's Admission Record located under the Profile tab of the electronic medical record (EMR), revealed R385 was admitted to the facility on [DATE] with a diagnosis of diffuse traumatic brain injury (TBI), and she was Full Code status. Resident alert to voices, aphasic in a vegetative state. The resident was bedbound and unable to communicate her needs and wants due to her condition, and was total care. Resident had a Brief Interview for Mental Status (BIMS) score of 99, which indicated severe cognitive impairment. Review of the Progress Note located under the Progress Notes tab of the EMR, dated [DATE], revealed on [DATE] at approximately 10:45 pm, Licensed Practical Nurse (LPN) 3 documented being called to R385's room by LPN5 related to no rise and fall of R385's chest and unable to obtain vital signs. (CPR) started by LPN3. At 10:50 pm, emergency medical services (EMS) were called. At 11:01 pm, first responders arrived and continued CPR. EMS stated, unable to get a heart rhythm. LPN3 attempted to notify the Medical Director and received no answer. At 11:07 pm, EMS notified [Name] emergency room (ER) Physician Assistant (PA) and received a stop CPR order. At 11:20 pm, EMS1 notified Deputy Coroner (DC) and refused to come to the facility due to R385 not being pronounced deceased . EMS stated she would not take R385 to [Name] Hospital because she was dead. At 5:19 am, the Director of Nursing was notified. At 5:30 am, R385 was pronounced deceased . At 5:55 am, Mother of R385 was notified. At 6:20 am, the Medical Director was notified. At 8:22 am, Mother and Deputy Coroner (DC) at the Facility. At 9:39 am, R385 out of the Facility with DC. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Emergency Medical Tech (EMT) report, provided by the facility, indicated EMS was notified on [DATE] at 10:51 pm, arrived at the facility at 11:01 pm, last time known well reported on [DATE] at 9:00 pm, first monitored rhythm indicated asystole (absence of heartbeat). During a telephone interview on [DATE] at 2:52 pm, LPN3 indicated she was assigned to R385 the night of [DATE] but was not the one who found R385 unresponsive. LPN3 stated she arrived at the facility between 7:00 pm and 8:00 pm on the evening of [DATE], made rounds to check her residents, and at that time, R385 was in her usual state with no concerns. She stated she started passing the evening medications and was unsure if she had given medication to R385, but checked on her during the medication pass. She stated at approximately 10:45 pm, she was notified by LPN5 that R385 was not breathing. LPN3 stated LPN5 began CPR, and she called 911. LPN3 indicated she was not sure when, but the Medical Director (MD) and Director of Nursing (DON) were called with no answer. LPN3 indicated she attempted to contact the DON approximately ten times through the night with no answer and made contact at 5:30 am the morning of [DATE]. When asked if the family was made aware of R385's change in condition, she stated yes after R385 was pronounced deceased at 5:55 am. When asked if a resident was not breathing, calling EMS and beginning CPR was a change in condition, LPN3 stated yes. During a telephone interview on [DATE] at 8:45 am, LPN5 stated she was working second shift, 7:00 pm to 7:00 am, on the D and E hall, which was at the end of C hall, which gave her a clear view of the C hall. LPN5 indicated she thought she saw someone go into R385's room, and she went in the room, no one was in the room, but she found R385 not breathing. LPN5 stated she notified LPN3 and started CPR. She stated LPN3 made calls and took notes. When asked if the family was made aware of R385's change in condition, she stated, The mother was called after R385 was pronounced deceased . When asked if a resident was not breathing, calling EMS, and beginning CPR was a change in condition, LPN5 stated yes. During an interview on [DATE] at 10:04 am, the DON confirmed that she was called the night of [DATE], and she did not get the call until she woke up the morning of [DATE]. When asked if she was on call, she indicated they did not have a call rotation. When asked why the family was not notified of R385's change of condition, she stated the mother was notified as soon as R385 was pronounced deceased , and when she signed off that she was pronounced, the event was complete. When asked if a resident was not breathing, EMS called and beginning CPR was a change in condition, she indicated the change of condition was not completed because R385 was not pronounced deceased until 5:30 am and then the family was notified. During a telephone interview on [DATE] at 11:09 am, the Family Member (FM) 2 confirmed she was not notified of R385's death until [DATE] at 5:55 am. She stated that the last time she saw R385 was on [DATE], and she was fine. She received a phone call on [DATE] from RN1 to notify her that she was being started on an antibiotic for an upper respiratory infection. FM2 stated she asked RN1 if she was okay, and she stated, Yes. FM2 stated she was told that she was found unresponsive at approximately 10:45 pm in the evening of [DATE]. She stated she was just in shock and confused as to why she wasn't informed before the morning. She stated she found out that R385 was not pronounced deceased until the morning of [DATE], when she died on [DATE]. FM2 stated this had been very traumatic and stressful to her and her family, knowing R385 passed on [DATE], and she wasn't called until [DATE], her death certificate stated [DATE] when in fact she knew she passed on [DATE]. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview [DATE] at 12:30 pm, the Unit Manager (UM) 2 indicated she was called and notified by LPN3 that R385 was found not breathing and 911 was called. UM2 indicated she went into the facility at approximately 12:00 am to support the staff. When asked if the family was notified and she stated no. When asked if the family should have been notified, she stated, no because they would want to come in and R385 had not been pronounced deceased yet. When asked if a resident was not breathing, EMS called and beginning CPR was a change in condition, she indicated the change of condition was not completed because R385 was not pronounced deceased .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30622 Based on record review, interviews, and review of facility policy titled, Freedom from Abuse Standard Addendum, the facility failed to protect the residents' right to be free from physical abuse by other residents for two of three residents (Resident (R) 65 and R54) reviewed for abuse out of 28 sample residents. The facility's failure to protect residents from abuse placed residents at continued risk of harm. Findings include: Review of the facility's policy and procedure titled, Freedom from Abuse Standard Addendum, effective October 24, 2022, revealed Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Abuse also included deprivation by an individual, employee, care giver of goods and services that are necessary to maintain the physical, mental, and psychosocial wellbeing .Resident to resident abuse of any type should be reviewed as a potential situation of abuse, and .staff should monitor behaviors that can provoke a reaction by residents or others which include verbally aggressive behaviors such as screaming, cursing, bossing around/demanding, insulting, intimidating. 1. Review of R65's Admission Record located under the Profile tab in the electronic medical record (EMR) revealed R65 admitted on [DATE] with diagnoses of major depressive disorder, brief psychotic disorder, unspecified dementia, bipolar disorder, post-traumatic stress disorder, paranoid schizophrenia, and anxiety disorder. Review of the admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 2/12/2025 indicated R65 had a Brief Interview for Mental Status (BIMS) of 12 out of 15, indicating he had moderate cognitive impairment. Review of the Care Plan located under the Care Plan tab of the EMR, initiated 2/2025, revealed R65 had impaired cognitive function/dementia or impaired thought processes r/t [related to] dementia. [R65] has a behavior problem related to physical aggression. 3/15/2025-Giver and Receiver of physical aggression. Review of the Incident Note, dated 3/15/2025 at 12:45 pm, and located in the EMR under the Progress Notes tab, revealed: at [approximately] 12:45 pm, it was reported by CNA [Certified Nurse Aide] that this resident got into a fight with another resident this morning. [This] writer went to speak with resident. [The] resident stated, yeah, I hit him because he talks too much smack all the time. I told him to wait until I got my coffee then I'll move. I hit him, [the] resident stated, he followed me to my room and threw water on me, then we started fighting again. [this] Writer completed [a] skin and pain assessment. [The] resident denies any pain or discomfort at this time. [The] writer noted skin tear on left hand middle finger. [The] writer completed first aide care to resident. [The] wound cleansed with normal saline, pat dry and covered with dry dressing. MD [Medical Director], CHE [mental health provider] DON [Director of Nursing], family member [Name] and . PD [police department] notified. [An] Order to begin Zyprexa 5MG [milligrams] PO [by mouth] Q [every] 12 HR [hour] PRN [as needed] x 14 days and place on 1:1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R54's Admission Record located under the Profile tab in the EMR revealed R54 admitted on [DATE] with diagnoses which included muscle weakness and major depressive disorder. Review of the quarterly MDS with an ARD of 3/17/2025 and located under the MDS tab in the EMR, revealed R54 had a BIMS of 13 of 15, indicating he was cognitively intact. Review of the Care plan located in the EMR under the Care Plan tab, revealed R54 [revised date] 3/15/2025 receiver and giver of physical abuse with another resident. Interventions included separating the residents, 1:1 supervision, and notifying all appropriate agencies. Review of the Incident Note located under the Progress Notes tab in the EMR, dated 3/15/2025, revealed R54 stated, yeah, I fought him because he hit me. I told him to move and let me through. Then he just hit me in the head. [The] resident stated, 'I followed him to his room and threw my water on him, then we started fighting again. Review of the police report, included with the facility's reported investigation and provided by the facility, indicated an officer was dispatched on 3/15/2025 to the nursing facility due to an altercation occurring between two residents. According to the nurse, [R54] stated he was waiting for [R65] to retrieve items from the breakfast cart and commented that [R65] needed to hurry up. According to the nurse, [R54] stated that was when [R65] attacked him, punching him. During an interview on 4/15/2025 at 12:41 pm, the DON stated that on 3/15/2025, R65 had a verbal altercation with R54. The DON stated R54 went into R65's room and threw water on him. She stated that the two residents then had a physical altercation. She stated R65 sustained a skin tear on his left middle finger. The DON stated after the incident, he was placed on 1:1 and R65 had a mental health evaluation. She stated the in-house psychiatric provider gave an order for medications if needed. She stated he did not require PRN medication and remained on 1:1 supervision for 72 hours. During an interview on 4/16/2025 at 10:19 am, Licensed Practical Nurse (LPN) 6 stated R65 feeds off of others' energy. She stated he did not like other residents coming into his room. She stated he did not ask for much but when he wanted something he wanted it right then. During an interview on 4/16/2025 at 12:15 pm, the DON stated she did not believe R65 was a threat to other residents. She stated R65 was provoked by R54 on 3/15/2025. She stated R54 followed R65 into his room after R65 did not get out of R54's way fast enough in the hallway. The DON stated R54 went into R65's room, and they exchanged words, then became physical with one another. She stated the residents were separated, assessed, and placed on 1:1 monitoring. She stated that minor injuries were sustained. The DON stated they were aware of R65's history at another facility of having resident-to-resident altercations. She stated orders for a PRN medication were received, but R65 did not require any medication. She stated no further incidents were reported. During an interview on 4/16/2025 at 12:20 pm, Unit Manager (UM) 1 stated private rooms were available if needed. Per her recollection, she stated the staff did not feel like R65 needed a private room since the incident did not occur with his roommate. She stated R65 was provoked by R54. She stated the two residents exchanged words and then had a physical altercation. UM1 stated they were separated and placed on 1:1 monitoring. She stated no further incidents have occurred between the two residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/2025 at 1:30 pm, the Administrator stated she was not aware of R65's resident-to-resident altercation at another facility. She stated she did not believe he was a threat to others currently. She stated she did not think he needed to be in a private room due to his history of aggression towards others. During an interview on 4/16/2025 at 3:41 pm, LPN3 stated the event did not happen on her shift, but it was reported to her on her shift. LPN3 stated R65's roommate reported R65 and R54 got in a fight earlier that day. She stated R65 told the nurse he had every right to defend himself. She stated R65 told her R54 wanted to leave his room, and R65 was blocking the way because he was getting something off the dietary cart. LPN3 stated R54 followed R65 to his room. She stated they exchanged words and then became physical with one another. She stated that by the time she came on shift and was notified, the residents were in their own rooms and were calm. She stated that no other incident occurred between the two residents.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30622 Based on record review, interviews, and review of the facility's document titled, RAI [Resident Assessment Instrument]/Care Planning Management, the facility failed to ensure the residents participated in care conferences for one of 28 sample residents (Resident (R) 65) reviewed for care conferences. This failure had the potential for the residents to have unmet care needs. Findings include: Review of the facility's document titled, RAI [Resident Assessment Instrument]/Care Planning Management, dated October 2023, indicated Invitations are mailed to the family/responsible party one week prior to the conference date. Invitations are completed by social services department. Social services invites each resident to the care conference personally on the morning of the care conference. Review of the Admission Record located under the Profile tab in the electronic medical record (EMR) revealed R65 admitted on [DATE] with diagnoses of major depressive disorder, brief psychotic disorder, metabolic encephalopathy, unspecified dementia, bipolar disorder, post-traumatic stress disorder, paranoid schizophrenia, and anxiety disorder. Review of the admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date(ARD) of 2/12/2025 indicated R65 had a Brief Interview for Mental Status (BIMS) of 12 out of 15, which indicated he had moderate cognitive impairment. During an interview on 4/16/2025 at 10:11 am, R65 stated he was not invited to a care plan meeting. He stated he did not know what that was. Review of the Baseline Care Plan Note located under the Documents tab in the EMR, revealed R65's sister was included in the baseline care plan meeting, but the record did not reveal R65 was invited. During an interview on 4/15/2025 at 12:46 pm, the Director of Nursing (DON) stated the responsible party was invited to the care plan meeting. She was not sure if the residents were invited to attend. During an interview on 4/16/2025 at 9:31 am, the Administrator stated that all interdisciplinary team (IDT) members should be included in the care plan meetings, and residents should be invited. The Administrator stated meetings could be held in the residents' room if that accommodated their needs.

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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** 52323 Based on observation, resident and staff interviews, and record review, the facility failed to provide tracheostomy care, supervision, and supplies for a resident who was care planned to self-care his own tracheostomy site to one of two residents (Resident (R) 13) reviewed for respiratory care of 28 sample residents. This failure had the potential to contribute to respiratory infection for R13. Findings include: Review of R13's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed R13 was admitted to the facility on [DATE] with diagnoses which included cervical disc disorder and complete traumatic amputation of level between unspecified hip and knee. Review of R13's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/2025 and located in R13's EMR under the MDS tab, revealed R13 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R13 was cognitively intact. Further review revealed R13 received tracheostomy care in the facility. Review of R13's Has a tracheostomy care plan, dated 3/12/2025, documented R13 performs his own trach care per his preference. The care plan included the following: For Inner cannula care, when allowed by resident, observe for Changing as he prefers and, on his terms, and schedule. Ensure all supplies are available timely .Trach care performed by resident as he wishes staff to observe for assistance. Review of R13's physician's order Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2025 located in R13's EMR under Orders tab, the report documented R13 received tracheostomy care and monitoring ordered by the physician as follows: Change the inner cannula, size six, daily and as needed, every night shift. Start date, 3/26/2025; Trach care every shift and as needed. Start date, 3/26/2025; Suction tracheostomy as needed for increased secretions. Start date, 3/26/2025; Change tracheostomy tie once weekly on Thursday on every day shift every Thursday. Start date, 3/26/2025. During an observation and interview on 4/14/2025 at 2:44 pm, R13 stated his tracheostomy size was 6G and he took care of his trach care by himself; the staff did not check on him when he cleaned it. R13 said and pointed to his bedside table and was observed there were no tracheostomy care supplies such as a tracheostomy care kit (contains sterile towel, sterile gauze pads, sterile cotton swabs, sterile small brush, sterile gloves.) or additional supplies (sterile 4x4 drain sponge, hydrogen peroxide, sterile water gauze, tracheostomy securing devise or tapes, ties.) per the facility's policy and the care plan instructed. There was no suction machine in R13's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/15/2025 at 12:24 pm, when asked, R13 stated he used a special brand of toilet paper to clean the surroundings skin of the tracheostomy tube, rolled a napkin, and put it below the tracheostomy tube to support it. R13 pointed to the white rolled napkin on his neck and said he ran out of the toilet paper about a week ago, so he used the same rolled napkin to clean and support it. R13 said if there was blockage in his tracheostomy tube, he would remove the inner cannula, cough out the mucus, and put it back in. R13 then pulled out his inner cannula and coughed to explain how he cleared his mucus in the tracheostomy tube. R13 was observed to have his inner cannula in his hand, and the entire inner cannula tube looked completely brown throughout the whole tube. When asked, R13 said the inner cannula had not been changed or cleaned since he was admitted to the facility more than a month ago, and it had not been changed or cleaned for more than a year. He said if staff could offer him some supplies, such as clean gauze, it would help. During an interview on 4/15/2025 at 1:05 pm, when the Director of Nursing (DON) was informed about R13's statements and the brownish inner cannula, the DON said she would get some tracheostomy care supplies for R13. During an observation and interview on 4/15/2025 at 2:24 pm, when R13's care nurse, Licensed Practical Nurse (LPN) 8, was asked why there were no tracheostomy care supplies and spare tracheostomy tube in R13's room ready for him to use, LPN8 stated she would look for it in the supply room. During an observation conducted in the supply room with LPN8, LPN8 did not know where the tracheostomy care supplies were in the supply room, and she said she did not know R13's tracheostomy tube size, she needed to check R13's record. LPN8 found some tracheostomy supplies, which included a tracheostomy kit. However, LPN8 was not sure if the tracheostomy tube and inner cannula would fit R13. An observation and interview on 4/15/2025 at 2:50 pm, was conducted with LPN8 in R13's room. There was a box of gauze and a new emergency tracheostomy tube size 6DCFN on R13's table. R13 stated they just brought it here not long ago. R13 said he would not use the tube. R13 stated he was size 6G. No suction was observed in R13's room. During an interview on 4/15/2025 at 3:30 pm, the DON stated tracheostomy care would follow the procedures documented in the policy. During an interview on 4/15/2025 at 4:48 pm, when asked, LPN8 stated she had not observed or performed tracheostomy care or replaced the inner cannula for R13. During an interview on 4/16/2025 at 8:43 am, LPN7 said she never provided tracheostomy care to R13. LPN7 stated the treatment nurse did. During an interview on 4/16/2025 at 9:04 am, the DON stated the facility was in a transition, and currently, there was no treatment nurse, and the nursing staff would provide all treatments to their assigned residents. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/2025 at 9:04 am, LPN2 said she had never provided tracheostomy care for R13 when she was assigned to take care of R13. LPN2 said R13 took care of his own tracheostomy care. LPN2 stated if R13 needed assistance and asked, she would be more than willing to help him. She said the order administration documented as completed with a V sign for tracheostomy care meant that the staff asked R13 and verified with him that he completed the tracheostomy care and cleaning. She said the staff asked R13 to make sure R13 did it, if R13 said yes, he did it, the staff would mark the order as administration completed. LPN2 said she never observed R13 perform tracheostomy care for himself, but she did observe if there were any discharges near the tracheostomy area during the shift.