

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER Reliable Health & Rehab at Lakewood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39926</p> <p>Based on staff interviews, record review, and review of the Long-Term Care (LTC) Resident Assessment Instrument (RAI) 3.0 Manual, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for three (3) of three (3) sampled residents (Resident (R) #24, R#25, and R#74) reviewed for hospice care. The MDS Assessments for the sampled residents did not reflect the residents had terminal illnesses.</p> <p>Findings include:</p> <p>Review of the LTC Facility RAI 3.0 dated October 2024 revealed J1400: Prognosis: Steps for Assessments: 1. Review the medical record for documentation by the physician that the resident's condition or chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness. 2. If the physician states that the resident's life expectancy may be less than 6 months, request that they document this in the medical record. Do not code until there is documentation in the medical record. 3. Review the medical record to determine whether the resident is receiving hospice services. Coding Instructions: Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services. Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services .O0110: Special Treatments, Procedures and Programs: .O0110K1, Hospice Care - Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.</p> <p>1. Review of Resident #24's electronic medical record (EMR) revealed the resident was admitted to the facility with diagnoses which included, but were not limited to congestive heart failure, dementia, atrial fibrillation, bipolar disorder and type 2 diabetes mellitus.</p> <p>Review of Resident #24's Physician's Order dated 11/6/24 revealed Admit to Hospice - (name of hospice). #1 to name of hospice #2 per daughter's request. Admission completed today, resident, hospice and resident's daughter made aware.</p> <p>Review of Resident #24's Quarterly MDS dated [DATE] revealed the resident was not assessed as having a terminal illness prognosis at J1400.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #24's Quarterly MDS dated [DATE] revealed the resident was not assessed as having a terminal illness prognosis at J1400.</p> <p>Review of Resident #24's Quarterly MDS dated [DATE] revealed the resident was not assessed as having a terminal illness prognosis at J1400.</p> <p>Review of Resident #24's Annual MDS dated [DATE] revealed the resident was not assessed as having a terminal illness prognosis at J1400. Review of Resident #24's Name of Hospice- Hospice Certification and Plan of Care for certification period 12/10/21 to 2/7/22 revealed I certify that this patient is terminally ill with a life expectancy of six (6) months or less if the terminal illness process runs its normal course. The statement was e-signed by the Hospice Physician.</p> <p>Review of Resident #24's Name of Hospice - Physician Certification/Recertification for certification period 2/4/25 to 4/4/25 revealed I certify, in my clinical judgement, based on my review of the patient's medical record and/or examination of the patient named above, that this patient's medical prognosis is terminal with a life expectancy of six (6) months or less, if the illness runs its normal course. The statement was electronically signed by the Hospice Physician.</p> <p>During an interview on 3/13/25 at 11:45 a.m., the MDS Coordinator stated R#24 was admitted to Name of Hospice #1 and continuously used that hospice until recently when the daughter requested she be switched to Name of Hospice #2 in November of 2024.</p> <p>2. Review of Resident #25's EMR revealed the resident was admitted to the facility with diagnoses which included, but not limited to Alzheimer's Disease, dementia, type 2 diabetes mellitus, hypertension, altered mental status and aspiration of fluid. Further review of the resident's medical record reviewed the resident was admitted to hospice on 7/19/24.</p> <p>Review of Resident #25's Quarterly MDS dated [DATE] revealed the resident was not assessed as having a terminal illness prognosis at J1400.</p> <p>Review of Resident #25's Quarterly MDS dated [DATE] revealed the resident was not assessed as having a terminal illness prognosis at J1400.</p> <p>Review of Resident #25's Significant Change MDS dated [DATE] revealed the resident was not assessed as having a terminal illness prognosis at J1400.</p> <p>3. Review of Resident #74's EMR revealed the resident was admitted to the facility with diagnoses which included dementian epididymitis, hypertension, post-traumatic stress disorder and seizures.</p> <p>Review of Resident #74's Physician's Orders dated 10/3/24 revealed Admit to hospice (name of hospice).</p> <p>Review of Resident #74's Annual MDS dated [DATE] revealed the resident was not assessed as having a terminal illness prognosis at J1400.</p> <p>Review of Resident #74's Quarterly MDS dated [DATE] revealed the resident was not assessed as having a terminal illness prognosis at J1400.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #74's Quarterly MDS dated [DATE] revealed the resident was not assessed as having a terminal illness prognosis at J1400.</p> <p>Review of Resident #74's Certification from Hospice Physician dated 6/28/24 revealed I attest that I have completed the face-to-face encounter. The clinical findings of this encounter have been provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six (6) months or less, should the illness run its normal course. The statement was electronically signed by the Nurse Practitioner.</p> <p>During an interview on 3/14/25 at 9:45 a.m., the MDS Coordinator stated she had overlooked coding the residents' prognoses for hospice. She stated she will review all the hospices residents' documentation and send corrections. She stated she used the Resident Assessment Instrument (RAI) 3.0 Manual for direction and reference when coding an MDS Assessment. She stated she does know J1400 Prognosis should be coded for hospice residents once an order has been received.</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>33516</p> <p>Based on observations, staff interviews, record review, and review of facility policy, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) was accurate for one (resident (R) #61 of seven residents reviewed. Specifically, the facility failed to ensure the PASRR was completed accurately upon admission.</p> <p>Findings include:</p> <p>Review of the facility policy titled Admission Criteria dated November 2017 read in part: Policy Statement: Our facility will admit only those residents whose medical and nursing care needs can be met. Policy Interpretation and Implementation . 7. Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medical Pre-Admission Screening and Resident Review.</p> <p>Review of the electronic medical record (EMR) revealed R #61 was admitted to the facility with diagnoses that included, but were not limited to bi-polar disorder and vascular dementia.</p> <p>Review of the Preadmission Screening Resident Review (PASRR) Level I Assessment (Form: DMA-613): Review Request dated 3/22/24 did not reveal the resident had the diagnosis of bi-polar disorder.</p> <p>During an interview on 3/14/25 at 11:38 a.m., the Director of Social Services (DSS) explained the process for PASRR stating it was dependent on the diagnosis. The DSS stated the hospital staff submitted the Level I to the Georgia state agency prior to admission to the nursing home facility. She stated they (the facility) received a copy of The Level I prior to admission for review and to see if it was pending or approved. The DSS stated she reviewed the form to ensure the diagnosis were documented accurately for the resident. She stated one of the sister facilities had completed an audit about six months ago and identified there was an issue. The DSS reviewed the PASRR for R#61 and stated it was not completed accurately and submitted a new form on 3/11/25. The DSS stated it was important to complete timely so the patient can be taken care of if they have behaviors and treated timely. She stated she should have completed a new Level I because the hospital did not include diagnoses of Bipolar.</p> <p>During an interview on 3/14/25 at 12:05 pm, the Nursing Home Administrator (NHA) did not know if a new Level I should have been submitted since the hospital did not indicate the resident had Bipolar on The Level I when they submitted it. The NHA stated there was not additional information for R#61's PASRR and it should have been resubmitted.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33516</p> <p>Based on observations, staff interviews, record review, and facility policy review, the facility failed to carry out activities of daily living (ADL) for a dependent resident for one (1) (Resident (R) #9) of 30 sampled residents reviewed. Specifically, the facility failed to provide nail care to a dependent resident.</p> <p>Findings include:</p> <p>Review of the facility policy titled Nail Care dated July 2024 read in part: Policy: Purpose of this procedure is to provide guidelines for the provisions of care to a resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines: .3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regularly scheduled shower/bath day. Nail care will be provided between scheduled occasions as the need arises.6. Principles of nail care: a. nails should be kept smooth to avoid skin injury.</p> <p>Review of the electronic medical record (EMR) revealed Resident (R)#9 was admitted to the facility with diagnoses that included, but were not limited to muscle weakness, and hemiplegia and hemiparesis following infarction affecting the left dominant side.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] included the Brief Interview for Mental Status (BIMS) score of two (2) out of 15, which indicated the resident was severely cognitively impaired. The assessment revealed the resident was dependent on staff for ADLs to include personal hygiene and nail care.</p> <p>Review of R#9's Care Plan identified the resident was dependent on staff for ADL care.</p> <p>Review of Shower Documentation & CNA (Certified Nursing Assistant) Skin Assessment Form read in part:1/29/25 nail care was left blank, 2/4/25 fingernails cleaned and cut, 2/14/25 fingernails cleaned, 2/28/25 fingernails cleaned, 3/4/25 fingernails cleaned and cut.</p> <p>Observation on 3/11/25 at 12:23 pm revealed the resident was in her room lying in bed with family visiting. The resident's nails appeared long with jagged edges and dark color debris under the nails.</p> <p>Observation on 3/12/25 at 3:25 pm revealed the resident was lying in bed with hands crossed. R#9's nails appeared long and jagged with debris under the nails.</p> <p>Observation on 3/13/25 at 3:02 pm revealed the resident was sitting up in bed. The resident's nails appeared long and jagged with debris under the nails.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 3/13/25 at 3:05 pm, CNA CC stated nail care was completed on shower days, two times a week, unless they noticed that they needed to be cut and cleaned during daily patient care that included cutting and trimming. CNA CC stated R#9's shower days were Tuesday and Friday mornings. She observed the residents' nails and stated they needed to be cleaned and cut. She stated documentation was completed on the Shower Documentation & CNA Skin Assessment Form after completion of the task.</p> <p>During an interview and observation on 3/13/25 at 3:10 pm, Licensed Practical Nurse (LPN AA) stated resident nails were cleaned and trimmed daily if needed. He stated they did not have a specific nail clipping day, it could be completed on the shower days or as needed. LPN AA stated the CNAs documented on the shower sheet if it was done and would let nurses know as needed. He stated if the nurse saw a hangnail or something it was documented in the nurses' notes. Observation of R#9's nails in her room, LPN AA said, dirt or something is under her nails, and about medium length, in need of a trim. He said, the left hand, which was contracted, nails in need of nail care, cleaned and trimmed. LPN AA stated it was important to complete nail care so residents would not injure themselves and good hygiene.</p> <p>During an interview and observation on 3/13/25 at 3:26 pm with the Director of Nursing (DON) stated ADL care included personal hygiene, which included nail care. He stated that dependent residents' nails were cleaned and trimmed during the shower at a minimum and as needed. He stated daily care included personal hygiene and nail care. Observation of Resident #9's nails with the DON, he said, I see dirt under the nails, long jagged nails and the left-hand contracture longer and jagged, they can be more clean.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33516</p> <p>Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure the resident did not experience a reduction in motion for one of one resident (R#9) reviewed. Specifically, the facility failed to assess and provide services to prevent contractures.</p> <p>Findings include:</p> <p>Review of the facility policy titled Contracture Management dated January 2024 read in part: Policy: Potential for contractures development and range of motion will be assessed upon admission, readmission, significant change in condition, and quarterly to identify any limitations in range of motion or potential for contracture development. Residents will be referred to the Therapy Department in accordance with this policy for screening and contracture identification. Therapy Department will screen all new admissions for the presence of contractures and the presence or absence of contractures will be noted on the Therapy Screen and/or the evaluation form. Therapy will continue to monitor the presence and/or severity of a contracture once identified or for the development of a new limitation/contracture during the quarterly/annual/significant change therapy screening process with the help of the nursing ROM (range of motion) Evaluation Tool and Contracture Potential Assessment.</p> <p>Resident (R)#9 was admitted to the facility with diagnoses that included, but were not limited to muscle weakness, and hemiplegia and hemiparesis following infarction affecting the left dominant side.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] included the Brief Interview for Mental Status (BIMS) score of two (2) out of 15, which indicated the resident was severely cognitively impaired. The assessment revealed the resident was dependent on staff for Activities of Daily Living (ADL) to include personal hygiene and nail care. The resident received occupational therapy from 9/9/24 through 10/24/24.</p> <p>Review of the current Physician Orders did not include an order for use of a splint or restorative therapy.</p> <p>Review of R#9's Care Plan initiated 3/13/25 identified the resident required restorative nursing for left hand contracture. The resident goal was to have no skin breakdown or other complications related to splint use. The interventions included staff was to explain to the resident every time the splint was put on or removed; staff to apply the resting hand splint to the left hand two hours on and two hours off; check for adequate circulation and signs and symptoms of skin breakdown when removed.</p> <p>Review of the Contracture Potential Assessment revealed:</p> <p>On 8/9/24 a score of 16 which indicated the resident had severe impairment /limitation on ROM tool and or contracture. Therapy Screen indicated/request completed.</p> <p>On 11/7/24 a score of 15 on the tool did not identify the impairment/limitation.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/7/24 a score of 15 on the tool did not identify the impairment/limitation.</p> <p>Observation on 3/11/25 at 12:23 pm revealed R#9 was in her room lying in bed with family visiting. The resident's left hand was contracted with no splint on.</p> <p>Observation on 3/12/25 at 3:25 pm revealed R#9 was lying in bed with hands crossed. The resident's left hand was contracted with no splint on.</p> <p>Observation on 3/13/25 at 3:02 pm revealed R#9 was sitting up in bed. The resident's left hand was contracted with no splint on.</p> <p>During an interview and observation on 3/13/25 at 3:05 pm, Certified Nursing Assistant (CNA CC) stated the resident's left hand was contracted and there was no injury. She stated the restorative department took care of the contractures, applied splints as ordered.</p> <p>During an interview and observation on 3/13/25 at 3:10 pm, Licensed Practical Nurse (LPN AA) stated he did not know if the resident had a splint.</p> <p>During an interview and observation on 3/13/25 at 3:26 pm with the Director of Nursing (DON), he stated he did not know about the contractures but would check. He did not return with information.</p> <p>During an interview on 3/14/25 at 9:44 am, the Director of Rehab (DOR) explained the process regarding splint use. She stated if a person was not on therapy, either the CNA or nursing would submit a referral to therapy and then Occupational Therapy (OT), Physical Therapy (PT) or Speech Therapy (ST) would screen the resident and decided if the person needed further evaluation for the next level and then they were picked up by therapy. The doctor or Nurse Practitioner sometimes made recommendations. She stated somebody made the referral and went from there. The DOR stated after the evaluation it was determined on the needs of the resident. She stated it took about 24-48 hours after referral to start the process. The DOR stated the resident received therapy services from 12/30/24 to 1/28/2025 and determined a resting hand splint was needed and ordered, the splints were shipped on 1/16/25. The DOR stated there should have been an order for restorative to follow and apply the splint up to four hours a time. She stated the resident was unable to tolerate 4 hours of splint use. She stated the resident should have had at least two hours and then off and tried again, should have minimum of two hours per day of wearing the splint. The DOR stated that after therapy was completed, a restorative form was completed and turned into the MDS coordinator who was in charge of the restorative program, but that was a process that started a few days ago, since she just started the position a few days ago. The DOR was unable to recall who gave the referral for restorative therapy for R #9. She stated the restorative CNA was responsible to place the splint on the resident as required. The DOR did not know if it was documented or who was responsible for documenting when the splint was placed on the resident or not placed on the resident. She stated they should document daily but the restorative CNA would know. The DOR stated he would look for documentation and if located would provide to the NHA to give to the surveyor.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/14/25 at 10:23 am, Restorative CNA (Restorative CNA CC) explained that once the rehab department discharged the resident they were then added to the restorative program. They were responsible to do ROM to the upper and lower extremities, splints, sit to stand, help dress and toilet residents. Restorative CNA CC stated the rehab department communicated verbally what needed to be done. She said, They (OT) said that the resident did have a splint, I never received a splint. I put one on her today. The Restorative CNA CC said, I would put wash clothes in her hands, when she was on restorative. R#9's restorative discontinued two Fridays ago. R#9 now back on restorative as of yesterday and I put the splint on this morning. Restorative CNA CC stated it was important to have the splint on because she had contractures and helped her open her hand somewhat. She said we do not document in restorative.</p>