STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115771	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Post Acute Care Center	2020 McGee Road Snellville, GA 30078

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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 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** 49396 Based on observations, staff and resident interviews, record review, and review of the facility's policy titled Self-Administration of Medication Program, the facility failed to ensure that three of 56 residents (R) (R45, R113, and R432) did not have unauthorized and unsecured medications at the bedside. This failure created the potential for medication errors and unauthorized access to medications by other residents. Findings include: Review of the facility's undated policy titled, Self-Administration of Medication Program, revealed under the Policy statement, It is the policy of the facility to allow the resident and or legal representative of that resident the right to self-administer medication when it has been deemed by the interdisciplinary team (IDT) that it is clinically appropriate. Under the section titled Procedure revealed, (5) If a resident request to self-administer drugs, it is the responsibility of the IDT to determine it is safe for the resident to self-administer drugs, before the resident may exercise that right. (6) When determining if self-administration is clinically appropriate for a resident, the IDT will at a minimum consider the following .(c)The resident's cognitive status, including the ability to correctly name medications and know what conditions they are taken for (7) The admitting nurse or designee will complete the Self-Administration of Medication Evaluation and report the findings to the Unit Manager or designee. (8) The interdisciplinary team must also determine: (a) Who will be responsible (the resident or the nursing staff) for storage; if medications are stored at the resident's bedside, a lockbox or locked drawer must be used to store the medications 1.Review of R45's Face Sheet indicated the resident was admitted with diagnoses that included but not limited to essential (primary) hypertension, hyperlipidemia, type 2 diabetes mellitus without complications, peripheral vascular disease, and gastroesophageal reflux disease without esophagitis. Review of R45's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed for Section C (Cognitive Pattern) a Brief Interview for Mental Status (BIMS) score of 6 (six), which indicated moderate cognitive impairment. Review of R45's care plan dated 3/29/2023 revealed, the resident has an HX (history) of alteration in gastro-intestinal status r/t (related to) infectious, gastroenteritis and colitis, GI (gastrointestinal) bleeding, abd (abdominal) pain. There was no documented evidence of interventions for self-administration of medications. Further review of the care plans lacked a care plan for self-administration of medications. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R45's Orders Summary Report dated 2/9/2025 lacked orders permitting the resident to self-administer medication. Review of the Self Administration of Medication assessment dated [DATE] revealed, R45 was not capable for self-administration of medication. Observation on 2/8/2025 at 10:39 am in R45's room revealed [Name] fast melts tablets (OTC medication used to treat indigestion) on the resident's bedside table. The resident stated she was unaware that she was not allowed to have medications at the bedside. Observation on 2/8/2025 at 12:34 pm revealed Certified Nursing Assistant (CNA) GG exiting R45's room. Upon inquiry, CNA GG stated she was unaware of whether R45 could self-medicate and would verify. Observation on 2/8/2025 at 12:42 pm with the Assistant Director of Nursing (ADON) revealed, R45's [Name] fast melts tablets were observed on the bedside table. ADON informed the resident that she was not permitted to self-medicate and removed the medication. R45 stated she was unaware of this rule and that her son had provided the medication. 2. Review of R113's Face Sheet indicated the resident was admitted with diagnoses that included but not limited to type 2 diabetes mellitus, cognitive communication deficit, anxiety disorder, hyperlipidemia, benign prostatic hyperplasia, insomnia, and depression. Review of R113's Quarterly MDS assessment dated [DATE] revealed for Section C (Cognitive Pattern) a BIMS score of 6, which indicated moderate cognitive impairment. Review of R113's care plan dated 9/19/2024 revealed, At Risk for Decreased Cardiac Output r/t HTN (hypertension), hyperlipidemia, DM 2 (diabetes melilites). There was no documented evidence of interventions for self-administration of medications. Further review of the care plans lacked a care plan for self-administration of medications. Review of R113's Order Summary Report dated 2/8/2025 lacked orders permitting the resident to self-administer medication. The EMR also lacked documentation that the resident had been evaluated for self-administration of medications. Observation on 2/8/2025 at 9:23 am in R113's room revealed a pill on the resident's bedside table. The resident stated he was unsure of the purpose of the pill and would not take it until he confirmed its use. Interview on 2/8/2025 at 9:30 am with Licensed Practical Nurse (LPN) HH confirmed that R113 was not assessed for self-administration of medications. LPN HH observed the pill on the bedside table, retrieved gloves, and picked up the pill, noting that it appeared dirty. LPN HH identified the pill as [Name], a blood pressure medication and stated that R113 should have received it during the 6:00 am medication pass. LPN HH further explained that R113 was unable to self-medicate, and staff were required to remain with him until he takes his medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/2025 at 2:22 pm with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), they confirmed the facility does not allow self-administration medication as a general rule. If someone has a request for self-administration, they will need permission, and an assessment will have to take place. DON further revealed if a resident has medication in their possession, it was typically a family member who brought in the medicines without their knowledge. The DON revealed, if there were concerns related to medications at the bedside, it should be removed, and education provided. 50374 3. R432 was admitted to the facility with a diagnosis that included but not limited to unspecified glaucoma (eye disease). Review of R432's Annual MDS dated [DATE] revealed for Section C (Cognitive Pattern), a BIMS score of 15 which indicated her cognition was intact. Review of the care plan dated 8/21/2024 documented R432 had impaired visual function related to glaucoma. There was no documented evidence of interventions for self-administration of medications. Further review of the care plans lacked a care plan for self-administration of medications. Review of R432's physicians orders revealed, [name] ophthalmic solution 0.5% (percent), Instill one drop in both eyes every 12 hours for glaucoma. Review of the Self Administration of Medication assessment dated [DATE] revealed, R432 was not capable for self-administration of medication. During an observation on 2/8/2025 at 8:44 am in R432's room revealed there was an eye drop medication ([name] ophthalmic solution) sitting on her bedside table position next to her. During an interview on 2/8/2025 at 12:17 pm with LPN DD confirmed the eyedrop medication on R432's bedside table. She stated R432 was a new admission and was not aware that her family had brought the eyedrops in from the hospital.

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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** 35180 Based on staff interview, record review, and review of the facility's policy titled, Care Plan-Comprehensive, the facility failed to develop a comprehensive person-centered care plan for two out of 56 residents (R) (R35 and R6). Specifically, the facility failed to develop a comprehensive person-centered care plan for R35 related to Methicillin-resistant Staphylococcus aures (MRSA) and R6 related to oxygen therapy. Findings include: A review of the facility's policy titled Care Plan-Comprehensive, dated January 2023 under the section titled Policy Interpretation and Implementation revealed, 1. An interdisciplinary team, in coordination with the resident, his/her family or representative, would develop and maintain a Comprehensive Care Plan for each resident. 2. The Comprehensive Care Plan has been designed to: (a) Incorporate identified problem areas; (b) Incorporate risk factors associated with the identified problems .4. Care plans are revised as changes in the resident's condition dictate. Reviews are made at least quarterly. 1. A review of the Admission Record revealed R35 had a diagnosis of Methicillin-resistant Staphylococcus aures infection as the cause of diseases classified elsewhere dated 12/20/2024. A review of the Entry Tracking Record Minimum Data Set (MDS) assessment dated [DATE] for R35 revealed, Section A-Identification Information, documented R35 was readmitted to the facility on [DATE]. A review of the Quarterly MDS assessment dated [DATE] for R35 revealed, Section I-Active Diagnoses, documented R35 had a Multidrug-Resistant Organism (MDRO). A review of R35's progress notes dated 12/30/2024 revealed that R35 was readmitted to the facility with a diagnosis of (MRSA). A review of R35's comprehensive care plans revealed there was no care plan for MRSA. During an interview with Licensed Practical Nurse (LPN)/MDS Coordinator BB on 2/9/2025 at 10:50 am, she stated that when a resident was newly admitted or readmitted with a condition or diagnosis related to infection, the Infection Preventionist (IP) would add the care area to the resident's care plan. LPN/MDS Coordinator BB acknowledged R35 triggered in the MDS for MDRO after being diagnosed during a hospitalization , and the resident should have been care planned for the infection. She added it was an oversight. During an interview with the Director of Nursing (DON) on 2/9/2025 at 1:34 pm, she stated that if a resident had any infection, including a diagnosis of MRSA or any MDRO, she would expect the care plan to reflect that care area. 47947 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the clinical record revealed R6 was admitted to the facility with diagnoses including asthma, dependence of supplemental oxygen, and malignant neoplasm of unspecified part of unspecified bronchus or lung. Review of R6's medical records revealed a physician order for continuous oxygen (O2) at 2 LPM (liters per minute) via nasal cannula with a start date of 10/26/2024. Review of R6's Quarterly MDS dated [DATE] revealed, Section C-Cognitive Patterns, a Brief Interview for Mental Status (BIMS) of three, which indicated significant cognitive decline; Section O-Special Treatments and Programs, documented R6 received oxygen therapy while a resident. Review of R6's clinical records revealed a physician order for continuous oxygen (O2) at 2 (two) LPM (liters per minute) via nasal cannula with a start date of 10/26/2024. A review of R6's comprehensive care plans revealed that it did not include an oxygen therapy plan. Interview with LPN/MDS Coordinator BB on 2/10/2025 at 10:30 am confirmed that R6 did not have a care plan for oxygen therapy. During an interview with the DON on 2/10/2025 at 10:40 am, she stated if a resident was receiving oxygen continuously and depends on oxygen therapy, she would expect the care plan to reflect oxygen therapy. Cross Reference F695

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 47947 Based on observations, staff and resident interviews, record review, and review of the facility's policy titled, Oxygen Safety, the facility failed to ensure one resident (R) (R6) was administered oxygen therapy in accordance with the physician order and to ensure that the oxygen concentrators' filters remained clean for three residents (R98, R64, and R105) out of 19 residents receiving respiratory treatments. This deficient practice had the potential to put residents at risk for increased respiratory infections, medical complications and potentially life-threatening complications. Findings include: Review of the facility's policy titled, Oxygen Safety, dated April 2022 under the section titled Oxygen Administration revealed, 1. Oxygen therapy is administered to the resident only upon the written order of a licensed physician. 1. Review of the clinical records revealed R6 admitted to the facility with diagnoses that included but not limited to asthma, dependence of supplemental oxygen, and malignant neoplasm of unspecified bronchus or lung. Review of R6's clinical records revealed a physician order for continuous oxygen (O2) at 2 (two) LPM (liters per minute) via nasal cannula with a start date of 10/26/2024. Observations on 2/8/2025 at 10:58 a.m. and 2/9/2025 at 8:45 a.m. revealed R6 receiving oxygen therapy via nasal cannula at 3 (three) LPM. Cross reference to F656 50374 2. Review of the clinical records revealed R98 was admitted to the facility with diagnoses that included but not limited to chronic obstructive pulmonary disease with acute exacerbation (COPD) (reduction of lung function). Review of R98's physician's order revealed, oxygen at 2 liters per minute (lpm) via nasal cannula to keep O2 saturation greater than 90 percent. Review of R98's physician's order revealed, change and date all respiratory supplies and tubing weekly. If oxygen concentrator is present, clean filter. During an observation on 2/8/2025 at 10:10 am revealed the filter on the oxygen concentrator contained a thick gray fuzzy substance. During an observation on 2/9/2025 at 7:59 am revealed the filter on the oxygen concentrator contained a thick gray fuzzy substance. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the clinical records revealed R64 was admitted to the facility with a diagnosis that included but not limited to asthma. Review of R64's physician's order revealed, O2 at 2 liters (l) via nasal cannula prn to keep oxygen saturation above 90 percent. Review of R64's physician's order revealed, R64 has asthma, please monitor and report to nurse or physician if resident has shortness of breath with activities of daily living care or while lying flat. During an observation on 2/8/2025 at 9:03 am revealed the filter on the oxygen concentrator contains a thick layer of gray fuzzy substance. During an observation on 2/9/2025 at 7:57 am revealed the filer on the oxygen concentrator contains a thick layer of gray fuzzy substance. 47946 4. Review of the clinical records for R105 revealed she was admitted to the facility with diagnoses that included but not limited to other asthma and cough variant asthma. Observation on 2/8/2025 at 8:32 am revealed R105's oxygen concentrator's built-in filter was dirty with a thick dark brown substance. Observation on 2/9/2025 at 8:03 am revealed R105's oxygen concentrator's built-in filter was dirty with a thick dark brown substance. Interview on 2/9/2025 at 10:10 am with the Director of Nursing (DON) stated on every Sunday night shift, the nurse assigned to that resident's hall was responsible for the maintenance and cleaning of the oxygen machine filter, ensuring the nebulizer machine was stored properly when not in use and oxygen tubing was stored in a bag when not in use. She stated, it is my expectation for all my unit nursing manager staff to make rounds on Monday morning to make sure all the maintenance and cleaning of the oxygen equipment were properly done on that Sunday night. Observation and interview on 2/9/2025 at 10:18 am with DON and Licensed Practical Nurse (LPN) CC both confirmed that R6's oxygen concentrator's built-in filter was dirty with a thick dark brown substance and tank setting was on three liters. LPN CC checked R6's physician orders in the facility's electronic records and confirmed that physician order was two liters. Observation and interview on 2/9/2025 at 10:30 am with LPN DD confirmed the Sunday night shift nurses were responsible for the respiratory maintenance cleaning of equipment weekly which includes the oxygen concentrators' filters. She stated she does her round every Monday morning to ensure staff cleaned all the equipment. She confirmed R98 and R64 oxygen concentrators' spongy-foam filter was dirty with a thick fuzzy gray substance. She also confirmed that R105's oxygen concentrator's built-in filter was dirty with a thick dark brown substance.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46691 Based on observations, staff interviews, record review, and review of the facility's policy titled Administering Medications, the facility failed to ensure the medication error rate was less than five percent. There were two errors with 26 opportunities for one of five residents R (R35) for a medication error rate of 7.69 percent. These failures had the potential to place R35 at risk of medical complications and decreased therapeutic effects of medications. Findings include: Review of the facility policy titled Administering Medications, revised April 2019, revealed the Policy Heading section stated, Medications are to be administered in a safe and timely manner, and as prescribed. The Policy Interpretation and Implementation section included . 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Review of R35's Electronic Medical Record (EMR) under Admission Record revealed diagnoses including, but not limited to, type 2 diabetes and irritable bowel syndrome (IBS). Review of R35's EMR under Clinical Physician's Orders revealed an order dated 12/21/2024 for Linzess oral capsule 145 micrograms (mcg), two capsules one time a day for IBS. Further review revealed an order dated 12/26/2024 for NovoLog Flex Pen subcutaneous solution pen-injector 100 unit/milliliter (ml) (insulin aspart) [a medication used to treat diabetes] inject per sliding scale. The sliding scale order included administering four units of insulin if the resident's finger-stick blood sugar (FSBS) was 206 to 235. During medication pass observation on 2/8/2025 at 10:35 am, Licensed Practical Nurse (LPN) AA was observed administering medications to R35. The medications administered included Linzess oral capsule 290 mg two capsules. Further observation revealed she checked R35's FSBS and determined, based on the physician's order for sliding scale insulin, that R35 required four units of insulin. Observation revealed LPN AA to dial the dose of four units on the NovoLog Flex Pen and administer the insulin to R35. She was not observed to prime the insulin pen needle with two units of insulin before dialing the dose on the pen. In an interview on 2/8/2025 at 10:45 am, LPN AA verified the container of Linzess was labeled as 290 mg per capsule and confirmed she administered Linzess 290 mg two capsules to R35. She verified the physician's order was for Linzess 145 mg capsules, two capsules one time a day. She stated she was unaware the label on the Linzess stated it was 290 mg capsules. She further stated she should have looked at the dosage on the medication bottle before administering the medication and would notify the provider for further instruction. During a continued interview, LPN AA confirmed she did not prime the NovoLog insulin pen needle with two units of insulin before dialing the dosage on the pen to four units and administering it to R35. She stated she was unaware she should prime the needle before dialing the dose on the pen. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/9/2025 at 10:45 am, the Director of Nursing (DON) stated her expectations were for nurses to follow the five rights of medication administration and ensure medications were administered according to physician orders. She stated the nurse should ensure the correct medication and dosage was administered to the correct resident at the correct time and by the correct route. She further stated that administering an incorrect medication dosage could potentially cause adverse effects for the resident. During further interview, the DON stated she expected nurses to follow the manufacturer's guidelines for the administration of insulin via an insulin pen. She stated insulin pen needles should be primed with two units of insulin before dialing the ordered dosage on the pen to ensure the resident received the ordered insulin dose. She further stated that if the pen was not primed, the resident could receive a decreased insulin dose, potentially resulting in an adverse outcome. She stated the Nurse Practitioner had recently provided education on insulin administration and she planned further education on medication administration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35180 Based on observation, staff interview, and review of the facility's policy titled Giving a Bed bath, the facility failed to ensure residents' basins, urinals, and bedpans were labeled and covered for 11 of 69 shared rooms (D2, D5, D18, D16, C9, C15, B16, B5, A15, A5, and A11). These failures had the potential to expose patients to infections due to cross-contamination. Findings include: A review of the facility policy, Giving a Bed bath, dated April 2022 under the section titled Steps in the Procedure revealed, 23. Clean washbasins, be sure the resident's name is written on the wash basin, place in a clean plastic bag and store it in the resident's bathroom, closet or nightstand and return any other supplies to designated storage areas. Observation of rooms on halls A, B, C, and D with the Infection Control Preventionist (ICP) on 2/9/2024 from 4:40 pm through 5:05 pm revealed the following: Room D2, bathroom, shared by two residents, revealed two basins in a clear plastic bag. Neither of the basins was labeled with a resident name. Room D5, a bathroom shared by two residents, revealed one basin on the floor, which was unbagged and unlabeled with a resident name. Additionally, two bedpans in a clear plastic bag and two basins in a clear plastic bag were observed. None of the items were labeled with a resident's name. Room D18, a bathroom shared by two residents, revealed two bedpans in a clear plastic bag and one basin in a clear plastic bag. None of the items were labeled with a resident name. Room D16 bathroom, shared by two residents, revealed one urinal attached to the toilet assistance bar. The urinal was not labeled with a resident name. Additionally, a clear plastic bag contained one bedpan and one basin. Neither of the items was labeled with a resident name. Room C9, a bathroom shared by two residents, revealed two bedpans in a clear plastic bag. Neither of the items was labeled with a resident name. Room C15, a bathroom shared by two residents, revealed one basin on the floor. The basin was not bagged or labeled with the resident's names. Room B16 bathroom, shared by two residents, revealed three unlabeled and unbagged urinals. Room B5, a bathroom shared by two residents, revealed two basins and one bedpan. The items were labeled with the resident's names and placed together in one clear plastic bag. Room A15 bathroom, shared by two residents, revealed one unlabeled and unbagged basin sitting on the floor. One basin and one bedpan were also observed in a clear plastic bag. Neither item was labeled with a resident name. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Room A5, a bathroom shared by two residents, revealed two basins in a clear plastic bag, which were not labeled with a resident name. Room A11, a bathroom shared by two residents, revealed two basins in a clear plastic bag, which were not labeled with a resident name. During an interview with the Infection Control Preventionist (ICP) on 2/9/2025 at 4:48 pm, she stated the Certified Nursing Assistants (CNAs) were supposed to check all the resident's rooms to ensure all basins, urinals, and bedpans were off the floor. All items were to be bagged in a clear bag and labeled with the resident name. The ICP confirmed that numerous bathrooms contained unlabeled and unbagged items. She acknowledged several items sitting directly on the floor, unbagged and unlabeled.