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	04/10/2026

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

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and facility policy review, the facility failed to ensure ongoing assessment and monitoring for complications before and after dialysis treatments were completed to ensure communication with the dialysis facility for one of two residents (Resident (R) 10) reviewed for dialysis of 32 sample residents. This failure had the potential to lead to uncommunicated and unassessed changes or complications for R10 and other residents receiving dialysis.Findings include:Review of the undated facility's policy titled, DIALYSIS, revealed Post Dialysis Monitoring: 1. Licensed nurse to obtain . Blood Pressure . Pulse . Presence/Absence of Bruit/Thrill as indicated . Licensed nurse will monitor for Signs/Symptoms of fluid overload/deficit . Dizziness . Neck vein distention . Remove pressure dressing from the shunt/fistula site upon return from Dialysis as indicated . Review of R10's admission Record located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses of end stage renal disease and dependence on renal dialysis. Review of R10's significant change Minimum Data Set (MDS) with an Assessment Reference Date of 11/26/2025 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) was not conducted due to severely impaired cognition. The MDS further indicated she received hemodialysis.Review of R10's physicians order located under the Orders tab of the EMR and dated 03/02/2026, revealed dialysis every Tuesday and Saturday. Additional physician's orders indicated to monitor for complications from dialysis one time a day every Tuesday and Saturday due to dialysis treatment, to monitor for complications from dialysis and to report to MD (medical doctor) or healthcare extender.Review of R10's care plan located under the Care Plan tab of the EMR, dated 08/14/2025 and last revised 03/17/2026, revealed The resident with ESRD [end stage renal disease] and hemodialysis to obtain vital signs per protocol and report significant changes in pulse, respirations, and blood pressure immediately. The care plan also indicated, Monitor/document/report to MD PRN [as needed] for s/sx [signs/symptoms] of the following: Bleeding, Hemorrhage, Bacteremia, septic shock . Changes in level of consciousness . heart and lung sounds .Review of R10's EMR under the Documents tab revealed no Dialysis Communication Form for the following dates R10 was scheduled for dialysis treatment: 03/07/2026, 03/10/2026, 03/14/2026, 03/21/2026, 03/24/2026, 03/28/2026, 03/31/2026, and 04/07/2026. During an interview on 04/10/2026 at 11:35 AM, Unit Manager (UM) 2 reviewed R10's medical record and looked at documents at the nurse's station and confirmed there were no Dialysis Communication Forms for dialysis treatments on the following dates: 03/07/2026, 03/10/2026, 03/14/2026, 03/21/2026, 03/24/2026, 03/28/2026, 03/31/2026 and 04/07/2026. UM2 stated when the resident returned to the facility after dialysis, the nurses were supposed to assess the resident and complete a Dialysis Communication Form. She stated the nurses were supposed to document their portion on the bottom of the form.vital signs and site assessment.

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 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** Based on observations, record review, staff interviews, and facility policy review, the facility failed to follow infection control guidelines during wound treatment for one of two residents (Resident (R) 10) reviewed for pressure ulcers and failed to follow infection prevention measures when an indwelling urinary catheter bag was placed on the floor for one of two residents (R10) reviewed for catheters of 32 sample residents. These failures had the potential to cause infections in the wound and the urinary tract for R10.Findings include:Review of the facility's policy titled, Dressings Non-Sterile, dated June 2025, revealed The purpose of this procedure are to provide guidelines for sterile dressing changes to protect wounds from injury and to prevent the introduction of bacteria . 20. Cleanse the wound. Use separate gauze for each cleansing stroke. Clean from the most contaminated area to the least contaminated area.Review of the facility's policy titled, Catheter Care, Urinary, dated June 2025, revealed The purpose of this procedure is to prevent infection of the resident's urinary tract . Be sure the catheter tubing and drainage bag are kept off the floor .1. Review of R10's Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R10 was admitted to the facility on [DATE]. R10's primary diagnosis was sepsis (life-threatening infection). Other diagnoses included septic shock, osteomyelitis (bone infection) of the sacral (base of the spine) and sacrococcygeal (base of spine and tail bone area) vertebra (bones of the spine) regions, and a history of urinary tract infections. Review of R10's significant change Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/26/2025 indicated a Brief Interview for Mental Status (BIMS) was not conducted due to severe cognitive impairment. The MDS also indicated R10 had a stage four pressure ulcer and an indwelling urinary catheter.Review of R10's Physician Orders located under the Orders tab in the EMR revealed an order dated 04/03/2026, documented STAGE 4 PRESSURE WOUND [a severe, full-thickness wound extending to exposed muscle, tendon, or bone] SACRUM FULL THICKNESS . Sodium hypochlorite solution (dakins [sic]) and cover with ABD [abdominal] pad and secure with Tape (paper) apply once daily and as needed . if saturated, soiled, or dislodged for 30 days every day shift for wound for 30 days.Review of R10's care plan located under the Care Plan tab of the EMR, dated 03/20/2026, titled, STAGE 4 PRESSURE WOUND SACRUM FULL THICKNESS which indicated, . Provide wound care per treatment order. An additional Care Plan titled, The resident has pressure ulcer stage 4 to sacrum, with an initiation date of 09/27/2025, indicated . the resident's Pressure ulcer will . remain free from infection . During an observation of R10 in her room on 04/09/2026 at 11:05 AM, Unit Manager (UM) 2 provided wound care to R10's stage four sacral pressure ulcer. With gloved hands, UM2 adjusted R10's brief, placing her gloved hand in R10's perineal (between rectum and vagina) area and partially removed the brief. With the same gloved hands, UM2 proceeded to clean R10's sacral pressure ulcer. UM2 did not remove the soiled gloves or perform hand hygiene prior to cleaning the wound. Then, UM2 changed the gloves during the wound cleaning but did not perform hand hygiene. UM2 then continued to clean the sacral pressure ulcer and using a gauze pad wiped from the perineal area, up the left buttock and up to the sacral wound and around the wound edge from the six o'clock position to the twelve o'clock position of the wound.During an interview with UM2 immediately after the completion of the wound care observation on 04/09/2026 at 12:00 PM, UM2 confirmed she did not remove the soiled gloves, perform hand hygiene, and apply clean gloves prior to cleaning R10's sacral pressure ulcer. UM2 also confirmed she used the same gauze pad she used to clean R10's perineal area up the buttock and around the wound edge going from a dirty area to a clean area. UM2 confirmed she should not have cleaned from the perineal area up the buttocks to the sacral wound.During an interview on 04/10/2026 at 1:00 PM, the Infection Preventionist (IP) was asked what her expectations were for a nurse performing wound care to an open wound. IP stated after removing a resident's brief and before beginning wound cleaning, the nurse was supposed to put on clean gloves and wound cleaning was to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be done from clean to clean and dirty to dirty. The IP stated it's not ok for the nurse to go from the perineal area up the buttocks and then around the wound edge. 2. Review of R10's Physician Order located under the Orders tab of the EMR,, dated 03/02/2026, indicated Change Indwelling catheter 16 FR [French = size] and Inflate with 10 CC [cubic centimeter - a unit of measure] of sterile water one time a day starting on the 28th and ending on the 28th every month.Review of the Care Plan located under the Care Plan tab of the EMR, dated 09/24/2025 and revised 01/15/2026, indicated The Resident has Indwelling catheter r/t [related to] wound healing of stage 4 pressure wounds to the sacrum. The goal was The resident will be/remain free from catheter-related trauma . Review of a Progress Note located under the Progress Notes tab of the EMR, dated 04/03/2026 at 11:20 AM, indicated STAGE 4 PRESURE WOUND SACRUM FULL THICKNESS . Wound Size (L x W x D [length by width by depth]): 8 x 13 x 1 cm.During an observation of R10 in her room on 04/09/2026, she was observed receiving a partial bed bath by Certified Nursing Aide (CNA) 5 and Certified Medication Aide Technician (CMAT) 1. While turning R10 from her left side to her right side, CNA5 removed the indwelling urinary catheter bag from hanging on the side of the bed and gave it to CMAT1 who was on the other side of the bed. CMAT1 then placed the Foley catheter bag on the floor. During an interview with CMAT1 immediately after the partial bed bath on 04/09/2026 at 12:21 PM, CMAT1 confirmed she placed the catheter bag on the floor and confirmed catheter bags should not be placed on the floor.During an interview on 04/10/2026 at 1:00 PM, IP was asked what her expectations were for placement of catheter bags. IP stated the catheter bag should be below the level of the bladder but not on the floor.