STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115680	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlyle Place	5300 Zebulon Road Macon, GA 31210

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 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49470 Based on staff interviews, record review, and review of the facility policy titled Freedom of Abuse, Neglect, and Exploitation; Abuse Prevention - Work Instruction, the facility failed to ensure that one resident (R) (R4) was free from involuntary seclusion when one side of his bed was pushed against the wall, and the other side of the bed was barricaded with a mattress lying horizontally on chairs. The mattress and wall blocked R4's view of his room, and he could not get out of his bed from approximately 10:30 pm on [DATE] until [DATE] at 7:30 am when a nurse discovered R4. The facility census was 32. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. Facility Administrator AA, Director of Nursing (DON), and Hospital Director were informed of the Immediate Jeopardy (IJ) on [DATE] at 11:30 am. The noncompliance related to the Immediate Jeopardy was identified to have existed on [DATE]. At the time of exit on [DATE], an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: Record review of the facility policy titled Abuse Neglect and Exploitation - Work Instruction, revised on [DATE], revealed the purpose 1.0: to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. 3.0 Abuse means willful infliction of injury, unreasonable confinement or punishment resulting in mental anguish. Involuntary Seclusion refers to the separation of Resident from other residents or from his/her room or confinement to his/her room against the Resident's will or the will of the legal representative. Record review of the Electronic Medical Record (EMR) revealed R4 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, psychophysiological insomnia, dementia, and right femur fracture. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the most recent Admission Minimum Data Set (MDS) assessment for R4, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating moderate cognitive impairment. Maximal assistance with toileting, walking not attempted, and no assistive devices. Two falls since admission. R4 expired in the facility on [DATE] due to comorbidities not associated with this seclusion. A review of a facility document titled Memo of Understanding, dated [DATE] and signed by Licensed Practical Nurse (LPN) QQ, revealed the previous Administrator BB documented the following, LPN QQ understands the protocol on physical restraints and the utilization of other interventions for fall prevention. During an interview on [DATE] at 12:10 pm, LPN QQ revealed that R4 had dementia and she had worked with him on multiple occasions. LPN QQ stated R4 had recurrent falls, and she wanted to keep him safe. LPN QQ revealed on [DATE], she worked the evening shift (7:00 pm to 7:00 am). She stated at approximately 9:30 pm, R4 was seated in a geriatric chair, and she wanted to lay the resident in his bed. She stated that R4 was uncooperative, and she asked for assistance from a Certified Nursing Assistant (CNA) and put R4 in bed. LPN QQ further revealed that R4 refused to stay in bed and repeatedly tried to get out of bed. At approximately 10:30 pm, LPN QQ stated she took a single mattress and barricaded the resident from getting out of bed. LPN QQ further stated she placed a single mattress perpendicularly against R4's bed, blocked the resident from getting out of bed, and had the other side of the bed pushed against the wall. LPN QQ stated that R4 continued to knock the mattress down and she took a chair or two and supported the mattress from falling. LPN QQ stated she was unable to recall how many chairs in total she used to support the mattress from falling. LPN QQ further revealed she wanted R4 to stay in bed and believed R4 was not restrained. LPN QQ stated she had tried multiple times to keep R4 in bed, but R4 consistently failed to follow her orders and continued to knock the mattress down multiple times. LPN QQ stated R4 was a large, combative man, and she had to barricade him to make him stay in bed. LPN QQ demonstrated and drew a diagram showing how she barricaded R4 in his room. During an interview on [DATE] at 1:33 pm, Registered Nurse (RN) OO revealed she was a weekend supervisor and was familiar with R4. RN OO stated R4 was a high fall risk and had hip surgery and an open wound. RN OO stated she recalled that on [DATE], she came in that morning and observed staff had used a mattress and blocked R4 from getting out of bed. RN OO observed a mattress placed perpendicular and leaned against R4's bed and the other side of the bed against the wall. RN OO stated she felt like that was not the correct intervention, so she removed the mattress and laid it down on the floor. RN OO further revealed she could not recall the number of chairs that were used to support the mattress from falling and stated the mattress blocked R4's view of his surroundings from the bed. RN OO stated she reported the findings to Administrator BB. During an interview on [DATE] at 1:56 pm, LPN PP revealed R4 liked to sit in a geriatric chair but would try and get out of the geriatric chair without help, and he could not ambulate without assistance. LPN PP stated that R4 was confused but not combative and was able to follow directions. During an interview on [DATE] at 11:05 am, the DON revealed that the previous Administrator BB had informed her that LPN QQ had barricaded R4 in his room. According to the DON, the incident occurred while she was on leave. The DON stated Administrator BB addressed the incident internally with a verbal warning and LPN QQ continued providing care to residents, including R4. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:30 am, Administrator BB revealed on [DATE], he was the Administrator on record. Administrator BB stated that on [DATE], RN OO reported that she discovered R4 barricaded with a mattress and chairs in his room. RN OO stated that R4 was unable to get out of bed. Administrator BB further revealed that LPN QQ should never have used a mattress to barricade R4 in his bed. Administrator BB stated that it was considered a restraint and that the use of restraints and involuntary seclusion was against facility policy and not permitted. Administrator BB confirmed staff were not in-serviced, LPN QQ was given a warning, and there was no further investigation. During an interview on [DATE] at 5:34 pm, the Medical Director (MD) revealed he was not made aware that R4 was restrained involuntarily on [DATE]. The MD stated he would have expected staff to report the incident to the State Agency. The MD further revealed that involuntary seclusion was not permitted and was against facility policy. During an interview on [DATE] at 2:17 pm, R4's Resident Representative (RR) revealed she was unaware R4 was barricaded in bed on [DATE]. The RR stated she would have preferred to be notified of the incident. During an interview on [DATE] at 2:57 pm, Administrator AA revealed he was the Executive Director in [DATE] and in charge of the entire facility. He stated that on [DATE], Administrator BB reported to him that LPN QQ had involuntarily restrained R4 in his room. During an interview with the Rehabilitation Director (RD) on [DATE] at 1:01 pm, she revealed that R4 participated in rehabilitation services. The RD stated that R4 was not combative but rather inquisitive. The RD revealed that R4 liked to be up in a geriatric chair most of the day. During an interview on [DATE] at 10:45 am, CNA CCC revealed that on [DATE], she worked the night shift with LPN QQ. CNA CCC stated that R4 was very confused, and LPN QQ wanted R4 to stay in his bed. CNA CCC further revealed on [DATE] that there was not enough staff to offer one-on-one care to sit in R4's room, and LPN QQ made the wrong decision and barricaded R4 in bed all night. She stated LPN QQ overstepped her boundaries and thought she was helping CNAs.

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49470 Based on staff interviews, record review, and review of the policy titled Freedom of Abuse, Neglect and Exploitation; Abuse Prevention - Work Instruction, the facility failed to protect the resident's right to be free from physical abuse by staff by failing to report an allegation of abuse in a timely manner to the State Agency (SA) for one of three residents (R)(R4) reviewed for abuse. On 4/16/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. Facility Administrator AA, Director of Nursing (DON), and Hospital Director (HD) were informed of the Immediate Jeopardy (IJ) on 4/16/2024 at 11:30 am. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/27/2023. At the time of exit on 4/19/2024, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: Record review of the facility policy titled Abuse Neglect and Exploitation - Work Instruction, last revised on 10/24/2023, revealed the facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. , law enforcement when applicable) within specified timeframes: A. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or B. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 2. Assuring that reporters are free from retaliation or reprisal; 3. Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service. Record review of the most recent Admission Minimum Data Set (MDS) Assessment for R4, dated 11/06/2024, revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating moderate cognitive impairment. During an interview on 4/10/2024 at 1:33 pm with Registered Nurse (RN) OO revealed on 10/28/2023 at approximately 8:00 am, after observing that a mattress was perpendicularly placed and leaned against R4's bed and held up by chairs, she removed the chairs and laid the mattress down. RN OO stated it was against facility policy to barricade and restrain residents from movement. RN OO stated that R4 was involuntarily restrained, and she reported the incident to the abuse Coordinator, Administrator BB. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/11/2024 at 11:05 am with Director of Nursing (DON) revealed that the previous Administrator BB informed her that Licensed Practical Nurse (LPN) QQ had barricaded R4 in his room. The DON stated that Administrator BB said he addressed the incident internally, but that Administrator BB should have reported it to the SA. During an interview on 4/12/2024 at 11:30 am, with Administrator BB revealed on 10/27/2023, he was the Administrator on record. He stated on 10/28/2023; RN OO reported to him that she discovered R4 barricaded with a mattress and chairs in his room. RN OO stated that R4 was unable to get out of bed. Administrator BB revealed that he did not notify the Medical Director (MD) regarding the incident, and he did not report the incident to the SA. During an interview on 4/17/2024 at 2:57 pm, with Administrator AA revealed he was the Executive Director in October 2023 and in charge of the entire facility. On 10/28/2023, Administrator BB reported to him that LPN QQ had involuntarily restrained R4 in his room. Administrator AA confirmed the incident was not reported to the SA and that Administrator BB told him he had addressed the situation. Administrator AA stated the proper channels of reporting to the SA were not followed.

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. 49470 Based on staff interviews, record review, and a review of the facility's policy titled Freedom of Abuse, Neglect and Exploitation; Abuse Prevention - Work Instruction, the facility failed to investigate, correct, and prevent allegations of abuse by staff for one of three residents (R) (R4) reviewed for involuntary seclusion. Specifically, when staff used a mattress and chairs to barricade R4 in his bed for more than eight hours. On 4/16/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. Facility Administrator AA, Director of Nursing (DON), and Hospital Director, were informed of the Immediate Jeopardy (IJ) on 4/16/2024 at 11:30 am. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/27/2023. At the time of exit on 4/19/2024, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: Record review of the facility policy titled Abuse Neglect and Exploitation - Work Instruction, revised on 10/24/2023 and effective on 10/17/2023, documented that the facility will develop and implement written policies and procedures to investigate abuse, neglect and exploitation of residents and misappropriation of resident's property. 4. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; b. Defining how care provision will be changed and/or improved to protect residents receiving services; c. Training of staff on changes made and demonstration of staff competency after training is implemented; d. Identification of staff responsible for implementation of corrective actions; e. The expected date for implementation; and f. Identification of staff responsible for monitoring the implementation of the plan. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies. Record review of a facility document titled Memo of Understanding, dated 10/30/2023 and signed by Licensed Practical Nurse (LPN) QQ, showed Administrator BB documented the following: Physical Restraints are any manual or physical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom or normal access to one's body. Each resident has the right to be free from actual or threatened physical or chemical restraints. Physical Restraints are prohibited unless indicated by the Physician with the proper documentation, care planning, assessments, and physician order. By signing below, LPN QQ understands the protocol on physical restraints and the utilization of other interventions for fall prevention. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/11/2024 at 11:05 am with the DON, she revealed that the previous Administrator BB informed her LPN QQ had barricaded R4 in his room. According to the DON, the incident occurred while she was on leave. The DON stated Administrator BB addressed the incident internally with a verbal warning, and LPN QQ continued providing care to residents, including R4. During an interview on 4/10/2024 at 12:10 pm, LPN QQ revealed that she was spoken to by the Administrator a few days after the incident with R4 related to a verbal warning. LPN QQ further revealed she continued working after the warning and confirmed she did take care of R4 after 10/27/2023. During an interview on 4/12/2024 at 11:30 am, Administrator BB revealed on 10/27/2023, he was the Administrator on record. Administrator BB stated that on 10/28/2023, RN OO reported that she discovered R4 barricaded with a mattress and chairs against his bed and the other side of the bed against the wall. RN OO stated that R4 was unable to get out of bed, and the mattress blocked his view of his surroundings. Administrator BB stated LPN QQ should never have used a mattress to barricade R4 in his bed. Administrator BB stated that it was considered a restraint and that the use of restraints and involuntary seclusion was against facility policy and not permitted. Administrator BB confirmed staff were not in-serviced, LPN QQ was given a warning, and there was no further investigation. Administrator BB further revealed a complete investigation should have been conducted. During an interview on 4/17/2024 at 2:57 pm, Administrator AA revealed he was the Executive Director in October 2023 and in charge of the entire facility. He stated that on 10/28/2023, Administrator BB reported to him that LPN QQ had involuntarily restrained R4 in his room. Administrator AA stated that the incident was not investigated further and that the proper channels of investigation were not followed.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 49470 Based on interviews, record reviews, and review of the job summaries for the Administrator and Director of Nursing (DON), the facility Administration failed to effectively oversee an abuse prevention program to promote, foster, and maintain an abuse-free environment. The facility census was 32. On 4/16/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. Facility Administrator AA, Director of Nursing (DON), and Hospital Director were informed of the Immediate Jeopardy (IJ) on 4/16/2024 at 11:30 am. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/27/2023. At the time of exit on 4/19/2024, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: Review of job summary for the Administrator revealed, is responsible for directing the day- to- day functions of the Health Centers in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing and personal care facilities. Is appointed by the governing board as Administrator of Record of the skilled nursing area per state and federal regulations. The description included job duties and responsibilities for the categories: strategic direction, results accountability, process improvement, interpersonal communication, leadership skills, safety, corporate and regulatory compliance, and operation improvement. Experience: Five years of healthcare experience in a skilled nursing center, including demonstrated management experience. Knowledge of healthcare regulatory standards, fraud, and abuse laws and state regulations is required. Review of job summary for Director of Nursing revealed, plan, organize, develop, and direct the overall operation of the skilled nursing department as well as all clinical staff in other nursing areas in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed, by the Director of Health Services, and the Medical Director. Collaborates with other disciplines and departments in providing a continuum of care to residents, assisting in budget and financial planning and control, establishes and monitors nursing standards and nursing plan for provision of care and services, nursing performance review, and quality assurance. The description included job duties and responsibilities for the categories: strategic direction, results accountability, process improvement, interpersonal communication, leadership skills, safety, corporate and regulatory compliance, and operation improvement. 1. Administration failed to ensure that one resident (R) (R4) was free from involuntary seclusion when one side of his bed was pushed against the wall, and the other side of the bed was barricaded with a mattress lying perpendicular against the side of the bed and supported by chairs. The mattress and wall blocked R4's view of his room, and he could not get out of his bed from approximately 10:30 pm on 10/27/2023 until 7:30 am on 10/28/2023 when a nurse discovered R4. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Cross-reference: F603 2. The Administration failed to protect the resident's right to be free from physical abuse by staff by failing to report an allegation of abuse in a timely manner to the State Agency (SA) for one of three residents (R)(R4) reviewed for abuse. Cross-reference: F609 3. Administration failed to investigate, correct, and prevent allegations of abuse by staff for one of three residents (R) (R4) reviewed for involuntary seclusion. Specifically, when staff used a mattress and chairs to barricade R4 in his bed for more than eight hours. Cross-reference: F610 4. Administration failed to identify concerns and effectively implement Quality Assurance Process Improvement (QAPI) plans related to the abuse prevention system, including staff to resident abuse allegations and implementing all components of the abuse policies. Cross-reference: F867 During an interview on 4/11/2024 at 11:05 am, with DON revealed that Administrator BB (the previous Administrator) informed her that Licensed Practical Nurse (LPN) QQ had barricaded R4 in his room. The DON stated the incident occurred while she was on leave. The DON stated that Administrator BB stated he had addressed the incident internally. The incident was not reported to the SA. The DON further revealed that no facility-wide in-service was conducted, LPN QQ was not suspended or dismissed from employment while an investigation occurred, and LPN QQ continued providing care to residents, including R4. During an interview on 4/12/2024 at 11:30 am, with Administrator BB it was revealed that on 10/27/2023, he was the Administrator on record. Administrator BB stated that on 10/28/2023, Registered Nurse (RN) OO reported that she discovered R4 barricaded with a mattress and chairs against his bed, and the other side of the bed was pushed against the wall. RN OO expressed that R4 was unable to get out of bed and was unable to view his surroundings. Administrator BB stated LPN QQ should never have used a mattress to barricade R4 in his bed. Administrator BB confirmed staff were not in-serviced, LPN QQ was given a warning, and there was no further investigation. Administrator BB stated he did not notify the Medical Director (MD) regarding the incident and did not report it to the SA. Administrator BB acknowledged a complete investigation should have been conducted. During an interview on 4/15/2024 at 5:34 pm, with MD revealed he was not made aware R4 was restrained involuntarily on 10/27/2023. The MD stated he would have expected staff to report the incident to the SA and that involuntary seclusion was not permitted and was against facility policy. The MD was a member of the QAPI committee and stated the incident was never discussed by the QAPI committee. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2024 at 2:57 pm, with Administrator AA it was revealed that he was the Executive Director in October 2023 and in charge of the entire facility. He acknowledged on 10/28/2023, Administrator BB reported to him that LPN QQ had involuntarily restrained R4 in his room. He further stated that the incident was not reported to the SA or investigated further. Administrator AA stated he believed proper channels of investigating and reporting to the SA were not followed, and the incident was not addressed in the QAPI meeting.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49470 Based on staff interviews, record review, and a review of the facility's policy titled QAPI Change Process- Work Instruction, the facility failed to identify concerns and effectively implement Quality Assurance Process Improvement (QAPI) plans related to abuse prevention system, including staff to resident abuse allegations and implementing all components of the abuse policies. The facility census was 32. On 4/16/2024 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. Facility Administrator AA, Director of Nursing (DON), and Hospital Director were informed of the Immediate Jeopardy (IJ) on 4/16/2024 at 11:30 am. The noncompliance related to the Immediate Jeopardy was identified to have existed on 10/27/2023. At the time of exit on 4/19/2024, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: Record review of the facility policy titled QAPI Change Process- Work Instruction, revised date 10/24/2023 revealed the purpose: 1.0 The facility has established and utilizes a systematic approach to performance improvement activities to ensure changes are effective and improvements are sustained. c. Once a potential problem is identified, the committee utilizes a systematic approach (e.g. Five Whys, flowcharting, fishbone diagram, Failure Mode and Effect Analysis, etc.) (specify one or more methods) to help identify the root cause of the problem. d. As corrective actions are taken, the committee continues to collect and analyze data to determine the effectiveness of any changes. 4. Corrective action - a. Once the root cause of a problem is identified, the QAA committee oversees the development of an appropriate corrective action. An appropriate corrective action is one that addresses the underlying cause of the issue comprehensively, at the systems level. b. Corrective action plans include: i. A definition of the problem -which includes determining contributing causes of the problem; ii. Measurable goals; iii. Step-by-step interventions to correct the problem and achieve established goals; and iv. A description of how the QAA committee will monitor to ensure changes yield the expected results. Record review of a facility document Memo of Understanding, dated 10/30/2023 and signed by Licensed Practical Nurse (LPN) QQ, showed Administrator BB (the previous Administrator) documented the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115680	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlyle Place	5300 Zebulon Road Macon, GA 31210

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Physical restraints are any manual or physical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom or normal access to one's body. Each resident has the right to be free from actual or threatened physical or chemical restraints. Physical restraints are prohibited unless indicated by the physician with the proper documentation, care planning, assessments, and physician order. A discussion was held with you on the use of a fall mat for a fall intervention that may have been considered a restraint. Fall mats are to be used on the floor at the bedside. Other interventions such as assisting the resident to the nursing station or providing resident with an activity are acceptable. The memo concluded that by signing below, LPN QQ understood the protocol on physical restraints and the utilization of other interventions for fall prevention, signed by the Administrator BB and LPN QQ. Administration failed to ensure concerns were identified and QAPI plans implemented, in a timely manner related to the abuse prevention system, including staff to resident abuse allegations, and implementing all components of the abuse polices. As part of the QAPI committee, facility administration failed to identify areas of concern for resident abuse, in a timely manner, and effectively implement interventions to prevent recurrence. A review of facility QAPI documentation revealed that the QAPI committee met quarterly on 10/10/2023, 1/9/2024, and 4/9/2024. There was no evidence in these meetings that identified the abuse allegation concern or the abuse prevention program implementation review prior to start of survey. Record review of the facility letter dated 4/18/2024 and titled Teammate Memorandum for Record, Administrator AA documented in a letter addressed to LPN QQ, on 10/27/2023 LPN QQ placed a mattress on the edge of the bed, resulting in R4 being secluded and restrained. LPN QQ's actions violated safe practices and danger to the life of self or others. As a result, the violation was considered serious in nature and resulted in termination on 4/18/2024. During an interview on 4/12/2024 at 11:30 am with Administrator BB (the previous Administrator) revealed on 10/27/2023 that the incident should have been brought to the QAPI committee and addressed for corrective action. Administrator BB stated that involuntary seclusion was considered a restraint, and the use of restraints and involuntary seclusion was against facility policy and was not permitted. During an interview on 4/15/2024 at 5:34 pm with Medical Director (MD) revealed he was not made aware R4 was restrained involuntarily on 10/27/2023. The MD revealed that he was a member of the QAPI committee and stated the incident was never discussed in the QAPI meeting. During an interview on 4/17/2024 at 10:15 am with Quality Analysis (QA) Registered Nurse (RN), revealed that she was not made aware LPN QQ had barricaded R4 in his room and the incident was not brought before the QAPI committee. The QA RN stated she would have expected the facility to report the incident immediately to the State Agency, investigate the incident, determine the root cause analysis, educate all staff, and provide corrective action as indicated in the facility QAPI policy. During an interview on 4/17/2024 at 12:37 pm, DON said she was a member of the QAPI committee, and the involuntary seclusion that occurred on 10/27/2023 had not been discussed with the QAPI committee, nor was the committee made aware of the incident.