STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115772	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesun Health and Rehabilitation Center	88 Johnson Road, Building #2 Lawrenceville, GA 30046

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50624 Based on record review, staff interviews, and review of the facility's policy titled iQIES or Other System Downtime MDS, the facility failed to ensure that required Minimum Data Set (MDS) assessments were transmitted within regulatory guidelines to the Centers for Medicare and Medicaid Services (CMS) Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System for 31 residents (R) (R89,R55, R56, R8, R62, R7, R33, R85, R3, R19, R86, R84, R16, R31, R91, R15, R25, R72, R75, R88, R81, R90, R77, R38, R45, R20, R92, R78, R50, R278, and R368) out of 44 sampled residents. Findings Include: Review of the undated facility's policy titled iQIES or Other System Downtime MDS, under the Policy section revealed, It is the policy of this facility to transmit MDS data timely so that the facility will not be negatively impacted by iQIES or other system downtimes. Under the Policy Explanation and Compliance Guidelines section revealed, 1. All required MDS assessment files will be transmitted to iQIES using the CMS wide area network within regulatory guidelines: PPS, quarterly, and discharge assessments will be transmitted within 14 days of the completion date in Z0500B. Review of the Resident Assessment Task in the Long-Term Care Survey Process revealed, MDS assessments as being more than 120 days old indicated: R89's Discharge assessment dated [DATE] was coded as 'export ready'. R55's Discharge assessment dated [DATE] was coded 'In Progress'. R56's Discharge assessment dated [DATE] was coded 'In Progress'. R8's Discharge assessment dated [DATE] was coded 'In Progress'. R62's Discharge assessment dated [DATE] was coded 'In Progress'. R7's Discharge assessment dated [DATE] was coded 'In Progress'. R33's Discharge assessment dated [DATE] was coded 'In Progress'. (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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R85's Discharge assessment dated [DATE] was coded 'In Progress'. R3's Discharge assessment dated [DATE] was coded as 'export ready'. R19's Discharge assessment dated [DATE] was coded as 'export ready'. R86's Discharge assessment dated [DATE] was coded 'In Progress'. R84's Discharge assessment dated [DATE] was coded 'In Progress'. R16's Discharge assessment dated [DATE] was coded as 'export ready'. R31's Discharge assessment dated [DATE] was coded 'In Progress'. R91's Discharge assessment dated [DATE] was coded 'In Progress'. R15's Quarterly assessment dated [DATE] was coded as 'In Progress'; Discharge assessment dated [DATE] coded as 'In Progress'. R25's Discharge assessment dated [DATE] was coded as 'export ready'. R72's Discharge assessment dated [DATE] was coded as 'export ready'. R75's Discharge assessment dated [DATE] was coded as 'export ready'. R88's Discharge assessment dated [DATE] was coded 'In Progress'. R81's Discharge assessment dated [DATE] was coded 'In Progress'. R90's Discharge assessment dated [DATE] was coded as 'export ready'. R77's Discharge assessment dated [DATE] was coded 'In Progress'. R38's Discharge assessment dated [DATE] was coded 'In Progress'. R45's Discharge assessment dated [DATE] was coded 'In Progress'. R20's Discharge assessment dated [DATE] was coded 'In Progress'. R92's Discharge assessment dated [DATE] was coded 'In Progress'. R78's Discharge assessment dated [DATE] was coded as 'export ready'. R50's Discharge assessment dated [DATE] was coded 'In Progress'. R278 's Admission assessment dated [DATE] was coded 'export ready'. R368 's Discharge assessment dated [DATE] was coded In Progress. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/18/2024 at 8:45 am with the MDS Coordinator revealed the coding was accurate as far as she knew. She stated she was unsure why the 'export ready' assessments had not been submitted. She stated that she was unable to submit them without a Registered Nurse (RN) signature and that the current Director of Nursing (DON) was the RN responsible for signing them and prior to that she had an RN that she worked with, but they let her go. The MDS coordinator confirmed and verified all 31 resident's assessments had not been submitted. During an interview on 7/18/2024 at 11:27 am, the Administrator stated that the DON had been out for 10-12 days, which was longer than they had expected and currently no one was responsible for signing off on the MDS. He stated they had an MDS RN that had led them to believe that she was going to take the job, but she did not take it and therefore they had got behind on the assessments. During an interview on 7/18/2024 at 11:30 am, the Assistant Director of Nursing (ADON) stated the workflow was for the MDS Licensed Practical Nurse (LPN) to complete the MDS assessments and to submit it to the DON for approval, but she was not sure who was responsible for submitting the assessments to CMS. She stated that they had several RN's who had been the MDS nurse, but they had quit or been let go. She stated that the position was currently open and that they were recruiting for the position. During a telephone interview on 7/18/2024 at 1:50 pm, the DON stated she did not set expectations of when the MDS assessments are submitted to CMS. She stated that she was asked by the Administrator to close the MDS assessments because the MDS RN coordinator had left employment at the facility. She stated that the MDS was overseen by the Administrator not the DON. She revealed that the practice of not completing the MDS assessments in time could have a negative consequence financially on the facility and this could have a negative effect on the quality of care provided to the residents. She stated she believed the MDS assessments were submitted late because there had been a lack of a consistent MDS RN coordinator in that department. She stated there had been four MDS RN Coordinator's in the last year, and each time one left, there was a back log of MDS assessments not completed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44757 Based on record reviews, staff interviews, and review of the facility's policy titled, Baseline Care Plan, the facility failed to develop a baseline care plan within 48 hours of admission that addressed two medications, (an opioid and a diuretic) for one out of five sampled residents (R) (R33) selected for unnecessary medications review. This had the potential to cause adverse medical effects for R33 with no known interventions for staff. Findings include: Review of the undated facility's policy titled; Baseline Care Plan under Policy Explanation and Compliance Guidelines revealed, 1. The baseline care plan will: (a.) Be developed within 48 hours of a resident's admission. (b.) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders; ii. Physician orders; iii. Dietary orders; iv. Therapy services; v. Social services; vi. PASARR recommendation, if applicable 2.(b.) Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk . 3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. Review of R33's medical records revealed an admitted [DATE] with diagnoses that included, chest pain, unspecified, heart failure, unspecified, paroxysmal atrial fibrillation, anemia, unspecified, hypokalemia, chronic kidney disease, stage 4 (severe), muscle weakness (generalized), difficulty in walking, need for assistance with personal care, essential (primary) hypertension, and unspecified diastolic (congestive) heart failure. Review of R33's physician orders revealed, Pain Evaluation Q (every) shift (record numeric value. 0=No Pain. 1-3= Mild Pain. 4-6= Moderate Pain. 7-1-=Severe Pain), with start date of 7/5/2024. Further review of the physician orders revealed, hydrocodone acetaminophen oral tablet 10-325 mg (milligram) with a start date of 7/6/2024, give one tablet by mouth every 12 hours as needed for pain and furosemide oral tablet 20 mg give three tablets by mouth two times a day for daily diuretics; hold for SBP (systolic blood pressure) less than 110 and/or HR (heart rate) less than 60 with a start date of 7/6/2024. Review of R33's baseline care plan dated 7/8/2024 under section 3. Health Conditions and subsection D. Medications revealed, 1. Medications resident is taking provided the option to select the following: a. Psychotropic medications b. PRN Psychotropics c. Diuretics d. Insulin e. Antibiotics f. Anticoagulants g. Opioids (documentation) h. Black Box medications; however, none of the boxes were checked. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/18/2024 at 2:20 pm with the Assistant Director of Nursing (ADON) revealed that the nursing staff monitor high risk medications on the MAR (medication administration record). She stated residents who have diuretics ordered are weighed daily on admission and depending on the dose ordered they would continue weekly weights. She stated if a resident were stable, they would complete monthly weights. She stated nursing completes a functional skilled assessment for skilled nursing residents daily. She stated opioid medications are monitored by the nurse practitioner and there was a tool in the EHR (electronic health record) that would trigger to monitor for side effects that was documented on the MAR. She confirmed the care plan should have interventions listed related to the high risk medications that nursing should be able to refer to for guidance. She stated she was not aware of how these items are care planned. Interview on 7/18/2024 at 4:43 pm with the ADON revealed, when a resident admits into the facility, nursing completes their portion of the baseline care plan along with the other different disciplines and try to do them [respective portions of the baseline care plan] within 24 hours. The ADON further revealed typically the DON (Director of Nursing) will check over it to make sure it was correct, if not the DON, the ADON. She stated, if the baseline care plans were not done correctly, that could cause the facility the inability to take care of the residents. She stated, the nurse on the floor would be asked to check for mistakes, make corrections, and make sure the care plans were aligned with the resident's care. Interview on 7/18/2024 at 3:59 pm with the Minimum Data Set (MDS) Licensed Practical Nurse (LPN) revealed, she was responsible for developing care plans after the comprehensive assessments were completed. She stated she was familiar with R33 and stated she had been recently readmitted to the facility however, she has not been able to get to R33's baseline care plan but would be sure to correct it. She acknowledged and stated, by those (opioid and diuretic) medications not being care planned, could affect R33 because the care plan should address the medications and interventions for staff to provide.

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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** 38154 Based on observation, staff and resident interviews, and review of the facility's policy titled, Comprehensive Care Plans, the facility failed to develop a care plan that included a communication or language preference for one of three sampled residents (R) (R179) whose primary language was not English. This deficiency had the potential to adversely impact the quality of care and quality of life provided to the resident. Findings include: Review of the undated facility's policy titled, Comprehensive Care Plans, under Policy Explanation and Compliance Guidelines revealed the following, Number 3. The comprehensive care plan will describe, at a minimum, the following: (f.) Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English-speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate. Number 4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: a. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan. b. A registered nurse with responsibility for the resident. c. A nurse aide with responsibility for the resident. d. A member of the food and nutrition services staff. e. The resident and the resident's representative, to the extent practicable. f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to: i. The RAI Coordinator. ii. Activities Director/Staff. iii. Social Services Director/Social Worker. iv. Licensed therapists. v. Family members, surrogate, or others desired by the resident. vi. Administration. vii. Discharge Coordinator. viii. Mental health professional. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ix. Chaplain. Review of the electronic medical record (EMR) for R179 revealed, she admitted to the facility with diagnoses to include Covid-19, presence of cardiac pacemaker, hypothyroidism, and generalized muscle weakness. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] for R179 revealed Section A: Identification Information, indicated her preferred language was Korean; Section C: Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment; Section D: Mood, a Mood score of zero, indicating no depression and no behaviors and Section GG: Functional Abilities and Goals, which indicated she required setup for eating and moderate to maximum assistance for all other activities of daily living (ADLs). Review of the Care Plan for R179 dated 1/19/2024 revealed there was no focus concern related to communication or language until 7/18/2024 which documented her preferred language as Korean with a goal of being able to make her needs known. Interventions included anticipating her needs, her preference to communicate in Korean, and discussing with her/family concerns regarding communication difficulty. Observation and interview on 7/17/2024 at 1:20 pm with R179 revealed in a response to a greeting in English, she gestured to indicate that she did not speak English. When asked if she spoke Korean, she nodded affirmatively. She was able to understand text communication via Google translator and confirmed that staff took good care of her. During an interview on 7/17/2024 at 3:47 pm with the MDS Licensed Practical Nurse (LPN), she stated she was hired in January 2024 and was the only MDS nurse currently on staff. She stated she was self-taught, mostly through online courses, regarding her knowledge of the MDS process and her duties as the MDS Nurse. She confirmed the most recent MDS assessment included R179's preference for Korean language for communication. During an interview on 7/18/2024 at 10:51 am with Registered Nurse (RN) AA, she stated the staff utilize the translator telephone line when attempting to communicate with a resident who speaks a language that they cannot speak. In addition, she stated staff also use a communication board with symbols to communicate with residents. Finally, she stated the attending nurse can create or update the care plan, but it was usually handled by one or more of the interdisciplinary team (IDT) members. During an interview on 7/18/2024 at 11:04 am with Certified Nursing Assistant (CNA) II, she stated she communicated with residents who do not primarily speak English by facing them when speaking, using the language tools like the translator line, or calling a family member. In addition, she stated several staff members speak different languages and can be called to assist anytime. During an interview on 7/18/2024 at 11:30 am with the Assistant Director of Nursing (ADON), she confirmed communication/language was not part of R179's care plan until today. She stated it would benefit residents and staff if communication was part of the care plan related to potential challenges such as language, cognition, or diagnosis. She stated members of the IDT are mostly responsible for creating and updating the care plan. (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 7/18/2024 at 2:30 pm with the Medical Director, he stated it would be helpful to the staff if communication was a focus concern in the care plan due to language(s) spoken by the resident or other challenges in communication whether cognitive, medical, or cultural.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44757 Based on observations, staff interviews, and review of the facility's policy titled Food Safety Requirements, the facility failed to ensure food items were properly stored, labeled with expiration dates, and that expired foods were disposed of in a timely manner. The deficient practice had the potential to affect 47 of 49 residents who consumed an oral diet. Findings include: Review of the undated facility's policy titled Food Safety Requirements, under Policy revealed, It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Under Definitions revealed, Food service safety refers to handling, preparing, and storing food in ways that prevent foodborne illness. Under Policy Explanation and Compliance Guidelines revealed, 1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: (b) Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms 3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage. (b) Dry food storage- keep foods/beverages in a clean, dry area off the floor and clear of ceiling sprinklers, sewer/waste disposal pipes, and vents. (c) Refrigerated storage- foods that require refrigeration shall be refrigerated immediately upon receipt or placed in freezer, whichever is applicable. Practices to maintain safe refrigerated storage include .(iv) Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by-date, or frozen (where applicable)/discarded. Observation of the kitchen on [DATE] at 9:00 am revealed a large dented can of corn. Observation of the pantry on [DATE] at 9:05 am revealed the following items which according to the manufacture label should be refrigerated after opening included: a container of (Name) soy sauce (not refrigerated after opening and no open date), a bottle of (Name) squeeze grape jelly 20 oz (ounce) (not refrigerated after opening and no open date), a container of Italian dressing (not refrigerated after opening and no open date), and a container of (Name) barbecue sauce (not refrigerated after opening and no open date). Observation of the kitchen pantry on [DATE] at 9:10 am revealed the following expired foods included: a bag of long grain rice with an expiration date of [DATE] with no open date and seven bags of (Name) marshmallows with an expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the kitchen pantry on [DATE] at 9:20 am revealed the following foods with no label displaying the date after packages had been opened included: mashed potato granules, (Name) long grain wild rice, a container of (Name) baking soda, (Name) corn bread mix- 5 (five) lbs.(pound) bag, two gravy mix bags, one brown gravy mix bag , yellow cake mix -5 lb bag., fudge brownie mix -5 lb bag. spaghetti wrapped in saran wrap, box of (Name) spaghetti (opened, unsealed box and no open date), two bags of breadcrumbs (one bag was not sealed and both bags had no label dates), plain white rice, saltine crackers (opened saltine cracker packages found in box), a container of chopped onions, a bag of lettuce, minced garlic 32 oz., butter found open and unwrapped in box, white American cheese slices in bag, shredded mozzarella in bag, corned beef, a bottle of (Name) grape juice, two quarts of (Name) cranberry juice, unknown meat in bag, and salmon in a bag that was discolored. Observation of the freezer on [DATE] at 9:30 am revealed the following food items with frost bite: (Name) Meat covered in frost with no open date and a bag containing fish covered in frost with no open date. Interview on [DATE] at 9:45 am with [NAME] GG revealed that the Certified Dietary Manager (CDM) was on vacation, and she was unable to confirm who was in charge in her absence. She confirmed and verified that there should be no open containers without a labeled open date on them. She revealed that it was the responsibility of all kitchen staff to label items that were opened. Furthermore, she confirmed that if there are any dented cans, the kitchen staff still use them. She confirmed and verified that the saltine cracker packages should not be opened, and crackers should not be loose inside the box. Interview on [DATE] at 10:30 am with the Administrator revealed that the CDM BB was on vacation and in her absence, he oversaw the kitchen. He stated he did not think dented can should be used. He revealed that staff should be labeling foods as they are opened. Interview on [DATE] at 3:14 pm with the Registered Dietitian Consultant (RD) revealed that she was employed by (Name of Corporation), she stated she usually worked from home and reviewed records to make recommendations related to dietary needs of the residents. She stated recently she had been tasked with monthly observations of the kitchen to determine compliance. She stated in her last walk through the kitchen, she found that the staff had dated opened items with the open dates and the kitchen was clean. She revealed that CDM BB was a working manager and has had a lot of staff turnover. She stated she discovered CDM BB was on vacation this morning when she arrived at the facility. She revealed she did not know who was in charge in the CDM BB absence.

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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. 38154 Based on staff interviews and review of the facility's policies titled, Infection Prevention and Control Program and Water Management, the facility failed to develop an effective water management plan which included routine water management activities to prevent the growth and spread of Legionella and other opportunistic waterborne pathogens throughout the facility's water system. The facility's census was 49 residents. Review of the undated facility's policy titled, Infection Prevention and Control under Policy Explanation and Compliance Guidelines revealed the following: Number 17. Water Management, (b): Control measures and testing protocols are in place to address potential hazards associated with the facility's water system. Review of the undated facility's policy titled, Water Management Program under Policy Explanation and Compliance Guidelines revealed the following: Number 8. The water management team shall regularly verify that the water management program is being implemented as designed. Auditing assignments will reflect that individuals will not verify the program activity for which they are responsible. Number 9. The effectiveness of the water management program shall be evaluated no less than annually. Routine infection control surveillance data, water quality data, and rounding data shall be utilized to validate the effectiveness. During an interview on 7/17/2024 at 5:06 pm with the Infection Prevention and Control Nurse (IPCN), she stated the facility had a water management plan with policies and procedures in place to prevent the spread of Legionella. During an interview on 7/18/2024 at 9:03 am with the Administrator, he stated the facility conducted annual testing, but he was not aware of other measures used to prevent the growth and spread of Legionella. During an interview on 7/18/2024 at 9:18 am with the Maintenance Director, he stated he performed daily temperature checks throughout the facility and annual testing for the presence of Legionella in the water system, but he was not aware of any other measures to prevent the growth of water-borne pathogens.