STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115730	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oceanside Care Center LLC	7 Rosewood Avenue Tybee Island, GA 31328

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49472 Based on observations, resident interviews, staff interviews, and record reviews, the facility failed to ensure that one of 33 sampled residents (R) (R2) was treated with dignity. This failure had the potential to diminish R2's quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life. Findings included: A review of R2's Admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 (indicating moderate cognitive impairment). During an observation on 8/29/2024 at 11:11 am, R2 was observed in his room and wearing a hospital gown. During an observation and interview on 9/3/2024 at 11:28 am, R2 was observed in his room and wearing a hospital gown. R2 stated that he had brought clothes to the facility, and when he returned from a hospital stay, his clothing was missing. He could not recall the date of the hospital stay or if missing clothing had been reported to anyone. During an observation and interview on 9/5/2024 at 10:19 am, R2 was observed to be wearing a hospital gown. He stated that he did not want to wear a hospital gown and preferred to wear clothes. During an interview on 9/3/2024 at 1:09 pm, Certified Nursing Assistant (CNA) III stated that she was not sure why R2 was always wearing a hospital gown, but she would change his clothes. CNA III stated she was unsure if R2 chose to be in a hospital gown. During an interview on 9/3/2024 at 1:12 pm, CNA KKK stated that when she gets R2 ready for dialysis, she typically dresses him in his sweatpants and a shirt. During an interview on 9/3/2024 at 1:23 pm, the Director of Nursing (DON) stated that most of the residents who do not get out of bed wear hospital gowns. The DON further stated wearing a hospital gown had not been identified as a problem or issue for R2. (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: 115730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oceanside Care Center LLC	7 Rosewood Avenue Tybee Island, GA 31328

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 9/5/2024 at 12:25 pm, the Administrator confirmed that R2 was wearing a hospital gown. The Administrator stated that R2 was very particular about how he looked and should not be wearing a hospital gown unless he desired to.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49687 Based on observations and staff interviews, the facility failed to ensure the call light was within reach for four of 33 sampled residents (R) (R28, R29, R15, and R16). This failure placed the residents at risk of accident, injury, and/or unmet needs related to an inability to call for staff assistance. Findings include: 1. A review of R28's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed section GG (Functional Abilities and Goals) documented no impairment of the upper extremities, and the resident was dependent on staff for activities of daily living (ADLs). Observation on 8/27/2024 at 11:08 am revealed that R28's call light was lying on the floor next to the head of the bed and was not within reach of R28. 2. A review of R29's Quarterly MDS assessment dated [DATE] revealed section GG (Functional Abilities and Goals) documented no impairment of the upper extremities, and the resident was dependent on staff for ADLs. Observation on 8/28/2024 at 1:38 pm revealed that R29's call light was coiled around the bed rails with the bottom pointed down toward the floor and was not within R29's reach. 3. A review of R15's Quarterly MDS assessment dated [DATE] revealed section GG (Functional Abilities and Goals) documented no impairment of the upper extremities, and the resident was dependent on staff for ADLs. Observation on 8/28/2024 at 1:46 pm revealed that R15's call light was not within R15's reach. 4. A review of R16's Quarterly MDS assessment dated [DATE] revealed section GG (Functional Abilities and Goals) documented no impairment of the upper extremities, requires set-up assistance with eating, and the resident was dependent on staff for ADLs. Observation on 8/28/2024 at 1:47 pm revealed that R16's call light was over the resident's bedroom light located over the resident's headboard and was not within R16's reach. In an interview on 8/27/2028 at 11:16 am, Certified Nursing Assistant (CNA) NN verified the call lights were not within reach of the residents and stated the call lights should not be on the floor. In an interview on 9/9/2024 at 3:16 pm, the Administrator stated call lights should always be within the residents' reach.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49479 Based on staff interviews, record review, and review of the facility policy titled Comprehensive Care Plans, the facility failed to develop a person-centered comprehensive care plan for one of 33 sampled residents (R) (R4). The deficient practice had the potential to affect the care and services provided to R4. Findings include: A review of the facility's undated policy titled Comprehensive Care Plans revealed the Policy Explanation and Compliance Guidelines section included 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS [Minimum Data Set] assessment. All Care Assessment Areas triggered by the MDS will be considered in developing the plan of care . 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. A review of R4's Face Sheet revealed an admitted [DATE] with diagnoses including but not limited to, chronic obstructive pulmonary edema (COPD) and congestive heart failure (CHF). A review of R4's MDS dated [DATE] revealed that R4 required the assistance of one staff member with activities of daily living (ADLs), had an indwelling urinary catheter, and received services of hospice. A review of R4's care plan, dated 8/14/2023, revealed the care plan contained one focus area of Resident enjoys TV, music (variety), coffee social, arts and crafts, drawing, coloring, special events, and parties. Further review of R4's care plan revealed no focus areas for ADLs, COPD, hospice, or an indwelling urinary catheter. An interview on 9/3/2024 at 1:23 pm with the Director of Nursing (DON) revealed that baseline care plans were created upon admission and a comprehensive person-centered care plan should be created by the 14th day. The DON stated the care plan was used by the nurses to determine what type of care a resident would require.

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NAME OF PROVIDER OR SUPPLIER: Oceanside Care Center LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 7 Rosewood Avenue Tybee Island, GA 31328	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49470 Based on observations, resident interviews, staff interviews, record review, and review of the facility's policy titled Activities of Daily Living (ADLs), the facility failed to provide ADL care for four of 33 sampled residents (R) (R18, R20, R16, and R15). This failure placed R18, R20, R16, and R15 at risk for unmet needs and a diminished quality of life. Findings include: Record review of the facility's undated policy titled Activities of Daily Living (ADLs), revealed the Policy Explanation and Compliance Guidelines section included 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. A review of R18's Face Sheet revealed diagnoses included cognitive communication deficit and muscle weakness. A review of R18's Quarterly Minimum Data Set (MDS), dated [DATE], revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 8 (indicating moderate cognitive impairment), and section GG (Functional Abilities and Goals) documented R18 was dependent for ADL care. Observation on 8/28/2024 at 10:30 am revealed R18's fingernails had black and brown substances under the nails, and her nails were approximately two inches long. In an interview on 8/28/2024 at 10:30 am, R18 stated she needed her fingernails trimmed. She further stated staff rarely offered to trim her nails and she couldn't remember the last time her nails were trimmed. 2. A review of R20's Face Sheet revealed diagnoses included hemiplegia and muscle weakness. A review of R20's Quarterly MDS, dated [DATE], revealed section C (Cognitive Patterns) documented a BIMS score of 15 (indicating little to no cognitive impairment), and section GG (Functional Abilities and Goals) documented R20 was dependent for ADL care. Observation on 8/28/2024 at 10:36 am revealed that R20's nails were covered with black and brown substances. In an interview on 8/28/2024 at 10:36 am, R20 stated he had been desperately trying to get his nails trimmed and further stated staff always told him they were busy. 3. A review of R16's Face Sheet revealed diagnoses included muscle weakness, lack of coordination, and cognition communication deficit. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R16's Quarterly MDS, dated [DATE], revealed section C (Cognitive Patterns) documented a BIMS score of 0 (indicating severe cognitive impairment), and section GG (Functional Abilities and Goals) documented that R20 was dependent for ADL care. Observation on 8/28/2024 at 10:15 am revealed R16's fingernails were two to three inches long and with black substance under the nails. In an interview on 8/28/2024 at 10:15 am, R16 stated the last time he had his nails cut was six months ago and stated he would prefer to have his nails trimmed. During an interview on 8/28/2024 at 2:04 pm, Certified Nursing Assistant (CNA) HH stated she cut residents' nails as needed and further stated she had not had time to trim residents' nails recently. CNA HH confirmed that R18, R20, and R16 had long nails that needed to be trimmed. During an interview on 8/28/2024 at 2:15 pm, Licensed Practical Nurse (LPN) CC confirmed that R16, R20, and R16's nails were unusually long and needed to be trimmed. LPN CC stated she was unaware their nails needed trimming and stated she would have staff trim all the residents' nails. 4. A review of R15's Face Sheet revealed diagnoses included unsteadiness on feet, lack of coordination, and cognition communication deficit. A review of R15's Annual MDS dated [DATE] revealed section C (Cognitive Patterns) documented a BIMS score of 0 (indicating severe cognitive impairment), and section GG (Functional Abilities and Goals) documented R15 was dependent on staff for assistance with ADLs, including toileting and personal hygiene. A review of R15's care plan revealed that R15 was incontinent of bowel and bladder. Interventions included checking on him every two hours and providing incontinent care as needed. Observation on 8/28/2024 at 10:10 am revealed R15 lying in his bed in a fetal position on his bed. An offensive odor was detected around R15's bed area. Observation on 8/28/2024 from 10:49 am to 11:10 am revealed R15 lying in the fetal position on his bed. An offensive odor was detected in the room and into the hallway across the hallway. Observation on 8/28/2024 at 2:10 pm revealed R15 lying in the fetal position on his bed, with an offensive odor in the room and hallway. During an interview on 8/28/2024 at 2:20 pm, CNA FF stated she was aware R15 had a bowel movement and explained she was busy passing out trays during lunch serve and had to continue passing trays to avoid cross-contamination. CNAFF stated she had to finish her task before she assisted R15 with ADL care. During an interview with the Director of Nursing (DON) on 9/3/2024 at 1:25 pm, she stated staff should check on R15 every two hours. The DON explained staff should take the trays down and assist any resident who required incontinent care. The DON further stated she would expect staff to assist a resident who required incontinent care, if necessary, and then proceed to pass out trays. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/9/2024 at 3:20 pm, the Administrator revealed staff should not have waited several hours before they assisted R15 with ADL care and explained she expected staff to check on R15 every two hours. The Administrator stated that R15 was nonverbal and was unable to make his needs known. The Administrator concluded she talked to staff and reeducated staff as soon as she became aware staff left R15 in his bowel movement for several hours.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 49687 Based on resident interviews, staff interviews, and record reviews, the facility failed to obtain a critical laboratory test for one of 33 sampled residents (R) (R6) in a timely manner. Specifically, the facility failed to obtain a urine specimen for five days after the physician's order. The deficient practice had the potential to place R6 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: A review of R6's electronic medical record (EMR) revealed diagnoses including, but not limited to, Human Immunodeficiency Virus (HIV). A review of the Annual Minimum Data Set (MDS) assessment, dated 7/4/2024, revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment). A review of R6's Progress Notes revealed an entry dated 8/8/2024 at 8:13 pm of MD [Medical Doctor] rounded . obtain UA C&S [urinalysis, culture and sensitivity]. Further review revealed an entry dated 8/12/2024 at 7:15 pm of Order for UA C&S received on 8/8/2024 has not yet been retrieved for testing for resident that is having urinary discomfort and pain to lower back area and states that the pain goes down her left leg. Resident continues with c/o [complaint of] severe pain 10/10, after prn [as needed] pain med [medication] administered as ordered and has agreed to let this nurse obtain a urine sample with a request to use a straight catheter this shift. Continued review revealed an entry dated 8/13/2024 at 5:12 am of Urine sample collected with no issues or complaints. The resident stated that she felt relieved and that her pain level had decreased while obtaining a urine sample. In an interview on 8/29/2024 at 11:07 am, R6 stated that she told the physician that she couldn't urinate. As a result, the physician ordered an in-and-out catheter to be performed. R6 stated the order sat there for four days before the specimen was collected. In an interview on 9/5/2024 at 12:48 pm, Licensed Practical Nurse (LPN) JJ verified a UA C&S was ordered for R6 on 8/8/2024. LPN JJ stated she performed clerical work that day and did not attempt to collect the urine sample. LPN JJ further stated she passed the information along to the nurse assigned to the resident and did not recall who that was. In an interview on 9/6/2024 at 9:24 am, LPN OO revealed when an order for a urinalysis was obtained, the nurse should collect the specimen. She further stated she was unsure why the urine specimen was not obtained for five days. In an interview on 9/6/2024 at 11:03 am, The Director of Nursing (DON) verified the physician's order for the urine specimen and stated it should have been collected when ordered and further stated she was unaware it was not obtained in a timely manner. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 9/5/2024 at 2:53 pm, Physician GGG revealed that when an order is given, it should be done within a 12 to 24-hour period. Physician GGG stated it was unacceptable for a urine specimen to not be obtained for five days.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49470 Based on observation, resident interviews, staff interviews, record review, and review of the facility policy titled Infection Control, the facility failed to ensure staff implemented infection control precautions to provide individual water mugs for two of 33 sampled residents (R) (R19 and R33) who shared a single water mug for an undetermined period in their room. This failure created the potential of exposing R19 and R33 to infections due to cross-contamination. Findings include: A review of the facility policy titled Infection Control Policy, dated 4/1/2024, revealed the Policy of The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. A review of R19's Face Sheet revealed an admitted [DATE] and diagnoses that included urinary tract symptoms, unspecified sepsis, and viral hepatitis. A review of the R19's Quarterly Minimum Data Set (MDS) dated [DATE] revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 8 (indicating moderate cognitive impairment) and section GG (Functional Abilities and Goals) documented R19 required minimal assistance with Activities of Daily Living (ADL). A review of R33's Face Sheet revealed an admitted [DATE] and diagnoses that included acute respiratory failure. A review of R33's Quarterly MDS dated [DATE] revealed section C (Cognitive Patterns) documented a BIMS score of 12 (indicating little to no cognitive impairment) and section GG (Functional Abilities and Goals) documented R19 required minimal assistance with ADLs. Observation on 8/27/2024 at 10:45 am in R19 and R33's room revealed one one-liter mug of water sitting on a table in the center of the room. In an interview on 8/27/2024 at 10:45 am, R19 stated staff were unable to offer him his own water mug and further stated staff expected him and R33 to drink from the same water mug. In an interview on 8/27/2024 at 10:49 am, R33 revealed he had been sharing the same water mug with R19 since he was admitted to the facility. During an interview on 9/3/2024 at 1:25 pm, the Director of Nursing (DON) revealed she was unaware that R19 and R33 were sharing a water mug. She stated residents sharing water mugs was an infection control concern. The DON verified the one water mug in R19 and R33's room and described the mug as filthy and needed to be replaced. She replaced the water mug and provided each resident with their own. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/9/2024 at 3:20 pm, the Administrator stated residents should not share water mugs and stated she would make sure each resident has their own water mug.