

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/22/2024
NAME OF PROVIDER OR SUPPLIER Palemon Gaskins Mem Nsg Home		STREET ADDRESS, CITY, STATE, ZIP CODE 710 North Irwin Avenue Ocilla, GA 31774	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914</p> <p>Based on family interview, staff interviews, and record review, the facility failed to ensure the family representative for two of four residents (R) (R13 and R A) were notified of a new pressure ulcer and the progression of the wounds. Specifically, the facility failed to ensure resident A family member was notified of the development of a pressure wound. The facility also failed to ensure R13's family/representative was notified of changes in the progression of R13's pressure wounds.</p> <p>The findings include:</p> <p>Record review for R13 revealed resident was admitted with diagnoses of but not limited to nausea, insomnia, pressure ulcer of heel, poly osteoarthritis, and generalized anxiety disorder.</p> <p>Review of the Annual Minimum Data Set (MDS) dated [DATE] revealed section M (Skin Conditions) indicated that R13 had a pressure ulcer that was unhealed and was unstageable due to coverage of the wound bed by slough and/or eschar.</p> <p>Review of progress note in the electronic medical record (EMR) dated 11/27/2024 18:55 Removed dressing from sacral area. Small amount of drainage noted. Area is now at stage 2. cleaned area with anasept solution. Applied TAO and vaseline gauze to wound and covered with sacral allevyn dressing. [sic] There was no family notification of the status of R13's wound.</p> <p>Record review for RA revealed resident was admitted to the facility with diagnoses of but not limited to vascular dementia, peripheral vascular disease, essential hypertension, gout, and pressure ulcer of the sacral region stage 2.</p> <p>Review of the Annual MDS dated [DATE] revealed section M (Skin Conditions) indicated that RA had a pressure ulcer that was unhealed and was receiving pressure ulcer care with application ointments and medications.</p> <p>Review of progress notes in the electronic medical record (EMR) dated 10/19/2024 revealed 10/19/24 Weekly skin assessment completed. Skin not intact. Dry and bruised skin to arms, legs and face. Lotion applied. Sacrum with an open area measuring 4cm X 4cm. Area cleaned, and TAO applied and an Allevyn dressing. No other areas of concern noted at this time. Will continue to monitor. [sic] There was no family notification of the status the residents wound.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 12/20/2024 at 11:46 am with family member of R A revealed that RA currently had an open wound to her sacral area that she was not notified of. Family member revealed that she became aware of the wound after assisting staff with the care of RA and saw the wound at that time. Further interview also revealed that the family member had not been made aware from facility staff, of any of the changes that had occurred, and stated she would always have to inquire about the status of RA before any information was obtained.</p> <p>Interview on 12/21/2024 at 12:15 pm with the Director of Nursing (DON) revealed that the facility did not have a Wound care nurse and that the Charge Nurses on the floor were responsible for completing the daily wound care treatments and documentation for the wounds, however, there was a wound care nurse that came from the hospital every week to measure residents wounds and make any treatment changes if needed. Continued interview also revealed that when there was a change in the residents' condition the family should be notified, and that information should be documented in the residents' chart. The DON confirmed that there was no documentation that the family had been notified of the changes that had occurred with the resident's wound status.</p> <p>Interview on 12/22/2024 at 9:10 am with the Administrator in Training revealed that whenever there was a change in a residents condition the family member should be notified and the notification should be documented in the residents' chart. During the interview it was also revealed that DON acknowledged that the wound documentation was concerning and there was no way to determine if the wound was progressing or declining. Further interview disclosed that there were no meetings conducted other than the regular morning meeting, that discussed the current condition of the residents.</p> <p>Interview on 12/22/2024 at 11:28 am with the Administrator revealed the expectation for the staff was to ensure that the residents family members were notified of any change in condition timely and in accordance with the state laws and regulations.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914</p> <p>Based on observations and staff interviews the facility failed to ensure that three of 17 residents' rooms (rooms [ROOM NUMBER]) were maintained to promote a clean and homelike environment. Specifically, the facility failed to ensure that the privacy curtains in rooms [ROOM NUMBER] were free from noticeable dirt and debris, the facility failed to ensure the sink in room [ROOM NUMBER] was functioning and operable for staff and resident use, and the facility also failed to ensure there were no visible black substance in the residents' bathroom of rooms [ROOM NUMBERS].</p> <p>The findings include:</p> <p>Observation on 12/20/2024 at 8:30 am in room [ROOM NUMBER] revealed the privacy curtain for bed 19 L (room [ROOM NUMBER] left side) had black and brown stains throughout the curtain facing the right side of the bed.</p> <p>Observation on 12/20/2024 at 8:35 am in room [ROOM NUMBER], the bathroom ceiling above the commode had a black colored substance that started from the ceiling vent outward covering the ceiling as well as black substances covering the wall from the ceiling down to where the towel rack was attached. Continued observation also revealed the door jamb of the bathroom door on the inside had the same black substance noted from the top of the door jamb down to the floor.</p> <p>Observation on 12/20/2024 at 8:45 am revealed the privacy curtain in 14R (room [ROOM NUMBER] right side) had brown stains on the outer aspect of the curtain facing the residents' bed on both ends.</p> <p>Observation on 12/20/2024 at 8:47 am in room [ROOM NUMBER] bathroom revealed a black substance on the ceiling above the commode that was from the air vent to the light fixture in the ceiling.</p> <p>Observation 12/20/2024 at 9:00 am, and on 12/21/2024 at 8:00 am, revealed the sink in resident room [ROOM NUMBER] had no running water, (Hot or Cold), and the wallpaper under the sink was peeling away from the wall.</p> <p>Observation on 12/21/2024 at 7:50 am in room [ROOM NUMBER] revealed the privacy curtain for bed 19 L had brown and black stains throughout the curtain facing the right side of the bed, and there were food stains on the outer aspect of the curtain on both ends.</p> <p>Observation on 12/21/2024 at 7:55 am revealed the bathroom ceiling above the commode in room [ROOM NUMBER] had a black colored substance that started from the ceiling vent outward covering the ceiling as well as black substances covering the wall from the ceiling down to where the towel rack was attached. Continued observation also revealed the door jamb of the bathroom door on the inside had the same black substance noted from the top of the door jamb down to the floor.</p> <p>Observation on 12/21/2024 at 8:10 am in room [ROOM NUMBER] revealed the privacy curtain that divided the room had black stains on the left side and the bottom of the curtain, as well as brown stains throughout the privacy curtain.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 12/21/2024 at 8:15 am in room [ROOM NUMBER] revealed the privacy curtain had brown colored stains throughout the curtain particularly on the outer aspects on each side, and the bathroom ceiling was also noted to have black markings from the ceiling vent to the light fixture that was affixed to the ceiling.</p> <p>Observation and interview on 12/21/2024 at 3:30 pm during walking rounds with the Interim Administrator, Director of Engineering, and Housekeeper BB confirmed all observations that were noted during the survey period. Interview with the Interim Administrator revealed the water in the sink for room [ROOM NUMBER] did work, however, the water was purposely turned off from the bottom to prevent the resident in that room from turning the water on and leaving it running causing the room to be flooded with water. Further observation revealed that the Director of Engineering turned the water on to discover that the pipes underneath the sink were leaking and needed to be repaired.</p> <p>Interview on 12/21/2024 at 3:45 pm with the Director of Engineering revealed that he was unaware that the sink in room [ROOM NUMBER] needed repair. When there were repairs that needed to be completed, the staff would notify the Administrative Assistant at the front desk, and she would put the work order into the system that indicated what and where the repairs were needed. During the interview there was no indication of a timeline in which repairs should be completed. Continued interview also revealed that once the repairs were completed, the work order was marked as completed in the computer system. Interview also revealed that the black substance on the ceiling above the commode in room [ROOM NUMBER] was from condensation and moisture and it happened because the building was old and once renovations were completed this would not occur. The black substance that was noted on the ceiling over the commode in room [ROOM NUMBER] was unidentified.</p> <p>Interview on 12/21/2024 at 4:00 pm with Housekeeper BB revealed that each resident's room is deep cleaned at least once a month. During the interview staff member revealed that the privacy curtains were removed and cleaned every two weeks and as needed. During the interview Housekeeper BB was unsure whether it had been two or three weeks since the privacy curtains in the rooms identified had been cleaned and or checked.</p> <p>Interview on 12/21/2024 at 4:10 pm with the Interim Administrator revealed that the curtains that were identified during the survey period, and during walking rounds, would be removed and replaced with clean ones starting on Monday. The expectation was that resident rooms were to be clean and free from debris at all times.</p> <p>Interview on 12/22/2024 at 11:28 am with the Administrator revealed the expectation for the staff was to ensure that the facility was clean and comfortable for the residents at all times in accordance with the state laws and regulations.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42463</p> <p>Based on staff interviews, record review, and review of the facility's policy titled, PASRR, the facility failed to submit for a Preadmission Screening and Resident Review (PASARR) Level II after a new mental illness diagnosis was added for one of three residents (R) (R15) reviewed for PASARR. This deficient practice had the potential to affect the appropriate level of care and services provided for R15.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, PASRR dated 1/1/2024, under the section titled, Policy revealed, It shall be the policy of [Name of Facility] to comply with Preadmission and Resident Review. PASRR is a federally mandated review process, requiring all people seeking Medicaid-certified nursing facilities admissions to be screened for mental illness or intellectual and developmental disability regardless of funding source or age. Under the section titled Procedure revealed, Residents will be screen prior to admission using the PASRR screening process; The facility will obtain a copy of the PASRR and the approval number for the resident; If the Screening is positive for possible SMI and/or ID/DD/RC, then a Level II Evaluation will be performed.</p> <p>Review of the electronic health record (EHR) under the Profile tab revealed that R15 was admitted to the facility on [DATE] with diagnoses of but not limited to, anxiety disorder and depression.</p> <p>Review of R15's Annual Minimum Data Set (MDS) dated [DATE] assessed a Brief Interview for Mental Status (BIMS) score of seven, which indicated severe cognitive impairment; Section I (Active Diagnosis) revealed, anxiety disorder, depression (other than bipolar), and Post Traumatic Stress Disorder (PTSD); Section N (Medications) revealed, the resident received antianxiety and antidepressant medications during look back period of assessment.</p> <p>Review of R15's HER under the Orders tab revealed physician orders dated 11/1/2024 revealed R15 was currently receiving mirtazapine tab 15 milligrams (mg)-give 7.5 mg by mouth at bedtime related to insomnia, and buspirone HCl Tab 5 mg-give 5 mg by mouth every 12 hours related to anxiety disorder.</p> <p>Review of R15's PASRR Level I assessment dated [DATE] revealed, R15 did not have a diagnosis of Mental Disorder, Anxiety, or Depressive Disorder.</p> <p>Review of R15's EHR under the Med Diag tab revealed, on 10/9/2020 major depressive disorder was added; on 9/30/2021 Post-Traumatic Stress Disorder was added, and on 4/27/2023 anxiety disorder was added.</p> <p>Further review of R15's clinical records revealed no submissions for a PASARR Level II after the new mental illness diagnoses were added.</p> <p>Review of the facility provided list of residents with Level II PASRR within the facility revealed, R15 name was not listed.</p> <p>(continued on next page)</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/22/2024 at 8:52 am with the Administrator In Training revealed, she was the Social Services Director (SSD), but they were in the process of training another staff member for the position. She reported as the SSD she would make sure she received a Level I screen from the discharging facility to ensure that they had a Level I screening prior to admission. She reported they struggle to get accurate information from the discharging facility therefore she reviewed the information for accuracy. She confirmed R15 did not have a Level II and stated that it was the behavioral health services responsibility to apply for a Level II if they received a qualifying diagnosis after admission. She confirmed they had not applied for Level II, and one should have been completed. She reported that they were in the process of auditing PASRRs for accuracy.</p> <p>Interview on 12/22/2024 at 11:24 am with the Administrator revealed, his expectation was that PASRRs were correct for each resident. He revealed that if the criteria reflected a Level II, he wanted it to be prepared correctly. He stated that his expectations were that staff should follow the law.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42463</p> <p>Based on staff interviews, record review, and review of the facility's policy titled, PASRR (Preadmission Screening and Resident Review), the facility failed to ensure an application for PASRR Level I that included a diagnosis of schizophrenia and depression was submitted prior to or on admission to the facility for evaluation and determination of specialized services for one of three Residents (R) (R12). This deficient practice had the potential to affect the appropriate level of care and services provided for R12.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, PASRR dated 1/1/2024, under the section titled Policy revealed, It shall be the policy of [Name of Facility] to comply with Preadmission and Resident Review. PASRR is a federally mandated review process, requiring all people seeking Medicaid-certified nursing facilities admissions to be screened for mental illness or intellectual and developmental disability regardless of funding source or age. Under the section titled Procedure revealed, Residents will be screen prior to admission using the PASRR screening process; The facility will obtain a copy of the PASRR and the approval number for the resident; If the Screening is positive for possible SMI and/or ID/DD/RC, then a Level II Evaluation will be performed.</p> <p>Review of the electronic health record (EHR) under the Profile tab revealed, R12 admitted to the facility on [DATE] with diagnoses that included but not limited to unspecified dementia, mild, with anxiety, schizophrenia, unspecified, depression, unspecified.</p> <p>Review of R12's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Section A (Identification Information) indicated the resident was currently not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Section C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) score of 14, which indicated little to no cognitive impairment. Section I (Active diagnoses) non-Alzheimer's dementia, Parkinson's disease, and schizophrenia. Section N (Medications) revealed resident received antidepressant medications during look back period of assessment.</p> <p>Review of R12's EHR under the Orders tab, physician orders dated 11/1/2024 revealed the resident was currently receiving escitalopram oxalate tab 10 milligrams (mg)-one tablet by mouth one time a day related to depression; risperidone 3 (three) mg- one tablet by mouth two times a day related to schizophrenia; mirtazapine 45 mg-one tablet by mouth at bedtime related to depression, and divalproex sodium tab delayed release 250 mg- three tablet by mouth at bedtime related to unspecified dementia, mild, with anxiety.</p> <p>Review of R12's PASRR Level I assessment dated [DATE] revealed, diagnosis of schizophrenia, anxiety, or depressive disorder was marked, No.</p> <p>Review of the facility provided list of residents with Level II PASRR within the facility revealed, R12 name was not listed.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/22/2024 at 8:52 am with Administrator In Training revealed, she was the Social Services Director (SSD), but they were in the process of training another staff member for the position. She revealed as the SSD she would make sure she received a Level I screen from the discharging facility to ensure the resident had a Level I screening prior to admission. She revealed they struggled to get accurate information from the discharging facility therefore she reviewed the information for accuracy. She revealed for R12 she called the State agency once she discovered that R12 did not have a qualifying diagnosis listed and was advised by the representative they would handle it. She confirmed that R12 had qualifying diagnoses on admission and that it was not completed accurately. She confirmed that it should have been re-submitted.</p> <p>Interview on 12/22/2024 at 11:24 am with the Administrator revealed, his expectation was that PASRRs were correct for each resident. He stated that if the criteria reflected a Level II, he wanted it to be prepared correctly. He stated that his expectations were that staff should follow the law.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>41914</p> <p>Based on observation, staff interviews, and record review, the facility failed to ensure that wound care documentation was accurate for residents in the facility that were receiving wound care. Specifically, the facility failed to ensure that the documentation on the weekly wound report was accurate to reflect the date wounds were identified.</p> <p>Findings include:</p> <p>Review of the facility document titled, Wound and Skin Status Report, revealed under date identified/present upon admit, the date that the report was completed was documented under this section, which did not indicate the actual date the wound or injury occurred. Further review also revealed for the months of March, June, and October of 2024, indicated the same date the wound status report was completed, as the dates of the identified wound and or skin alteration.</p> <p>Interview on 12/21/2024 at 2:00 pm with Registered Nurse (RN) CC revealed that it was noted three weeks prior to the surveyors entering the facility for the annual survey, that there was a problem with the documentation of wounds by the wound care nurse that came to the facility on ce a week. Interview also revealed that there was a skin sweep that was conducted by the staff member and the Director of Nursing (DON) to ensure that no other residents in the facility had any wounds that were not identified. During the interview it was also disclosed that there was no documentation that confirmed the skin sweep had taken place and the concern with the wounds was not incorporated into the QAPI plan for evaluation and monitoring.</p> <p>Interview on 12/22/2024 at 9:10 am with the Administrator in Training revealed she acknowledged that the wound documentation was concerning and there was no way to determine when the wound was identified and if the wound was progressing or declining. Further interview revealed there were no meetings conducted other than the regular morning meeting that discussed the current condition of residents.</p> <p>Interview on 12/22/2024 at 11:28 am with the Administrator revealed his expectation for staff was to ensure that the documentation of resident wounds were accurate.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>41914</p> <p>Based on observations, staff interviews, and review of the facility's policy titled, [Name of facility] 2024 QAPI Plan, the facility failed to identify, develop, and implement corrective action plans that addressed the notification of wound progression and treatment for four of four residents (R) (RA, R11, R13, and R78) to the responsible parties (RP) and or family representatives, failed to ensure resident living environment was clean and home-like, failed to ensure infection control practices were adhered to as it relates to Enhanced Barrier Precautions (EBP), and failed to ensure Level II Preadmission Screening and Resident Review (PASRR) were submitted for residents with qualifying diagnoses.</p> <p>Findings include:</p> <p>Review of the undated facility policy titled, [Name of facility] 2024 QAPI Plan, revealed the following: Under scope Quality Assurance Performance Improvement Program (QAPI) activities will be integrated across all the care and service areas of our organization. Each area should have a representative on the QAA (Quality Assessment and Assurance) committee. If a representative is not available, the area should still be addressed through committee discussions. Our service areas will work together whenever possible to integrate care and services across our continuum of care to better meet the needs of the residents living in our community. Our QAPI activities will cross service areas and departments and we will work together to assure we address all concerns and strive to continuously improve the provided services. On an annual basis, and as needed, a Facility Assessment will be conducted to include an overview of the services and care areas that are provided. Any new service areas or changes in population or service areas identified during the Facility Assessment will be included in our QAPI plan.</p> <p>1. Did not ensure R A, R11, R13 and R78 responsible parties (RP) and/or family representatives were notified of new pressure ulcers and wound progression as evidence by not monitoring for proper notification to the RP and resident family representatives for progression and/or decline through the QAPI process.</p> <p>The Administrator was unable to provide evidence or information that revealed the facility had or was currently addressing the concern associated with the notification of wound progression for the four residents in the facility that had active wounds, or that the facility was systematically reviewing the issue to develop an action plan to ensure that the residents family members and RP were being notified of the residents wound status.</p> <p>2. Did not ensure that residents family representatives and RP were notified of change in condition and wound status.</p> <p>Interview on 12/21/2024 at 2:30 pm with the DON (Director of Nursing) revealed that whenever there was a change in a resident's condition or status the RP should be notified and that information documented in the resident's medical record. Further interview also revealed that the concern of notification that was identified by the survey team was not identified as a problem with the administrative staff and was not being monitored utilizing the QAPI process.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. Did not ensure that the residents' living environment was clean and home-like.</p> <p>During the three days of the survey, there were observations of privacy curtains on one of two halls that were visibly soiled, unidentified black substances found on the ceiling and walls of resident's bathrooms, and a nonfunctioning sink in one of four residents' rooms on the short hall.</p> <p>Interview on 12/21/2024 at 3:00 pm with the Administrator in Training (AIT) revealed that the facility will be undergoing a renovation in the next fiscal year that would solve the concerns that were identified during the survey. When asked if the concerns identified had been implemented into the QAPI program the AIT stated no, due to the renovations that they planned would solve most of the concerns identified.</p> <p>4. Did not ensure that EBP were implemented during care and services for residents with indwelling medical devices and wounds.</p> <p>Interview on 12/22/2024 at 8:30 am with DON revealed that the facility staff had not been educated on the use of EBP and was not being utilized during care and services for residents that had open wounds and for resident that had indwelling medical devices.</p> <p>5. Did not ensure that residents requiring Level II PASSR were properly screened.</p> <p>Interview on 12/22/2024 at 8:52 am with AIT revealed prior to her current role she was the Social Services Director (SSD). She reported as the SSD she made sure she received a Level I screening from the discharging facility to ensure that they had a Level I screening prior to admission. SSD revealed they struggled to get accurate information from the discharging facility therefore she reviewed the information for accuracy. She revealed that it was the behavioral health services responsibility to apply for a Level II if they received a qualifying diagnosis after admission. She confirmed they had not applied for Level II, and one should have been completed. She revealed that they were in the process of auditing PASRRs for accuracy and had not implemented this concern in their QAPI for monitoring.</p> <p>Interview on 12/22/2024 at 11:24 am with the Administrator revealed, his expectation was that PASRRs were correct for each resident. He revealed that if the criteria reflected a Level II, he wanted it to be prepared correctly. He revealed his expectations were that staff should follow the law.</p> <p>6. Review of the QAPI documentation revealed the following concerns that were being monitored by QAPI process:</p> <p>A. Medication reconciliation with the pharmacy identified on 10/3/2023 and ongoing.</p> <p>B. Dietary Satisfaction main kitchen serving gravy too often with meals identified on 10/10/2023.</p> <p>C. Increase participation with in-person care plan meetings for family members identified 12/2023.</p> <p>Interview on 12/22/2024 at 1:30 pm with AIT and current Administrator revealed there were no other issues identified for QAPI review and monitoring.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115713	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/22/2024
NAME OF PROVIDER OR SUPPLIER Palemon Gaskins Mem Nsg Home		STREET ADDRESS, CITY, STATE, ZIP CODE 710 North Irwin Avenue Ocilla, GA 31774	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41914</p> <p>Based on observation, staff interviews, and review of the facility's policies titled Handwashing/Hand Hygiene, and Enhanced Barrier Precautions, the facility failed to wash/sanitize hands and change gloves during wound treatment for one of four residents (R) (R78) with pressure ulcers, failed to apply Personal Protective Equipment (PPE) during intravenous antibiotic therapy administration for R78, and failed to establish enhanced barrier precautions to reduce the spread of multidrug-resistant organisms.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Handwashing, effective 1/1/2020, included under Purpose:</p> <p>1. Hands should be washed in accordance with the following guidelines:</p> <ul style="list-style-type: none"> a. Before resident contact. d. Before performing wound care. g. After contact with non-intact skin, body fluids or excretions, or wound dressings. j. After removing gloves. k. After contact with patient's skin. <p>2. In addition to handwashing, personnel should wear gloves in accordance with the standard precautions. When gloves are worn, handwashing is recommended after removing them because gloves may be perforated during used and bacteria can multiply rapidly on gloved hands.</p> <p>Review of the undated facility policy titled, Enhanced Barrier Precautions, under Policy revealed: It shall be the policy of (Facility Name) to utilize Enhanced Barrier Precautions (EBP) guidelines for healthcare staff when providing care to individuals considered at risk of carrying or transmitting multidrug-resistant organisms (MDROs) or individuals with device care or use such as - central line, urinary catheter, feeding tube, tracheostomy or who are receiving wound care for any skin opening requiring a dressing.</p> <p>Observation on 12/21/2024 at 3:00 pm of wound care for R78 revealed Registered Nurse (RN) AA gathered wound care supplies, placed a cloth pad on R78's bed, and informed R78 that she was going to do his treatment. RN AA donned gloves and removed the old dressing. RN AA removed gloves, donned gloves and cleaned the area to sacrum. RN AA removed gloves, donned gloves and applied Santyl to inside of wound. RN AA packed wound and covered wound with 4x4 and covered wound with dressing. RN AA removed gloves. Hand hygiene was not practiced when providing wound care. RN AA did not wash/sanitize hands before during or after wound care.</p> <p>Interview on 12/21/24 at 10:59 am with RN AA revealed RN AA had no answer as to why she did not wash or sanitize her hands before, during or after wound care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 12/21/2024 at 1:11 pm with the Director of Nursing (DON) revealed that RN AA had education on infection control and handwashing.</p> <p>Record review for R78 revealed the following medications included but not limited to Invanz Injection Solution Reconstituted 1gm (gram) intravenously (IV) (meaning in the vein) one time a day related to pressure ulcer of sacral region unstageable, Doxycycline Hyclate Oral Tablet 100 mg (milligram) by mouth two times a day related to pressure ulcer of sacral region unstageable.</p> <p>Observation on 12/21/2024 at 12:30 pm revealed a medication observation with Registered Nurse (RN) AA. During the observation RN AA proceeded to prepare an IV antibiotic Ertapenem 1gm for administration. Nurse entered residents' room, washed hands with soap and water and donned a clean pair of gloves. Staff member did not wear a gown during the administration of the medication. There was no personal protective equipment (PPE) in or near the residents room for staff use.</p> <p>Interview on 12/21/2024 at 12:45 pm with RN AA revealed she was not aware of the process for EBP, or wearing PPE when providing care for residents with wounds, catheters, or any indwelling medical devise. Further interview also revealed that only gloves were worn because she was not aware that a gown should have been donned as well when administering the IV antibiotic to the resident.</p> <p>Interview on 12/21/2024 at 2:30 pm with the Director of Nursing (DON) revealed that she was unaware that the nursing staff were to wear PPE while providing care to residents with indwelling medical devices and during wound care. DON also indicated that the wearing of PPE during the care for these types of residents was only to protect the staff from contracting infections from the resident.</p> <p>Interview on 12/22/2024 at 8:00 am with Certified Nursing Assistant (CNA) DD revealed that she was unaware what EBP was, and staff member was not able to verbalize any training on the EBP process.</p> <p>Interview on 12/22/2024 at 8:10 am with Environmental Services Aide EE revealed that there had not been any education provided by the facility on EBP precautions and or when they should be implemented.</p> <p>Interview on 12/22/2024 at 8:15 am with CNA FF revealed that there had not been any training provided by the facility on EBP precautions and when they should be implemented.</p> <p>Interview on 12/22/2024 at 8:30 am with RN CC revealed there was currently no policies and procedures for the use of EBP however, that she would write the policy and procedures for the use of EBP and provide education to all staff.</p> <p>Interview on 12/22/2024 at 9:23 am with the Administrator in Training revealed that the expectation was that staff be educated with all the infection control practices that were recommended by the Centers for Disease Control (CDC). Further interview also revealed that she was not aware that the staff did not understand and were not educated on EBP. During the interview it was also disclosed that going forward the staff would be educated fully on infection control practices.</p> <p>Interview on 12/22/2024 at 11:28 am with the Administrator revealed the expectation for the staff was to ensure that infection control policies and procedures were always followed for the health and safety of the residents in accordance with the state laws and regulations.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>41165</p>