| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115685 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Heardmont Health and Rehabilitation | 1043 Longstreet Road<br>Elberton, GA 30635 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of the facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment, the facility failed to ensure a single use resident care item was not shared between residents in two of 21 rooms (room [ROOM NUMBER] and room [ROOM NUMBER]). Specifically, a foam wedge was taken from room [ROOM NUMBER] and used to reposition a resident bed in room [ROOM NUMBER]. This deficient practice had the potential to place the resident at risk for medical complications, unmet needs, and a diminished quality of life.Findings include:Review of the facility's policy titled Cleaning and Disinfection of Resident-Care Items and Equipment revised October 2018, under the Policy statement revealed, Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Blood bore Pathogens Standard. Under the section titled Policy Interpretation and Implementation number one sub-section d, revealed reusable items are cleaned and disinfected or sterilized between residents, (1) Single resident use items are clean/disinfected between uses by a single resident and disposed of afterwards (e.g. bedpans, urinals).Observation on 9/26/2025 at 8:15 am revealed, Certified Nursing Assistant (CNA) DD entered room [ROOM NUMBER] and took a foam wedge from the closet in the room and exited the room. Continued observation revealed, CNA DD then took the foam wedge to room [ROOM NUMBER] and used the foam wedge to reposition the resident in (bed 3) so that she could assist with the morning meal. During an interview on 9/26/2025 at 8:30 am with CNA DD revealed that she did go into room [ROOM NUMBER] and obtain a foam wedge from a closet and took the foam wedge into room [ROOM NUMBER]. She stated she wiped the wedge with a wipe and then placed the wedge on the right side of resident, to assist with maintaining the resident in an aligned supine position (on her back) at a 45-degree angle, so she could eat breakfast safely. She acknowledged that she should have placed a cover over the wedge before using it with the resident. She revealed that the resident in room [ROOM NUMBER] did not have a wedge of her own. CNA DD revealed that when residents do not have a wedge and they know another resident that has a wedge, they would use the other residents wedge for the resident who needed one. She revealed this was her normal practice. During an interview on 9/26/2025 at 2:49 pm with Registered Nurse (RN) AA, revealed that all residents should have a wedge for positioning if they need one. She stated staff should not use a wedge that was assigned to one resident for any other residents. She revealed it was not acceptable for staff to do this even if they clean the foam wedge and covered it. She stated this could cause cross contamination and possible infection control problems. She confirmed the facility uses foam wedges and she stated the proper procedure when a resident is identified to need a wedge is to notify the House Keeping Supervisor who would check the storage building and provide a new wedge for the resident who needed it. Interview on 9/26/2025 at 3:06 pm with the DON further explained that the facility used foam wedges for positioning residents. She revealed that the nursing staff determined which residents needed a foam wedge through observations. She revealed if the need for a foam wedge was determined then the nurse would call the physician for an order and then they would develop a care plan for this intervention. She revealed that if a foam wedge was stored in a residents<br>(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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | closet it was specifically for that resident's use only. She stated it was not acceptable to use a foam wedge with multiple residents or share a foam wedge with multiple residents. She stated her expectation of staff was to use the foam wedge for the resident it was assigned to only. She stated the use of a foam wedge with more than one resident was not hygienic and could lead to cross contamination and facility acquired infections. Interview on 9/27/2025 10:36 am with the DON revealed the foam wedge utilized during breakfast in room [ROOM NUMBER] was a single resident use item and should not be shared with any other residents. |