STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115717	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reliable Health & Rehab at Lakewood	1980 Arrow Street, SW Atlanta, GA 30310

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility's policies titled, Self-Administration of Medications, and Bedside Medication Storage, the facility failed to ensure they had a physician's order for medication stored at the bedside and the residents had been assessed for the ability to safely self-administer medications for one of two residents (R) (R92) reviewed for self-administration of medications. This deficient practice had the potential to cause adverse reactions if unsecured medications were accessed or ingested. Findings include:Review of the facility's policy titled, Self-Administration of Medications, reviewed on 08/01/2025, revealed under Policy: In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. Under Procedures: A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process. C. The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan.Review of the facility's policy titled, Bedside Medication Storage, reviewed on 08/01/2025, revealed under Policy: Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. Under Procedures: A. A written order for the bedside storage of medication is present in the resident's medical record. B. Bedside storage of medications is indicated on the resident medication administration record (MAR) and the medication label for the appropriate medications. F. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party.Review of R92's electronic health record (EHR) revealed he was admitted on [DATE] with diagnoses including, but not limited to, cerebral infarction unspecified, major depressive disorder recurrent severe with psychotic symptoms, post-traumatic stress disorder (PTSD) unspecified, hemiplegia and hemiparesis following other cerebrovascular disease affecting the left non-dominant side, other speech and language deficits following other cerebrovascular disease, and cerebral atherosclerosis.Review of R92's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Section B (Hearing, Speech, and Vision) documented R92 used corrective lenses. Section GG (Functional Abilities and Goals) documented functional limitations in range of motion (ROM) with impairment on one side of both the upper and lower extremities.Review of R92's physician orders revealed three active orders for ophthalmic medications: Name brand Celluvisc Ophthalmic Gel 1% (percent) (Carboxymethylcellulose Sodium) ordered to instill one drop in both eyes four times a day for dry eyes, with an order date of 12/10/2025. No physician order for self-administration of medications or bedside storage of medications was identified in R92's EHR.Review of R92's EHR (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed no assessment for self-administration of medications was found.Observation on 04/28/2026 at 10:52 AM in R92's room revealed an open box of Name brand Classic lubricant eye drops on the bedside table.Observation on 04/29/2026 at 11:42 AM in R92's room revealed an open box of Name brand Classic lubricant eye drops on the bedside table.Interview and observation on 04/28/2026 at 11:42 AM with Certified Nursing Assistant (CNA) AA revealed no residents self-administer medications in the facility and that only nurses gave medications. She stated she had been told to be on the lookout for any items residents were not supposed to have, including medications and other items, for safety purposes. She stated the facility's protocol when prohibited items were found was to let a nurse know, and the nurse then got a supervisor involved. She stated that when she previously reported eye drops to nursing, she was told R92 could have them because he was independent. She stated the potential negative outcome related to the eye drops being unsecured at the bedside was that another resident could access them and ingest them, causing harm.Interview and observation on 04/28/2026 at 12:53 PM with the Infection Preventionist (IP) revealed she had the two boxes of Name brand Classic lubricant eye drops in her hands. The IP revealed R92 had an order for eye drops and stated he must have received the eye drops from the Veterans Association (VA). She stated he did not care what they told him. She stated he should not be having the Name brand Classic lubricant eye drops because it was a hazard for other people. Any residents could come in and take eye drops, could drink the eye drops and could cause harm. Interview on 04/28/2026 at 1:34 PM with the Administrator revealed that typically if a resident had medications at the bedside, the resident would need to be assessed for self-administration of medications. She stated the resident should not have eye drops in his room. She stated the potential negative outcomes included another resident accessing the items and adverse effects related to ingestion.

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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 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, staff interviews, and review of the facility's policy titled, Maintenance Service, the facility failed to ensure that it was maintained in a safe, clean and comfortable home-like environment including stained and damaged ceiling tiles in one resident bedroom (room [ROOM NUMBER]A), near the facility nurses' station, in the glass day room, and in the middle of the east hall.Findings include:Review of the facility's policy titled, Maintenance Service review date January 2024, revealed under Policy Interpretation and Implementation:1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to:a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.b. Maintaining the building in good repair and free from hazards.1. During initial screening and observation on 04/28/2026 at 10:07 AM, several ceiling tiles revealed tannish-brown stains, varying in size, located near the facility nurses' station on the side that you would approach the desk.Observation on 04/28/2026 at 11:12 AM, noted the presence of brown rings, roughly 16 inches in diameter, on the ceiling tiles located directly above the bed in room [ROOM NUMBER]A.Observation on 04/30/2026 at 10:47 AM, several ceiling tiles contained stains in circular shapes and variation in sizes located near the facility nurses' station.Observation on 04/30/2026 at 10:51 AM in the glass day room, specifically near the window in the seating area above a resident's chair, two ceiling tiles were noted with stains, each exhibiting brown circular stains approximately three inches in diameter on each side.Observation on 04/30/2026 at 11:00 AM, the east hall's ceiling tiles revealed a brown circular shape approximately 10 inches in diameter on the ceiling tile in the middle of the hall.Observation on 04/30/2026 at 12:30 PM noted a white, moldy substance on the ceiling tile near the facility nurses' station.Interview and observation during the walking tour on 04/30/2026 at 11:04 AM, the Maintenance Director inspected room [ROOM NUMBER]A and noted the ceiling tiles exhibited tan and brown stains, along with bulging. The Maintenance Director indicated that this issue was a result of rain; however, there was a risk that the tiles could fall on the resident. It was confirmed that immediate replacement was necessary. Additionally, he verified that two separate ceiling tiles in the glass dayroom also displayed tan and brown stains. Furthermore, he confirmed the presence of several circular brown stains of varying sizes located near the nurse station.Interview and observation on 04/30/2026 at 11:38 AM with the facility Maintenance Director on the east hall revealed that the Maintenance Director was in the process of replacing the ceiling tile subsequent to the photograph being taken, but he verified the existence of the discolored ceiling tile.Interview on 04/29/2026 at 2:14 PM with the Administrator disclosed that there were leaks in the roof, which was repaired on 12/16/2025. She confirmed that the brownish stains were due to recent rainfall. She mentioned that she had been conducting daily inspections and had not observed any issues, having performed rounds on 04/28/2026. Nevertheless, stains were appearing as a consequence of leaks from the rain that fell yesterday. She shared there was a potential risk of tile overload that could drop on a resident.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and review facility policy titled, Abuse Policy, the facility failed to protect one resident (R) (R113) from sexual abuse perpetrated by another resident (R12) out of 4 residents reviewed for abuse. This deficient practice had the potential to result in harm and emotional distress.Findings include:Review of the facility's policy titled, Abuse Policy, reviewed on January 2025revealed under Policy: Our facility will not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, or staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. It is our goal to achieve and maintain an abuse free environment. Under Definitions: Sexual Abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault.1. Review of R113's electronic health record (EHR) revealed she was admitted on [DATE] with diagnoses including, but not limited to, senile degeneration of the brain, restlessness and agitation, and Alzheimer's disease, unspecified.Review of R113's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. Section GG (Functional Abilities and Goals) documented R113 was fully dependent on toileting, showering and bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. Section O (Special Treatments, Procedures, and Programs) documented R113 was receiving hospice care.2. Review of R12's EHR revealed he was admitted on [DATE] with diagnoses including, but not limited to, vascular dementia moderate with mood disturbance, Alzheimer's disease unspecified, major depressive disorder recurrent mild, obsessive-compulsive personality disorder, unspecified psychosis not due to a substance or known physiological condition, and unspecified mood affective disorder.Review of R12's MDS assessment dated [DATE] documented a BIMS score of 4, indicating severely impaired cognition. Section GG documented impairment on one side of the lower extremities with use of a manual wheelchair, and documented R12 was fully dependent for toileting, showering and bathing, lower body dressing, and putting on and taking off footwear.Review of R12's care plan revealed a focus, initiated 08/31/2017 which stated: R12 has a behavior problem Sexually verbally and physically inappropriate. 1/18/24-Resident inappropriately touch a female resident. 3/9/24. R12 enter into a female room attempted to touch her. Documented interventions included: If reasonable, discuss the resident's behavior. Explain/behavior is inappropriate and/or unacceptable and Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation to alternate location as needed. A separate care plan focus, initiated 01/24/2024, identified R12 as receiving a mood stabilizer medication to manage indicators of behavior related to (r/t) physical behavioral symptoms directed towards others (abusing others sexually touch female residents inappropriately), with an intervention to Monitor/record occurrence of target behavior symptoms (SPECIFY: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/sexual aggression towards staff/others, etc.) and document per facility protocol.Review of R12's physician orders revealed a physician order dated 01/15/2026 for Sertraline Hydrochloride (HCl) 50 milligrams (mg) orally once daily documented as ordered for obsessive compulsive disorder (OCD) related sexual obsession.Review of the facility's Incident Investigation Report (Facility Incident Number 202600337) revealed that on 01/09/2026, a Certified Nursing Assistant (CNA) observed R12 in R113's room with his right hand inside R113's pants while she was seated in a geriatric chair. R12 was immediately removed from the room and escorted to a separate hall. The investigation concluded: Based on the investigation and the C.N.A. statement, R12 did touch R113 inappropriately. The facility substantiated the allegation of abuse.Record review of a witness statement authored by the CNA , dated 01/09/2026, revealed she documented she was taking a resident to the lunch room when she noticed R12 in R113's room and observed his right hand in her (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pants, after which she entered the room, directed him to stop, removed him from the room, and reported the incident to the Director of Nursing (DON) and the charge nurse.Review of a second witness statement, authored by staff member Licensed Practical Nurse, revealed: Writer notified by staff that 107 B (R12) was in resident's room [ROOM NUMBER] A (R113) with his hand in her pants.Review of progress notes revealed a nurse's note dated 01/09/2026 at 1:22 PM documenting: Resident noted by staff, resident from room [ROOM NUMBER]b in residents' room with his hand in her pants.Review of a nurse's notes revealed a note dated 01/09/2026 at 1:48 PM that documented: Call placed to 911. Awaiting arrival. A nurse's note dated 01/09/2026 at 5:37 PM documented the responding law enforcement officer's name, badge number, and case number.Interview on 04/30/2026 at 9:22 AM with the Administrator revealed a CNA notified the nurse after observing R12 in R113's room with his right hand in her pants while she was seated in her wheelchair. She stated there was no evidence that he had gone into her brief and a skin assessment was conducted with no findings. She stated that R12 was immediately removed from the room and escorted to another room. She stated the facility immediately followed protocol, law enforcement was contacted, the family was notified, and the incident was reported to the state and to corporate office. She stated R12 was sent to the acute care hospital, and the facility conducted an abuse in-service and initiated an investigation. She stated through the investigation it was found that R113 unintentionally called people to come to her room, and the facility care planned this behavior. She stated R12 was diagnosed with a urinary tract infection (UTI) upon admission to the acute care hospital and was subsequently moved from the west hall to the south hall, as the south hall houses primarily male residents. She confirmed the abuse allegation was substantiated. She stated the potential negative outcome was that if he had gotten into her brief, he could have sexually assaulted her, and she would not have been able to communicate it.

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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 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. Based on observations, staff and resident family interviews, record review, and a review of the facility policy titled, Comprehensive Care Plan, the facility failed to develop and implement a comprehensive care plan for two of eight sampled residents (R44 and R3). The deficient practice placed R44 and R3 at risk for unmet care and services.Findings include: Review of the facility's policy titled, Comprehensive Care Plan, reviewed 1/15/2026, revealed under Policy: 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 includes 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. Further review of the section Definitions: Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. Policy Explanation and Compliance Guidelines revealed: (1) The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed. (2) The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the 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. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. (3) The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment. c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR (Pre admission Screening and Resident Review) recommendations. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate. 1. A review of R44's care plan dated 03/11/2026 revealed no care plan in place for antipsychotic medication use or indication. A review of the Physician's Orders for R44 included but was not limited to an order dated 06/10/2025 for Haloperidol oral tablet 10mg, give 1 tablet by mouth two times a day for Schizophrenia. Additional orders dated 05/09/2025 included behavior monitoring and psychiatric medication side effect monitoring. During an interview on 04/29/2026 at 12:56 PM, the MDS Coordinator stated that all residents receiving antipsychotic treatment should have a comprehensive care plan in place. The MDS further revealed that this care plan should be implemented beginning with the date the medication was originally ordered to ensure proper monitoring. During an additional interview on 04/29/2026 at 2:00 PM, the MDS Coordinator conducted a review of R44's clinical record and revealed that a care plan for antipsychotic medication management was not in place. The MDS Coordinator acknowledged the omission and stated a care plan was added to the resident's record during the course of the survey. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/2026 at 1:25 PM, the Administrator stated that the process for reviewing residents with antipsychotics includes the Interdisciplinary Team (IDT) reviewing the order, consent, and initiating behavior monitoring. The Administrator stated that during that process, the expectation was that a care plan be initiated and revised as needed. 2. Review of R3's care plan dated 03/13/2026 indicated a problem of an indwelling catheter secondary to neurogenic bladder related to prostate cancer. Goals included, but not limited to, the resident will remain free from catheter-related trauma through the review date. Interventions included but were not limited to. CATHETER: The resident has (18 Fr (French) (Indwelling Catheter). Position the catheter bag and tubing below the level of the bladder and away from the room entrance. Monitor and document intake and output as per facility policy. Monitor for pain/discomfort due to the catheter. Monitor/report to MD for s/sx (signs/symptoms) UTI (urinary tract infection): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul-smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. There is no mention of the amount of water to be placed in the bulb, placement of a leg strap, or securement device to prevent tension, or catheter care. Review of the Physician's Orders for R3 included, but was not limited to: Cath (catheter): Check the leg strap to ensure it is present and in place every shift for Facility protocol related to Malignant neoplasm of prostate. Cath: Resident admitted with 18F catheter attached to a bedside drainage bag. Observation and interview on 04/29/2026 at 9:35 AM with R3 revealed that, during a wound care observation, the resident had a Foley catheter positioned under his left leg, and there was no Foley securement device or leg strap to prevent tension on the catheter. Observation made on 04/29/2026 at 11:15 AM of R3 receiving Foley catheter care revealed that the resident again had the Foley catheter positioned under his leg rather than over his leg to allow free flow of urine, and that no securement device or leg strap was present to prevent pulling and tension on the Foley catheter. An interview with Certified Nursing Assistant (CNA) AA on 04/29/2026 at 11:40 PM revealed that she was assigned to R3 that day but had not seen the resident with a Foley catheter leg strap and was unaware that he required one. An interview with the Infection Preventionist (IP), Licensed Practical Nurse (LPN) on 04/29/2026 at 3:03 PM revealed that she has previously provided education on Foley catheter care and the use of leg straps for Foley catheters to the CNAs. Still, there were several agency CNAs she had not yet educated. An interview with the MDS Coordinator on 04/30/2026 at 2:20 PM confirmed that interventions were missing from R3's care plan. The physician had ordered a leg strap to secure the Foley catheter on R3, but it was not included in the care plan. She stated that the negative outcomes include trauma to the residents' meatus, bleeding, and dislodgement of the Foley catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 4/30/2026 at 1:30 PM revealed that she agreed that the care plan was missing components of standards of care for a Foley catheter, as was the physician's order. The Administrators stated that the care plan was expected to be complete and that the physician's orders be clear and complete.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policy titled, Comprehensive Care Plan, the facility failed to revise the comprehensive care plan for one of 33 sampled residents (R) (R92) to reflect interventions implemented. This deficient practice had the potential to result in staff being unaware of current interventions, placing R92 and other residents at risk of not receiving the care and services needed.Findings include:Review of the facility's policy titled, Comprehensive Care Plan, reviewed on 01/15/2026, revealed under Policy: 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 includes 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 Policy Explanation and Compliance Guidelines revealed: . 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the residents' progress. Alternative interventions will be documented, as needed. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.Review of R92's care plan revealed a focus, initiated 02/22/2019 and most recently revised on 01/27/2024, which stated R92 is resistive to care and noncompliant with smoking, and that he continues to go outside beyond facility property to smoke. A documented intervention dated 08/08/2023 stated: Review smoking policy with resident. An additional care plan focus, initiated 05/23/2019, identified R92 as a smoker who requires supervision while smoking, with documented interventions stating: The resident requires SUPERVISION while smoking and Notify charge nurse immediately if it is suspected resident has violated smoking policy.Review of R92's care plan revealed no revisions were made to reflect interventions implemented in response to R92's repeated and ongoing noncompliance with the non-smoking policy. Interventions not reflected in the care plan included daily room searches for smoking paraphernalia, placement of a smoke detector in R92's room, relocation of R92's room closer to the nursing station, every-two-hour visual rounds to check for smoke, nursing checks upon return from outings, the PAR (Patient at Risk) process initiated 04/03/2026 for vaping noncompliance, and the 30-day discharge notice issued on 04/13/2026 for repeated violation of the non-smoking policyReview of R92's Smoking Materials Monitoring Form for the month of April 2026 revealed initials documented on April 3, 2026, April 6, 2026, April 7, 2026, April 8, 2026, April 9, 2026, April 10, 2026, April 13, 2026, April 14, 2026, April 15, 2026, April 16, 2026, April 20, 2026, April 21, 2026, April 22, 2026, April 23, 2026, April 24, 2026, and April 25, 2026, with no initials documented on the remaining days of the month, indicating daily room searches were not consistently completed and documented.Review of the Patient at Risk (PAR) Smoking PAR Tracking form revealed a PAR was initiated on 04/03/2026 with the reason documented as: Resident observed by Certified Nursing Assistant (CNA) and Activity Assistant vaping in room. Resident issued 30-day discharge. Week 1 Interdisciplinary Team (IDT) assessment dated [DATE] documented: Resident continued to violate smoking policy. Checked daily for smoking. Vapor and being removed. Week 2 IDT assessment dated [DATE] documented: Resident room check. Vapor device removed. Resident refused to comply with facility policies. Week 3 IDT assessment dated [DATE] documented: Resident room check, no sign of vapor. Resident has been in compliance out of time. Continued to check for vapor. Week 4 and Week 5 reflected no IDT signatures and no documentation completed.Review of the PAR Patient at Risk Grid revealed five entries for R92, all listed under the problem of Violating Non-Smoking Policy, with initiation dates of 05/16/2024, 05/22/2024, 05/29/2024, 06/05/2024, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115717	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reliable Health & Rehab at Lakewood	1980 Arrow Street, SW Atlanta, GA 30310

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/13/2024, with the 06/13/2024 entry reflecting a date resolved noted as discharge from PAR.Interview on 04/28/2026 at 12:53 PM with the MDS Coordinator BB revealed that R92's non-compliant behavior related to smoking and vaping had been ongoing and that his room had always had to be searched for cigarettes and vaping paraphernalia. She stated the facility became a non-smoking facility in 2020 and she became aware of R92 smoking in the facility since that time. She stated the current interventions include weekly room searches and that the facility recently had a meeting with the Veterans Administration (VA) regarding discharge.Interview on 04/30/2026 at 10:22 AM with the MDS Coordinator BB revealed she stated the care plan should have been updated to reflect the interventions put in place for the resident related to his non-compliance with the smoking policy. She stated the failure to update the care plan was an oversight. She stated the potential negative outcome was that no one would have known about his non-compliance with the smoking policy, and that he could have brought danger to other residents.Interview conducted on 04/30/2026 at 9:22 AM and 04/28/2026 at 1:34 PM with the Administrator revealed the care plan should have been updated to reflect the new interventions related to the resident's non-compliance with the smoking policy. She stated she did not know why the care plan was not updated. She stated her expectation for the Minimum Data Set (MDS) Coordinator was to update the care plan to reflect interventions when they were put in place. She stated the potential negative outcome was that other nurses would not be able to see the new interventions that were put in place for the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility's policy titled, Smoking Policy, the facility failed to ensure the environment remained free from accident hazards for one of two residents (R) (R92) reviewed for accident hazards. Findings Include:Review of the facility's policy titled, Smoking Policy, revised May 2017, revealed under Policy: The facility will ensure that the safety of the residents is protected by close supervision of residents who smoke. This will include completion of a smoking assessment, supervised smoking schedule, daily searches for tobacco products, matches, and lighters on non-compliant smokers, and weekly searches of compliant smokers. These searches will be documented. The policy further stated under Procedure: 1. Residents will not be allowed to keep cigarettes, cigars, pipes, matches, or lighters in their personal possession or in their rooms. Daily searches for matches, cigarettes, pipes, cigars, and lighters will be conducted for all residents who are not compliant with the Smoking Policy by nursing and documented daily until compliance with the Smoking Policy is established for 30 days. The policy further stated under Smoking Incident Reports, under Policy: An incident report will be completed if any smoking materials are found with a resident or in their room. Under Procedure: When cigarettes, cigars, matches, or lighters are found in a resident's room or on their person, it will be reported immediately to the Charge Nurse or Management Staff. The Charge Nurse will complete an incident report. The smoking materials will be retrieved from the resident and placed in the appropriate storage area. This incident will be reviewed in 'Patients at Risk' meeting and followed for four weeks or until the issues are resolved. Interventions and care plans will be completed as indicated. The policy further stated under Room Searches under Policy: Resident searches and room searches for cigarettes, cigars, pipes, matches, and lighters for all non-compliant smokers will be completed daily. Weekly searches will be completed for compliant smokers. Under Procedure revealed: Evening Nursing Staff will do daily searches (prior to midnight) of all non-compliant smoking residents and document findings on a form of their choice or the MAR (medication administration record). If any smoking devices are found, the nurse will retrieve the smoking devices and complete an incident report.Review of R92's Electronic Health Record (EHR) revealed he was admitted on [DATE] with diagnoses including, but not limited to, cerebral aneurysm nonruptured, cerebral infarction unspecified, major depressive disorder recurrent severe with psychotic symptoms, post-traumatic stress disorder (PTSD) unspecified, hemiplegia and hemiparesis following other cerebrovascular disease affecting the left non-dominant side, other speech and language deficits following other cerebrovascular disease, and cerebral atherosclerosis.Record review of R92's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Section GG (Functional Abilities and Goals) documented functional limitations in range of motion (ROM) with impairment on one side of both the upper and lower extremities, with use of a manual wheelchair.Review of R92's care plan revealed a focus, initiated 02/22/2019 and most recently revised on 01/27/2024, which stated R92 is resistive to care and noncompliant with smoking, and that he continues to go outside beyond facility property to smoke. A documented intervention dated 08/08/2023 stated: Review smoking policy with resident. An additional care plan focus, initiated 05/23/2019, identified R92 as a smoker who requires supervision while smoking, with documented interventions stating: The resident requires SUPERVISION while smoking and Notify charge nurse immediately if it is suspected resident has violated smoking policy.Record review of R92's Smoking Materials Monitoring Form for the month of April 2026 revealed staff initials documented on April 3, 2026, April 6, 2026, April 7, 2026, April 8, 2026, April 9, 2026, April 10, 2026, April 13, 2026, April 14, 2026, April 15, 2026, April 16, 2026, April 20, 2026, April 21, 2026, April 22, 2026, April 23, 2026, April 24, 2026, and April 25, 2026, with no initials documented (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the remaining days of the month, indicating daily room searches were not consistently completed and documented.Review of the Patient at Risk (PAR) Smoking PAR Tracking form revealed a PAR was initiated on 04/03/2026 with the reason documented as: Resident observed by Certified Nursing Assistant (CNA) and Activity Assistant vaping in room. Resident issued 30-day discharge. Week 1 Interdisciplinary Team (IDT) assessment dated [DATE] documented: Resident continued to violate smoking policy. Checked daily for smoking. vape devices and being removed. Week 2 IDT assessment dated [DATE] documented: Resident room check. Vape device removed. Resident refused to comply with facility policies. Week 3 IDT assessment dated [DATE] documented: Resident room check, no sign of vapor (sic). Resident has been in compliance out of time. Continued to check for vapor. Week 4 and Week 5 reflected no IDT signatures and no documentation completed.Review of the PAR Patient at Risk Grid revealed five entries for R92, all listed under the problem of Violating Non-Smoking Policy, with initiation dates of 05/16/2024, 05/22/2024, 05/29/2024, 06/5/2024, and 06/13/2024, with the 06/13/2024 entry reflecting a date resolved noted as discharge from PAR.Review of progress notes revealed the following documentation related to R92's noncompliance with the facility's non-smoking policy:Review of a social/psychosocial note dated 01/02/2026 documented: Resident can be non- compliant with smoking policy and often is checked for safety.Review of an activity note dated 04/03/2026 at 10:40 AM documented: R92 was observed by the Respiratory nurse using a vapor device in his room. The Respiratory nurse reported visible vapor present in room at the time of observation. Resident was informed that behavior was a violation of the non-smoking facility policy. At this time resident was pending a discharge due to violation of the facility's non-smoking policy.Review of a physician note dated 04/03/2026 documented: Facility name has a strict on site non- smoking policy. R92 has broken this multiple times by vaping in his room. He was accepted to a personal care home and I was informed he is going to be given a discharge notice.Review of an activity note dated 04/14/2026 at 2:19 PM documented: On Tuesday, April 14, 2026, writer was informed by Activity Assistant that she and CNA observed R92 vaping in his room. Resident was asked to surrender the vape device but, resident refused to cooperate with staff. Male charge nurse intervened and was able to retrieve the vape without further incident. Resident complied with charge nurse. Resident has been issued a 30-day discharge at this time.Review of a nurse's note dated 04/17/2026 at 8:02 AM documented: Resident was observed vaping in the room. Resident remains alert and verbally responsive. No signs of pain or distress.Review of a nurse's note dated 04/17/2026 at 10:40 AM documented: Resident seen smoking, informed we are a smoke free facility and he can not smoke in the rooms. Resident replied he is about to leave and to go talk to [NAME] and the higher ups, they know.Review of a nurse's note dated 04/20/2026 at 5:38 PM documented: Nurse on duty reported that she saw R92 vaping in his room. Spoke to resident about it, resident stated that he needs to vape every day, that why he's leaving.Review of a social/psychosocial note dated 04/20/2026 at 6:23 PM documented: R92 was found Vaping in the Room, Resident told the charge nurse he will continue to vape in the room because that is the reason why he is getting a discharge.Review of an activity note dated 04/29/2026 at 4:54 PM documented: R92 was observed by State Surveyor smoking a vape device in his room. Staff followed the facility policy and addressed the concern with the resident.Review of an activity note dated 04/29/2026 at 4:59 PM documented: R92 room check on 04/29/2026 for the possession of a vape device. Writer and Social Service conducted a room search and discovered three vape devices under the sheets. During the interaction, resident became angry and verbally aggressive, stating, 'I can't stand y'all .I hope I never see you again. Y'all make me sick.' Writer and Social Worker informed the resident of facility's nonsmoking policy and reiterated that vape devices are not permitted in his possession. The items were removed in accordance with the facility policy.Review of a nurse's note dated 04/29/2026 at 10:19 AM documented: It was reported to me that the resident was vaping in his room in the presence of the State Surveyor. Resident alert and verbally responsive.Review of a nurse's note dated 04/30/2026 at 9:53 AM documented: Resident in the room as nurse was doing her rounds found resident with a vape (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	device. Resident stated that if you take it, its okay because he will just get another one.Review of a social/psychosocial note dated 04/30/2026 at 9:09 AM documented: R92 was observed by State Surveyor smoking a vape device in his room. Staff followed the facility policy and addressed the concern with the resident, upon Room search some vapors was found in R92's room the vapors was taken away from him.Observation on 04/28/2026 at 2:37 PM in R92's room revealed two cans of name brand Air Freshener on the bedside table.Observation on 04/28/2026 at 11:48 PM in R92's room revealed a cloud of smoke upon entering and a blue vape pen was found on the resident's bed. When asked about the vape pen, R92 stated the social worker let him have it and repeatedly stated go see the social worker. Two cans of Name brand Air Freshener were also observed on the bedside table. R92 stated he used the air freshener to spray his blanket because it smelled like urine and would not allow staff to remove it.Observation on 04/29/2026 at 11:42 AM in R92's room revealed two cans of Name brand Air Freshener remained on the bedside table.Interview on 04/29/2026 at 11:42 AM with Certified Nursing Assistant (CNA) AA revealed she stated she had been told to be on the lookout for any items residents were not supposed to have, including medications and other items, for safety purposes. She stated that when she previously reported the air freshener to nursing, she was told R92 could have it because he was independent. She stated that when she attempted to remove items, he became upset and combative. She stated she had never seen a vaping situation in a facility before and acknowledged it was unacceptable. She stated the potential negative outcome related to the vape pen was that another resident could access it, that he could overdose on it, or that it could cause lung problems. She stated the potential negative outcome related to the air freshener was that it could be sprayed in someone's eyes.Interview conducted on 04/28/2026 at 12:04 PM with the Social Worker revealed she stated the facility was in the process of discharging R92 due to his smoking behaviors, as the facility was a non-smoking facility. She stated interventions in place include searching his room and confiscating any vapes or cigarettes found. She stated R92 had smoked cigarettes in his room in the past and now vapes. She stated they had caught him smoking in his room on more than one occasion, including both cigarettes and vapes. She stated the last time his room was checked was two days prior to the survey observation and that his room was not checked the day before the survey due to competing demands. She stated the potential negative outcome from his smoking in the room is that he could set the entire building on fire, endangering all residents. She stated she was not aware he had air freshener at his bedside. She stated R92 does whatever he wants regardless of what staff tell him and that when staff attempted to speak with him about his behavior, he responded by saying, I don't care, I'm going to leave anyway.Interview on 04/28/2026 at 12:38 PM with the Infection Preventionist and the Social Worker revealed the Infection Preventionist stated that regardless of what staff told him, R92 did not comply, and that even when vapes and prohibited items were confiscated, he found ways to obtain new ones shortly after. The Social Worker stated the interventions in place included daily room checks, involvement of the Activities Director, and family education. She stated approximately one month prior, when she went to confiscate items, she spoke with him calmly and he allowed her to search the room and had never outright refused to allow staff to take the vapes. The Infection Preventionist stated the unsecured items posed a hazard because any resident could enter the room, access the items, and cause harm, including having the air freshener sprayed in their eyes.Interview on 04/28/2026 at 12:53 PM with MDS Coordinator BB revealed that R92's non-compliant behavior related to smoking and vaping had been ongoing and that his room had always had to be searched for cigarettes and vaping paraphernalia. She stated the facility became a non-smoking facility in 2020 and she became aware of R92 smoking in the facility since that time. She stated the current interventions include weekly room searches and that the facility recently had a meeting with the Veterans Administration (VA) regarding discharge.Interview on 04/29/2026 at 1:14 PM with the Activities Director revealed she stated R92 was very non-compliant, had broken several facility policies, and could be verbally abusive and at times physically aggressive. She stated his non-compliance regarding smoking in his room had increased in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequency and she had been aware of him smoking in his room since 2025, with vaping more recently. She stated interventions in place included placement of a smoke detector in his room and daily room checks conducted by herself and nursing. She stated she maintained a log of room checks which began on 04/03/2026 and also kept a record of all items confiscated from his room. She stated she had instructed nursing to check him upon return from outings. She stated the facility was not currently conducting smoking assessments because it was not a smoking facility. She stated the potential negative outcome related to the vape pen was fire risk and respiratory harm to R92 and other residents.Interview on 04/28/2026 at 1:34 PM with the Administrator revealed she stated R92 was very non-compliant and cursed at staff when they attempted to redirect him. She stated he went out frequently and returned with smoking items, and that every time staff had observed him with smoking paraphernalia, it had been confiscated. She stated the facility became a non-smoking facility in 2020 and first observed R92 being non-compliant with the smoking policy in 2025, with vaping becoming more frequent in 2026. She stated interventions included smoke detectors in his room, frequent rounds every two hours with visual checks for smoke, and relocation of his room closer to the nursing station. She stated the facility did not maintain logs of the every-two-hour rounds conducted in his room. She stated the potential negative outcome of R92's smoking behavior was that if he were to drop ashes, the facility could catch fire.

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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, and review of the facility's policy titled, Medication Storage in the Facility, the facility failed to securely lock the Treatment Cart. This deficient practice had the potential to create a hazardous condition in which any resident could access the treatment cart and come into contact with topical creams that could be toxic if ingested. The census was 94.Findings include:Review of the facility's policy titled Medication Storage in the Facility, effective date 10/01/2025, revealed under Policy: . The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Section B revealed that Medication rooms, carts, and medication supplies are locked or attended by authorized personnel. An observation and interview on 04/29/2026 at 9:35 AM revealed that, after observing wound care for R3 with the Wound Care Licensed Practical Nurse (LPN), the treatment cart was left in the [NAME] hall, across the hall from R3's room, which was been unlocked and unattended for 30 minutes. An interview with the wound care LPN revealed that he confirmed the treatment cart was unlocked and unattended. An interview with the Infection Preventionist (IP) LPN on 04/29/2026 at 11:09 AM revealed that she had spoken with the wound care nurse about this after the incident. She confirmed that he told her the treatment cart was left unlocked.An interview with the Administrator on 04/30/2026 at 1:40 PM revealed that she expected all medications, including topical medications, to be locked when not in sight of a licensed nurse or authorized person.

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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 interviews, and review of the facility's policy titled, Infection Prevention and Control Program, the facility failed to prevent cross-contamination of dirty laundry from clean laundry. This deficient practice had the potential to cause the spread of infection throughout the facility. The census was 94.Findings include:Review of the facility's policy titled Infection Prevention and Control Program, reviewed 01/06/2026, under Policy Explanation and Compliance Guidelines revealed: .12. Linens: b. Clean linen shall always be separated from soiled linen.Review of the facility's policy titled Handling Soiled Linens reviewed February 2024, revealed under Policy Explanation and Compliance Guidelines: . 11. Soiled linen shall always be kept separate from clean linen.An observation of the laundry area on 04/30/2026 at 10:25 AM revealed that all doors to the washers and dryers were open upon entering the clean linen area. The clean linen, sheets, towels, blankets, and washcloths were folded on the table to the left of the washer and dryer room. Next to the dryers on the right side of the room were residents' clean clothes on a rack, piles of folded clean clothes to be hung, a rack of unlabeled clothes, and a bag of unlabeled clothes, all next to the dryers and directly in front of the dirty laundry room that had an open door allowing exposure of possible pathogens from the dirty laundry to the clean resident clothes. It was also observed that, to bring the dirty clothing and linen to the washer, the dirty barrels had to be pushed past the clean clothing on the racks. An interview with Environmental Staff DD and EE, who were working in the laundry on 04/30/2026 at 10:30 AM, revealed that they felt they had reduced the spread of infection by keeping all doors open, covering the dirty barrels, and circulating the air. They revealed that the one rack of clothes (not covered) and the bagged clothes on the floor next to the dirty area were no-name clothes that were sometimes distributed to residents in need. The rack of clean clothing parked in front of the open door to the dirty linen room was personal resident clothes that need to be distributed. They stated that the staff member who distributed clean clothes worked only at night, when the clothes were delivered to the residents.An interview with the Environmental Services Director on 04/30/2026 at 11:00 AM revealed that the door to the dirty side of the laundry should always be closed and that there should be no linen on top of the dirty barrels.An interview with the Infection Preventionist nurse on 04/30/2026 at 11:50 AM revealed that when she was shown pictures and concerns about cross-contamination between dirty and clean laundry, she confirmed there was a problem with cross-contamination in the laundry, but she was not aware of the concern until then. An interview with the Administrator on 04/30/2026 at 1:40 PM revealed that the residents' clothes should not be where they were at this time; they should be handed out immediately once they were clean. She expected the laundry to be organized to prevent cross-contamination between dirty and clean clothes, and a negative outcome could be the spread of infection through the laundry.