STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115686	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nancy Hart Operation LLC	2117 Dr George Ward Road 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, staff and resident interviews, record review, and review of the facility's policies titled, Handwashing/Hand Hygiene and Infection Prevention and Control Program, the facility failed to ensure proper hand hygiene practices were followed, failed to implement Enhanced Barrier Precautions (EBP), and failed to establish a water management program to address the risk of waterborne pathogens, including Legionella. These failures had the potential to contribute to the transmission of infectious diseases among residents and staff. The census was 65.Findings include:Review of the facility's undated policy titled Handwashing/Hand Hygiene, revealed section (7.l) revealed, Use of alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: After contact with objects.in the immediate vicinity of the resident.Review of the facility's policy titled, Infection Prevention and Control Program, review date May 2022, included, Water Management: A water management program has been established as part of the overall infection prevention and control program. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. Additionally, review of the policy revealed there was no content addressing EBP, and the facility was unable to provide an EBP policy.1. Observations on 7/23/2025 at 2:09 pm revealed Laundry Aide MM entered and exited multiple resident rooms while delivering clean clothing and placing items inside residents' closets without performing hand hygiene at any point during the process.Observations on 7/24/2025 at 2:00 pm revealed Laundry Aide MM entered and exited multiple resident rooms while delivering clean clothing and placing items inside residents' closets without performing hand hygiene at any point during the process.In an interview on 7/24/2025 at 5:15 pm, Laundry Aide MM confirmed that she did not perform hand hygiene after entering and exiting each resident's room, and was uncertain about the exact moments when hand hygiene should be performed. Laundry Aide MM reported receiving hand hygiene training during her initial hire in 2020, and stated she had not received any additional or refresher training since.2. Review of the facility-provided MDS [Minimum Data Set] Resident Matrix, dated 7/22/2025, revealed three residents with an indwelling urinary catheter and two residents with a pressure ulcer. Review of a facility-provided document titled Long Term Care CNA Skills Checklist revealed EBP was not on the checklist. In an interview on 7/23/2025 at 2:05 pm, Certified Nursing Assistant (CNA) NN stated EBP involved applying barrier cream every two hours. She reported that she does not currently wear a gown for any resident and only performs hand hygiene before entering resident rooms, not after. She stated that she had not been required to demonstrate specific Personal Protective Equipment (PPE) competency check-offs, only general CNA skills.In an interview on 7/23/2025 at 1:07 pm, the Director of Nursing (DON) revealed that EBP had not been implemented at the facility. The DON described EBP as fairly new and acknowledged that no staff training had been conducted and no procedures, policies, or protocols were in place at the time of the interview.In an interview on 7/24/2025 at 10:03 am, the DON revealed that hand hygiene and PPE competency check-offs had not been conducted since she assumed her role. During the interview, the DON also mentioned that she had identified seven residents who met the criteria for EBP.3. Review of the facility's infection surveillance records revealed no documentation of a water management program or Legionella monitoring.Review of a (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility-provided document titled Emergency Management Plan, dated 7/24/2025, revealed Samples are sent to State Lab. Lead, copper, E.coli, and coliform.In an interview on 7/23/2025 at 2:37 pm, the Maintenance Director revealed that the facility had not implemented a formal Water Management Program. He stated he possessed a Centers for Disease Control and Prevention (CDC) printout on the topic but had not developed a functional plan and admitted not fully understanding the program's requirements. He noted that an external company collected monthly well water samples, but was unsure of the specific contaminants tested. A follow-up with the Environmental Management Services confirmed that the testing is limited to lead, copper, and coliform (E. coli), with no monitoring for Legionella and no risk assessment or control measures in place.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to ensure a safe, clean, and comfortable homelike environment in seven of 26 resident rooms. This deficient practice had the potential to impact the quality of life and safety of all residents occupying the areas. Findings include:Observation on 7/22/2025 at 11:30 am of room [ROOM NUMBER] revealed a two-inch hole in the wall behind the resident's door, and a two-inch hole in the door leading to the bathroom.Observations on 7/22/2025 beginning at 11:23 am revealed Rooms 108, 200, 201, 202, 203, 204, and 205 had chipped and peeling paint on the walls near the residents' beds and window areas. Further observations revealed the ceiling ventilation units in Rooms 108, 200, 201, 202, 203, 204, and 205 had a buildup of fuzzy material covering the ventilation slats. Continued observations of Rooms 108, 200, 201, 202, 203, 204, and 205 revealed jagged closet edges, soiled baseboards, and scuffed walls. During a walk-through observation on 7/24/2025 at 1:12 pm, the Maintenance Director verified all identified concerns.During an interview on 7/24/2025 at 2:00 pm, the Maintenance Director acknowledged that the rooms had ongoing cosmetic and structural issues. He stated that the repairs were pending due to supply delays and the fact that he was the only maintenance staff member at this time. He stated he understands the importance of the environmental concerns, emphasizing peeling paint, holes in walls, and dust accumulation, which are not consistent with creating or sustaining a homelike environment for all residents. He confirmed that the staff put work orders into the computer system, and he sorts them according to priority.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to implement care plan interventions for one of 36 sampled residents (R) (R33). This deficient practice had the potential to place R33 at increased risk of medical complications and unmet care needs. Findings include:Review of the electronic medical records (EMR) revealed that R33 was admitted to the facility on [DATE] with diagnoses including, but not limited to, type 2 diabetes mellitus (DM) and stage 3 chronic kidney disease.Review of R33's admission Minimum Data Set (MDS), dated [DATE], revealed Section I (Active Diagnoses) documented diabetes mellitus as an active diagnosis. Section N (Medications) documented that R33 received insulin. Review of the care plan for R33 revealed a Focus date initiated 7/7/2025, of the resident has diabetes mellitus. The Goal included that the resident will be free from any signs or symptoms of hyperglycemia or hypoglycemia through the next review date. Interventions included administering diabetes medication as ordered by the doctor, monitoring and documenting for side effects and effectiveness, monitoring and documenting signs of hyperglycemia and hypoglycemia. Review of the Physician Orders for R33 revealed an order dated 7/3/2025 for insulin glargine subcutaneous solution 100 units/milliliter (ML) (a medication used to manage high blood sugar), inject 16 units subcutaneously at bedtime for DM.Review of the Medication Administration Record (MAR) for R33, dated July 2025, revealed that R33 was scheduled to receive a nightly dose of insulin glargine subcutaneous 16 units at bedtime and was scheduled for 9:00 pm. Further review of the July 2025 MAR revealed that the insulin glargine was not administered on 16 of 19 dates, and there was no documentation of monitoring for signs of hypoglycemia or hyperglycemia. In an interview on 7/23/2025 at 12:10 pm, Licensed Practical Nurse (LPN) HH stated she regularly cared for R33 and was unaware the resident was a diabetic. She confirmed that she had not administered any diabetes medications to him and had not been monitoring for signs or symptoms of hyperglycemia or hypoglycemia. She also stated that she had not seen it documented in the care plan.In a telephone interview on 7/23/2025 at 7:53 pm, LPN CC stated she regularly cared for R33. She further stated she was unsure if R33 was a diabetic, and she had not monitored R33 for signs of hypoglycemia or hyperglycemia or administered the insulin as ordered by the physician. In a concurrent interview on 7/24/2025 at 12:10 pm with the Director of Nursing (DON), Unit Manager (UM), and MDS Coordinator, the DON stated that her expectation is for nurses to review the care plans developed for each resident and to implement them. The DON further acknowledged that monitoring R33 for signs and symptoms of hypoglycemia was overlooked, despite being included in the care plan, because it was not included on the MAR.Cross-reference F760

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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 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, Policy and Procedure Manual: Clinical P&P Respiratory Care, the facility failed to ensure that oxygen therapy was provided as ordered for two of six residents (R) (R69 and R46) with oxygen orders. In addition, the facility failed to ensure respiratory circuits were cleaned as ordered for two of six residents (R46 and R48) with respiratory circuits. This deficient practice had the potential to place R69, R46, and R48 at increased risk of respiratory complications.Findings include: Review of the policy titled, Policy and Procedure Manual: Clinical P&P Respiratory Care, dated 4/1/2022, revealed the “Procedure” section included, 1. Verify that there is a physician’s order for respiratory procedures or oxygen use. Review the physician’s orders for oxygen administration. … 10. Oxygen, trach, and nebulizer tubing is changed weekly and dated as verification that the tubing was changed. … 1. Review of the electronic medical record (EMR) for R69 revealed diagnoses including, but not limited to, acute chronic diastolic (congestive) heart failure and chronic respiratory failure with hypoxia. Review of the “Physician Orders” for R69 revealed an order dated 7/23/2025 for Oxygen at 2 liters per minute via (by way of) NC (nasal canula) PRN (as needed). Observations on 7/22/2025 at 1:21 pm, 7/23/2025 at 11:45 am, 7/24/2025 at 11:00 am, and 1:00 pm revealed R69 was in his bed and receiving oxygen via NC via a concentrator. The flow rate was set at 3 LPM. Observation and interview on 7/24/2025 at 1:30 pm of R69 with Registered Nurse (RN) Unit Manager (UM) BB confirmed the resident was receiving oxygen at 3 LPM. She further confirmed that R69 had a physician order for oxygen at 2 LPM. RN BB stated that she would adjust the oxygen setting. 2. Review of the electronic medical record (EMR) revealed R46 was admitted to the facility on [DATE] with pertinent diagnoses, including but not limited to, chronic obstructive pulmonary disease (COPD) with acute exacerbation, hypertension, anemia, and a history of venous thromboembolism. Review of R46's Annual Minimum Data Set (MDS) assessment, dated 6/11/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 4 (which indicates severe cognitive impairment). Section O (Special Treatments, Procedures, and Programs) documented that the resident received oxygen while a resident. Review of the “Physician’s Orders” for R46 revealed an order dated 2/5/2025 for oxygen via NC at 2 LPM continuous. Observation on 7/22/2025 at 10:04 am revealed R46 in her room receiving oxygen via a NC via a concentrator with the flow rate set at 3 LPM. Observation revealed the oxygen tubing was dated 7/7/2025. In a concurrent observation and interview on 7/23/2025 at 10:10 am with R46 in her room, observation revealed R46 was not receiving oxygen. Further observation revealed the oxygen concentrator was turned off. R46 stated she did not turn the concentrator off. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/22/2025 at 2:00 pm, Licensed Practical Nurse (LPN) JJ confirmed that R46’s oxygen flow rate was set incorrectly and should be set to 2 LPM. In an interview on 7/23/2025 at 10:16 am, LPN DD confirmed that R46’s oxygen concentrator was turned off and that the resident was not receiving oxygen. LPN DD further confirmed that the oxygen tubing was dated 7/7/2025 and acknowledged it was overdue for replacement. She stated tubing should be changed weekly and confirmed it was two weeks past due. In an interview on 7/23/2025 at 2:10 pm, the Director of Nursing (DON) stated it was the nurse's responsibility to check oxygen settings each shift and change the oxygen tubing weekly.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled, Administration of Insulin, the facility failed to ensure that one of 15 residents (R) (R33) with physician orders for insulin received the insulin as prescribed by the physician. This deficient practice had the potential to place R33 at risk of medical complications and unmet needs. Findings include:Review of the facility's policy titled, Administration of Insulin, reviewed date 4/29/2025, reveals the Policy section included, It is the purpose of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. The Policy Explanation and Compliance Guidelines section included, 1. All insulin will be administered in accordance with physician's orders. 3. For new or emergency orders for insulin, the facility may use medications from the emergency kit.Review of the electronic medical records for R33 revealed an admission date of 7/3/2025 with diagnoses including, but not limited to, type 2 diabetes mellitus (DM) and stage 3 chronic kidney disease.Review of R33's admission Minimum Data Set (MDS), dated [DATE], revealed Section I (Active Diagnoses) documented diabetes mellitus as an active diagnosis. Section N (Medications) documented that R33 received insulin. Review of the Physician Orders for R33 revealed an order dated 7/3/2025 for insulin glargine subcutaneous solution 100 units/milliliter (ML) (a medication used to manage high blood sugar), inject 16 units subcutaneously at bedtime for DM.Review of the Medication Administration Record (MAR) for R33, dated July 2025, revealed that R33 was scheduled to receive a nightly dose of insulin glargine subcutaneous 16 units at bedtime and was scheduled for 9:00 pm. Further review of the July 2025 MAR revealed that the insulin glargine was not administered on 7/3/2025, 7/4/2025, 7/5/2025, 7/6/2025, 7/9/2025, 7/8/2025, 7/9/2025, 7/10/2025, 7/11/2025, 7/12/2025, 7/13/2025, 7/14/2025, 7/15/2025, 7/16/2025, 7/17/2025, 7/18/2025, 7/19/2025, 7/20/2025, or 7/21/2025. The MAR was marked with the number 9 on 7/3/2025, 7/4/2025, 7/5/2025, 7/6/2025, 7/9/2025, 7/10/2025, 7/11/2025, 7/13/2025, 7/15/2025, 7/16/2025, 7/17/2025, 7/18/2025, 7/19/2025, 7/20/2025, and 7/21/2025. The MAR was marked with the number 2 on 7/12/2025 and the number 3 on 7/14/2025. Review of the Chart Codes, located on the MAR, revealed 2 = Drug refused, 3 = Absent from home with meds, and 9 = other/see progress notes.Review of the Progress Notes for R33 revealed entries dated 7/3/2025, 7/13/2025, 7/14/2024, 7/21/2025, 7/22/2025 documented Awaiting pharmacy. There was no documentation for the other days when the insulin was not administered. In a telephone interview on 7/23/2025 at 7:53 pm, Licensed Practical Nurse (LPN) CC stated that she had not administered the insulin because it had not been received from the pharmacy, and she had continued to reorder it. LPN CC stated she had not called the pharmacy or notified the physician for further instructions and stated she assumed the insulin would eventually arrive.In a telephone interview on 7/23/2025 at 8:47 pm, Pharmacist CC stated the pharmacy delivered to the facility one or two times a day. Pharmacist CC stated an order for insulin glargine for R33 had not been ordered, and there was no prescription for it on file. In a concurrent interview on 7/24/2025 at 12:10 pm with the Director of Nursing (DON), Unit Manager (UM), and MDS Coordinator, the DON stated that her expectation was for nurses to follow the physician's orders as written. When a new resident is admitted , orders are to be entered immediately, and any issues with medications must be communicated promptly to the pharmacy. She emphasized that medications must be administered on schedule. If medication is not available, staff are expected to contact the physician directly for guidance. The UM stated that if medication was unavailable, staff have access to four emergency kits, and if the medication was still not available from the emergency kit, they will physically go to the pharmacy to obtain it. The DON further acknowledged that she could not explain why the nurse failed to follow through with obtaining the insulin.