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	09/18/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, staff interviews, record review, and review of the facility's policy titled, Confidentiality of Information and Personal Privacy, the facility failed to ensure the privacy of resident's health information for two of 14 sampled residents (R) (R16 and R4). The deficient practice created the potential for residents' health information to be accessed by unauthorized personnel and visitors.Findings include:Observation on 9/17/2025 at 9:15 am revealed Registered Nurse (RN) AA walked away from the medication cart which was in the resident hallway, facing away from the resident's room, leaving R16's information on the electronic medication administration record (eMAR) visible on the medication cart unattended.Observation on 9/17/2025 at 9:53 am, RN AA left the medication cart unattended in the common area with prepared medications on the med cart table with the eMAR screen visible to other residents and visitors of R4's information.Interview on 9/17/2025 at 12:15 pm with nurse RN AA confirmed that she forgot to minimize the eMAR screen while unattended during medication administration for R4. She revealed that it was important to minimize the eMAR screen so no one could see resident's information. Interview on 9/17/2025 at 2:30 pm with the Director of Nursing (DON) revealed her expectations for the protection of resident's personal information during medication administration were the nurses were to minimize the eMAR screen while it was unattended. The risk of leaving the eMAR visible while cart was unattended could lead to violation of HIPAA (Health Insurance Portability and Accountability Act). Interview on 9/18/2025 at 4:00 pm with the Administrator revealed her expectations regarding residents' rights specifically regarding privacy of health information were for staff to use privacy screens or log out if needing to leave it unattended. If working in an office, her expectations included locking documents away.

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
	115690	A. Building B. Wing	09/18/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, record review, and review of the facility's policy titled, Administering Medications, the facility failed to ensure the medication cart located on the 200 hallway was locked when unattended during medication pass. The deficient practice created the potential for residents, unauthorized staff and visitors to have access to medication stored on the medication cart.Findings include:Review of the facility's policy titled Administering Medications, revised April 2019 under Policy Interpretation and Implementation, statement 19, During administration of medication, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.Observation on 9/17/2025 at 9:15 am revealed Registered Nurse (RN) AA walked away from the medication cart, which was located on the 200 hallway, facing away from the resident's room, leaving the medication cart unattended. RN AA returned to the medication cart twice to get gloves and tissue, leaving the medication cart unlocked and unattended.Interview on 9/17/2025 at 12:15 pm with RN confirmed that she forgot to lock the cart while unattended during medication administration. She confirmed that the unlocked cart was in the hallway facing the common area visible to visitors, staff and other residents. She revealed that it was important to keep the medication cart locked when she walked away so no one could potentially access medications. Interview on 9/17/2025 at 2:30 pm with the Director of Nursing (DON) revealed her expectation for the maintenance of the medication cart when unattended was that all nurses were to maintain medication carts locked. The risks could lead to a resident having direct access to medication. Interview on 9/18/2025 at 4:00 pm with the Administrator revealed her expectations include locking medication carts when unattended.