STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115695	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Union County Nursing Home	164 Nursing Home Circle Blairsville, GA 30512

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** Based on observations, staff interviews, record review, and review of the facility's policy titled, Comprehensive Care Plan Meetings, the facility failed to implement the comprehensive care plan for one of 34 residents (R) (R82). The deficient practice had the potential to prevent R82 from receiving services according to their care needs.Findings include:Review of the facility's undated policy titled, Care Plan Meetings revealed under Purpose: .Each resident will have an individualized interdisciplinary plan of care in place.The Comprehensive Care plan will be ongoing, focusing on each induvial resident as a unitary being. Resident and their representative will play an active role in the development of goals and implementation of the residents' Comprehensive Care Plan. Under Procedure: number 2.This comprehensive care plan will address resident goals, actual and potential problems, needs, strengths, and individual preferences for the resident.Review of R82's Electronic Medical Record (EMR) revealed diagnoses that included, but were not limited to bilateral hearing loss, receptive expressive language disorder, dementia, cognitive communication deficit. Review of R82's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment; Section B (Hearing, Speech, and Vision) a score of 2 for hearing, indicating moderate difficulty-the speaker has to increase volume and speak distinctly-and that a hearing aid or other hearing appliance is used.Review of the care plan dated 5/1/2024 revealed the following problem: She has moderate hearing difficulty with the use of her hearing aids. The speaker must adjust voice tone and speak distinctly. Per resident's daughter, she has 80% hearing loss and is good at reading lips. On 9/25/2024, the family brought in new hearing aids. She has clear speech and is usually understood. She usually understands others. Interventions included: Face resident and speak distinctly when in conversation with her. Provide hearing aid care and storage as ordered. Assist resident as needed.Review of the physician orders revealed an order: Nurse to insert hearing aids daily and ensure hearing aids are on charger every night, two times a day.During an initial screening on 9/30/2025 at 10:04 am, R82 was observed lying in bed and noted to be very hard of hearing, loudly telling the surveyor that she is deaf. Bilateral hearing aids were observed fully charged, with green indicator lights on, sitting on the bedside drawer. R82 asked the surveyor to place them in, stating that it'll help me hear better, and added that staff needed to help her get them in.On 9/30/2025 at 2:40 pm, staff were observed leaving the room. When the surveyor entered, the charged hearing aids were still on the bedside table and not in the resident's ears. R82 did not hear the surveyor, pointed to the hearing aids, again fully charged with green indicator lights on, and stated she can't hear.On 10/1/2025 at 8:26 am, 12:45 pm, and 4:20 pm, R82 was observed lying in bed without hearing aids, which remained on the bedside drawer, fully charged. Communication between the surveyor and R82 was unsuccessful, as R82 asked the surveyor to come closer, stated she was deaf, and again asked the surveyor to place her hearing aids in and check if they were working.Interview on 10/1/2025 at 4:28 pm, with Licensed Practical Nurse (LPN) AA, revealed that when communicating with R82 she comes close, speaks loudly, and that R82 can also read lips. When asked if she places the hearing (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aids in R82's ears, LPN AA paused for a moment and replied, The hearing aids were in, I saw them in her ears. The surveyor and LPN then entered the resident's room, where LPN AA acknowledged that the hearing aids were not in the resident's ears but were on the bedside drawer.In a phone interview on 10/2/2025 at 9:40 am, with the family member for R82 revealed that staff are supposed to place the residents' hearing aids in the morning and remove them at night, but they often forget to do so. She further stated that this concern had been discussed with staff during interdisciplinary team meetings.Interview on 10/2/2025 at 9:53 am, with the Registered Nurse (RN/MDS coordinator, she stated that care plans are individualized for each resident and developed to address their specific diagnoses and conditions. She explained that care plans guide staff in providing appropriate care and are updated as needed to reflect changes in the residents' condition. She added that her expectation is for staff to refer to the care plan when providing daily care and services.Interview on 10/2/2025 at 10:00 am with the Director of Nursing (DON), revealed that her expectation is for nursing staff to follow the care plans in the course of their work to ensure residents receive care as planned.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **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 Medications, the facility failed to ensure one of four residents (R) (R82) bilateral hearing aids were applied as ordered by the physician. The deficient practice had the potential to reduce R82 quality of life by increasing the probability of impaired communication.Findings include:Review of the facility's policy titled, Administration of Medications, dated 2/2021, revealed under Procedure: D. The person administering the drugs immediately following the administration must chart medication administration as being given on the eMAR. The eMAR applies the date, time administered, dosage, ect., and e-signs by the person entering the data.Review of R82's Electronic Medical Record (EMR) revealed diagnoses that included, but were not limited to bilateral hearing loss, receptive expressive language disorder, dementia, and cognitive communication deficit.Review of R82's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment; Section B (Hearing, Speech, and Vision) a score of 2 for hearing, indicating moderate difficulty-the speaker has to increase volume and speak distinctly-and that a hearing aid or other hearing appliance is used.Review of the care plan dated 5/1/2024 revealed the following problem: She has moderate hearing difficulty with the use of her hearing aids. The speaker must adjust voice tone and speak distinctly. Per resident's daughter, she has 80% hearing loss and is good at reading lips. On 9/25/2024, the family brought in new hearing aids. She has clear speech and is usually understood. She usually understands others. Interventions included: Face resident and speak distinctly when in conversation with her. Provide hearing aid care and storage as ordered. Assist resident as needed.Review of the physician orders revealed an order: Nurse to insert hearing aids daily and ensure hearing aids are on charger every night, two times a day.Review of the Medication Administration Record (MAR) for the last month revealed that the task of inserting hearing aids daily and ensure hearing aids were on the charger every night, twice a day at 9 am and 9 pm, was checked as completed without omissions.During an initial screening on 9/30/2025 at 10:04 am, R82 was observed lying in bed and noted to be very hard of hearing, loudly telling the surveyor that she is deaf. Bilateral hearing aids were observed fully charged, with green indicator lights on, sitting on the bedside table. R82 asked the surveyor to place them in, stating that it'll help me hear better, and added that staff needed to help her get them in.Observation on 9/30/2025 at 2:40 pm, staff were observed leaving the room after providing care. When the surveyor entered, the charged hearing aids were still on the bedside table and not in the resident's ears. R82 did not hear the surveyor, pointed to the hearing aids, again fully charged with green indicator lights on, and stated she can't hear.Observations on 10/1/2025 at 8:26 am, 12:45 pm, and 4:20 pm, R82 was observed lying in bed without hearing aids, which remained on the bedside table, fully charged. Communication between the surveyor and R82 was unsuccessful, as R82 asked the surveyor to come closer, stated she was deaf, and again asked the surveyor to place her hearing aids in and check if they were working.Interview on 10/1/2025 at 4:28 pm, with Licensed Practical Nurse (LPN) AA, who was responsible for the care of R82 was asked how she communicates with the resident, LPN AA stated that she comes close, speaks loudly, and that R82 can also read lips. When asked if she places the hearing aids in R82's ears, LPN AA replied, The hearing aids were in, I saw them in her ears. The surveyor and LPN then entered the resident's room, where LPN AA acknowledged that the hearing aids were not in the resident's ears but were on the bedside table. Continued interview also revealed that staff member was asked about the physician's order documented on the MAR, Nurse to insert hearing aids daily and ensure hearing aids are on charger every night, two times a day, LPN AA could not explain why she had documented the task as completed when it had not been done. She admitted that going forward, (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she would follow the MAR more closely.Phone interview on 10/2/2025 at 9:40 am with the family member of R82 revealed that staff are supposed to place the residents' hearing aids in the morning and remove them at night, but they often forget to do so. She further stated that this concern had been discussed with staff during interdisciplinary team meetings.Interview on 10/2/2025 at 10:00 am with the Director of Nursing (DON), she stated that her expectation is for nursing staff to follow physician's orders as written, and that if a task is checked off on the MAR, it indicates that the task-whether medication administration or inserting hearing aids-has been 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policies, titled Cleaning and Disinfection of Resident-Care Items and Equipment and Enhanced Barrier Precautions, the facility failed to ensure infection control practices were followed for four of 15 residents (R) (R7, R9, R75 and R83). Specifically, the facility failed to maintain Enhanced Barrier Precautions (EBP) when administering medications via gastrostomy tube for R9, and providing urinary catheter care for R7, the facility also failed to ensure shared medical equipment was sanitized between R75 and R83 during medication administration.Findings include:Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 2/2021 under Policy Interpretation and Implementation: 1.c.non-critical items are those that come in contact with intact skin but not mucous membranes. 1. Non- critical resident-care items include bedpans, blood pressure cuffs, crutches and computers. d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment).Review of the facility's undated policy titled, Enhanced Barrier Precautions, under Policy Explanation and Compliance Guidelines: Number two (2.) Initiation of Enhance Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: I. Wounds.and /or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes.PICC lines .even if the resident is not known to be infected or colonized with a MDRO.3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room.b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities.4. High-contact resident care activities include a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens. F. Changing briefs or assisting with toileting. g. Device care or use: central lines, urinary catheters, feeding tubes, .PICC lines.h. Wound care: any skin opening requiring a dressing.Observation on 10/1/2025 at 8:35 am, revealed Licensed Practical Nurse (LPN) AA performed a blood pressure check on R83 prior to administering medications and did not clean the blood pressure cuff or the pulse oximeter either before or after checking the resident's vitals.Observation on 10/1/2025 at 8:45 am, revealed LPN AA proceeded to check R75 blood pressure without sanitizing the blood pressure cuff or the pulse oximeter before or after use. Immediately following the task.Interview on 10/1/2025 with LPN AA confirmed that the blood pressure cuff and pulse oximeter was not sanitized between residents use and should have been. LPN AA stated that the wipes were missing from the basket attached to the machine for use.2. Review of R9 electronic medical records revealed diagnoses that included, but were not limited to dysphagia, and gastrostomy status.Review of the care plan dated 7/22/2025 revealed the following problems and interventions:The resident requires a feeding tube to meet nutrition, and hydration needs related to diagnoses of dysphagia (oral and oropharyngeal phases) and gastroesophageal reflux disease (GERD).Review of the last Quarterly MDS assessment dated [DATE] revealed in Section K (Swallowing/Nutritional Status) that Resident 9 (R9) was receiving tube feedings.Review of the physician's orders revealed the following: The resident is NPO (nothing by mouth) and receives nutrition and medications through a PEG tube only. The resident is to remain on enhanced barrier precautions.Observation on 10/1/2025 at 1:23 pm, LPN AA administered a bolus feeding and medications via PEG tube to R 9. LPN AA wore only gloves as Personal Protective Equipment (PPE) and did not don a gown while providing the feeding and medication administration. Upon exiting the room, the surveyor asked LPN AA what the Enhanced Barrier Precautions (EBP) signage posted above the door indicated. LPN AA read the sign aloud and stated, I should have gowned up before providing care, but was unable to explain the purpose of the precaution or the rationale for donning a gown prior to care.Review of R7's electronic medical records revealed diagnosed included but not limited to UTI, Foley catheter to be placed for dx obstructive uropathy, BPH with lower urinary tract symptoms, acute kidney failure, chronic kidney disease-stage 4, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acquired absence of kidney.Review of the admission Minimum Data Set, dated [DATE] revealed section H Bladder and Bowels: indwelling catheter.Review of R7's care plan revealed that the resident requires an indwelling Foley catheter due to a diagnosis of obstructive uropathy. Interventions include changing the Foley catheter and drainage bag based on clinical indications, such as infection, obstruction, or when the closed system is compromised.Observation on 10/1/2025 at 2:30 pm, revealed catheter care was provided to R7 by two Certified Nursing Assistants (CNAs), CNA BB and CNA CC, neither CNA wore gowns during the procedure. When asked what the signage posted by the door meant, CNA BB stated that it meant to gown up but explained that the infection control nurse had told them they did not need to. CNA CC then corrected CNA BB, stating that gowns were required when providing close-contact care.In a joint interview on 10/1/2025 at 2:40 pm, with the Unit Manager/Infection Preventionist Registered Nurse (RN DD) and the Director of Nursing (DON) they stated that Enhanced Barrier Precautions (EBP) are used to protect residents during high-risk activities such as wound care, urinary catheter care, enteral feeding, and central line care. They explained that the facility does not write specific physician orders or care plan entries for EBP; rather, signage posted on the resident's door indicates that PPE is required. The DON added that her expectation is for staff to don gowns when providing high-contact care to residents with a catheter, PEG tube, PICC line, or wound. Regarding shared medical equipment, the DON further stated that her expectation is for staff to sanitize all shared equipment between each resident use.