STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115690	A. Building B. Wing	06/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D Scott Hudgens Center for Skilled Nursing, The	3500 Annandale Lane Suwanee, GA 30024

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 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** 35180 Based on record review, staff interviews, and review of the facility's policy titled, Comprehensive Care Plans, the facility failed to develop a comprehensive person-centered care plan for two of 18 sampled residents (R) (R13 and R29). This deficient practice had the potential for the residents not to receive treatment and/or care according to their needs. Findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 10/23/2023, under the section titled, Policy revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Under the section titled, Policy Explanation and Compliance Guidelines for Number two revealed, The comprehensive care plan will be developed within seven days after rhe completion of the comprehensive Minimum Data Set (MDS) assessment. All Care Assessment Areas (CAAs) triggered by the MDA will be considered in developing a plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. Number five revealed, The comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS Assessment. 1. Review of R13's clinical record revealed diagnoses that included dementia, Rhett's Syndrome, anxiety disorder, major depressive disorder, and profound intellectual disabilities. Review of R13's Quarterly MDS dated [DATE] revealed Section N (Medications) indicated she received antipsychotic and antidepressant medications during the assessment period. Review of R13's Annual MDS dated [DATE] revealed that cognitive deficit/dementia was triggered in the CAAs with the decision to develop a care plan. Review of R13's Physician's Orders revealed that she was received olanzapine five mg (milligrams) QAM (every morning) and olanzapine 15 mg QHS (every night) for behaviors related to Rhett's Syndrome; and paroxetine HCL 20 mg QD (every day) for Major Depressive Disorder (MMD). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R13's care plans revealed that she had care plans developed for the use of antidepressant medications related to depression, the use of psych medications to adjust behavior management, and Rhett's Syndrome for assistance required due to constantly hitting her head with her right hand. Further review of R13's Rhett's Syndrome care plan revealed a documented intervention was to see the care plan for cognitive function, which was not developed for R13's current care plan. A continued review revealed that no individualized interventions were present in R13's care plan to address cognitive concerns related to dementia or cognitive deficit, nor to monitor progress towards a therapeutic goal. Interview on 6/15/2024 at 10:11 am with the MDS Coordinator revealed she would sometimes incorporate resident cognitive deficit interventions into other care areas within a resident's care plan. She added that R13 also had a diagnosis of Rhett's Syndrome and dementia, which caused cognitive issues, and she believed the care plan for Rhett's Syndrome addressed cognitive impairments. She confirmed that on review of R13's care plan, there were no interventions for cognitive deficits/dementia, and the Rhett's Syndrome care plan had a documented intervention to refer to the care plan for cognitive impairment, which she had not developed for R13. The MDS Coordinator confirmed that interventions for cognitive deficits/dementia should have been developed for R13. During an interview on 6/16/2024 at 10:43 am with the Director of Nursing (DON) revealed, that it was her expectation that the MDS Coordinator would update and develop care plans for each resident based on the resident's individual needs. The DON stated that due to the nature of the resident population in the facility, most of the residents were considered cognitively impaired, so a resident that had a cognitive impairment might have interventions for cognitive impairment/dementia under other care areas; however, the DON stated she expected that individualized interventions related cognitive issues should be listed in the care plan, even if they were documented in other areas. The DON confirmed that R13 had cognitive impairment that required specialized interventions for certain behaviors, which she expected the MDS Coordinator to document within the care plan. 46691 2. Review of R29's Quarterly MDS dated [DATE] revealed Section E (Behaviors) documented hallucinations and delusions, Section I (Active Diagnoses) documented schizophrenia, and Section N (Medications) documented she received an antipsychotic medication. Review of R29's physician orders revealed an order dated 4/17/2024 for clozapine (an antipsychotic medication used to treat schizophrenia) 25 mg one tablet by mouth two times a day related to schizoaffective disorder and an order dated 4/17/2024 for Risperdal (an antipsychotic medication used to treat schizophrenia) 0.5 mg one tablet by mouth two times a day related to schizoaffective disorder. Review of R29's care plan revealed there was no focus area, goals, or interventions for the use of antipsychotic medications. Review of t R29's Medication Administration Records (MARs) dated 4/2024, 5/2024, and 6/2024 revealed R29's medications were administered as ordered by the physician. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/16/2024 at 9:30 am, the MDS Coordinator stated she was responsible for ensuring the care plans were accurate and up to date according to the MDS assessments. She verified that R29 received an antipsychotic, which was ordered on 4/17/2024, and that there was no focus area, goals, or interventions on R29's care plan for the use of antipsychotic medication. She stated she developed care plan focus areas based on the MDS assessments, and once the care plan was developed, a nurse manager reviewed the care plan to check for accuracy. She confirmed the use of antipsychotic medication should be included in R29's care plan and stated it was just overlooked. Interview on 6/16/2024 at 9:40 am, the DON stated the MDS Coordinator was responsible for ensuring care plans were accurate at each MDS assessment. She stated she or another Registered Nurse (RN) at the facility also reviewed completed care plans to check for accuracy. She further stated since R29 received antipsychotic medication, her care plan should have a focus area, goal, and intervention related to the use of the medication and it was an oversight that it was not developed.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 35180 Based on staff interviews, record review, and review of the PBJ (Payroll Based Journal) [NAME] Report for First Quarter (Q1) of fiscal year 2024 (October 1-December 31), the facility failed to accurately report its staffing data to the Centers for Medicare and Medicaid (CMS) related to Registered Nurse (RN) coverage and Licensed Nursing Coverage 24 hours a day. The facility census was 31 residents. Findings include: Review of the PBJ [NAME] Report for Q1 2021, October 1 through December 31, revealed the facility reported data, which declared there was no coverage by a RN for at least eight hours for the following dates: 1. October 7, October 8, October 21, and October 22. 2. December 2, December 3, December 30, and December 31. Review of the PBJ [NAME] Report for Q1 2021, October 1 through December 31, revealed the facility reported data, which declared there was no coverage by Licensed Nursing Coverage 24 hours a day for the following dates: 1. December 27, December 28, December 29, December 30, and December 31. Review of the facility's staffing hours and payroll verification revealed a RN was in the facility on 10/7/2023, 10/8/2023, 10/21/2023, 10/22/2023, 12/2/2023, 12/3/2023, 12/30/2023, and 12/31/2023. A further review revealed licensed staff was present in the facility for 24 hours a day on 12/27/2023, 12/28/2023, 12/29/2023, 12/30/2023, and 12/31/2023. During an interview on 6/15/2024 at 1:30 pm with the Accounting Assistant (AA) revealed, she received the staffing hours from the facility's Payroll Specialist (PS), who was currently out of the county and unavailable for an interview. The AA stated, the facility utilized an electronic payroll reporting system, and she used that information to create a spreadsheet that listed all the staff's hours. She stated she would then manually upload the hours into CMS's PJ&J reporting system online. The AA stated she does not know why there would have been a discrepancy in the hours unless she had not been provided accurate information from the PS. During an interview on 6/15/2024 at 1:54 pm with the Administrator revealed, the scheduler makes the schedule to ensure enough RN and licensed staff coverage in the facility. If there are any callouts, the scheduler would adjust the schedule. The scheduler would then report the hours to the PS, and then the PS and AA would use the electronic payroll system to document and verify the hours worked by the staff. The AA would ensure the hours are sent to CMS. The Administrator explained that salaried staff, which included some of their licensed staff, did not clock in, and that may have been the cause of the discrepancy. The Administrator stated that moving forward, the facility would ensure that salaried hours were also included in the reported hours.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 44960 Based on staff interviews and review of the facility's policies titled, Infection Prevention and Control Program and [Name of the Facility] Position Description, the facility failed to have a qualified Infection Preventionist who had completed the required specialized training in infection prevention and control. This failure placed all residents at risk for the potential transmission of infections and communicable diseases. The facility census was 31 residents. Findings include: Review of the facility's policy titled, Infection Prevention and Control Program dated 10/23/2023 under the section titled, Policy Explanation and Compliance Guidelines: revealed, Number one, The designated Infection Preventionist (IP) is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases Number 16. Staff Education: (a.) All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. Review of the facility's policy titled, [Name of Facility] Position Description undated, under the section titled Qualifications revealed The IP must be qualified by education, training, experience or certification An IP must have obtained specialized IPC training beyond initial professional training or education prior to assuming the role. Training can occur through more than one course, but the IP must provide evidence of training through a certificate of completion or equivalent documentation. During an interview on 6/15/2024 at 8:52 am with the Director of Nursing (DON) revealed, she had not completed any specialized training in infection prevention and control. The DON revealed she had completed one module in the training and the facility currently did not have anyone employed at the facility certified as an IP. During an interview on 6/16/2024 at 9:15 am with the Administrator identified the DON as the person responsible for coordinating the implementation and updating the facility's infection control practices. The administrator confirmed there was no other staff member at the facility certified as an IP.