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	11/21/2025

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

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **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 deposited monetary funds were returned timely after discharge to the family of one resident (Resident (R) 88) out of a total of 23 residents reviewed in the sample. The facility's failure to ensure funds were returned to the resident's family in a timely manner after her discharge created the potential for the resident/resident's family to experience negative financial outcomes related to their inability to access the funds.Findings include:Review of the facility's undated Refund Policy (incorrectly) indicated, Refunds will be reviewed and issued for Deposits, Prepaid Room and Board, Advance Payments, and Ancillary Services. Approved refund requests will be processed and issued within forty-five [45] days. Review of the admission Record found in the Electronic Medical Record (EMR) under the Profile tab revealed R88 was admitted to the facility on [DATE]. The resident's diagnoses included heart failure and early onset Alzheimer's disease, and the record indicated R88 was admitted to the facility for hospice services. The record indicated Family Member (FM) 1 was R88's Responsible Party (RP) and that the resident was discharged from the facility upon her death on [DATE] (four days after her admission to the facility).Review of a Progress Note, dated [DATE] and found in the EMR under the Notes tab, indicated the resident was severely cognitively impaired.Review of R88's financial documents, provided by the facility, revealed the resident received hospice services covered by Medicare; however, her room and board fees were paid privately. The records indicated a deposit of $9,750.00 was made by FM1 to cover R88's room and board costs on the date of her admission to the facility ([DATE]). The financial documentation indicated the out-of-pocket cost of the resident's room and board services for her stay ([DATE] - [DATE]) was $1,300.00 (or $325.00 per day).Review of an email document from FM1 to the Business Office Manager (BOM), dated [DATE] and provided by the facility, indicated, How soon can I get our refund since [R88] passed on Monday night [[DATE]].Review of an email document from the BOM to FM1, dated [DATE] and provided by the facility, indicated, My condolences, I'm actually working on the paperwork now.Review of an email document from FM1 to the BOM, dated [DATE] and provided by the facility, indicated, I'm guessing the refund should be between $8 - $8.5K [thousand]. Will you [just] return the credit to the charge card I paid you with?Review of an email document from FM1 to the BOM, dated [DATE] and provided by the facility, indicated, Hitting you up again. I need to close [R88's] accounts, but if you are crediting the credit card, I have to leave it open. I need to know how and when you are crediting please.Reveal of an email document from the BOM to FM1, dated [DATE] and provided by the facility, indicated, I called to inform [with] you that yes, we are working on getting the refund of the balance over to you as well as to let you know it is our policy to issue a check form of a refund. Please let me know if you have any questions or concerns, I'm here to assist in any way I can.Review of an email document from FM1 to the BOM, dated [DATE] and provided by the facility, indicated, Would you be so kind to tell me when you will be mailing our refund check, as we are getting ready to move. Also, the amount.Review of an email document from the BOM to FM1, dated [DATE] and provided by the facility, indicated, I will look into the time frame, and I will let you know.Review of an email document from FM1 to the facility's Corporate Financial Department, dated (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] and provided by the facility, indicated, I'm just checking the status of the refund check on the resident named above [R88]. The resident passed away four days after initial payment of $9,750.00 was made. The total refund due is $8,550.00 . Can you tell me what date the check was mailed out if it's been mailed as of yet?Review of an email document from the facility's Corporate Financial Department to the BOM, dated [DATE] and provided by the facility, indicated, I forwarded this to [staff member] who handles accounts payable.Review of an email document from the facility's Corporate Financial Department to the BOM, dated [DATE] and provided by the facility, indicated, Thank you for following up. The refund check has not been mailed out yet. It is expected to be mailed next week. I will keep you posted once it has been sent.Review of an email from the facility's Corporate Financial Department to the BOM, dated [DATE] (32 days after R88's discharge from the facility) and provided by the facility, indicated, I'd like to let you know that the payment [to FM1 for R88's refund] will be sent today as follows: Refund Amount: $8,150.00. Check Payable To: [FM1]. During an interview with the Administrator on [DATE] at 4:00 pm, he acknowledged the facility's policy indicating funds were to be returned to a resident within 45 days after discharge did not reflect the Federal Regulation indicating a 30 day time frame for the return of funds after discharge, confirmed R88's money had not been mailed to the family until [DATE], and stated his expectation was excess funds deposited by residents/their responsible parties for resident care in the facility were expected to be returned no later than 30 days after discharge.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to protect residents from abuse by ensuring chemical restraints were not used unless medically necessary for two residents (Resident (R)16 and R47) out of a total of six residents reviewed for unnecessary medication. The facility's failure to ensure identified behaviors and potential side effects were consistently monitored for these residents created the potential for the residents to experience side effects related to the administration of unnecessary medication. A total of 23 residents were reviewed in the sample.Findings include:1. Review of the admission Record found in the Electronic Medical Record (EMR) under the Profile tab revealed R16 was admitted to the facility on [DATE]. The resident's diagnoses included Parkinson's disease and schizophrenia.Review of R16's Care Plan, dated 7/16/2025 and found in the EMR under the Care Plan tab, indicated the resident had a diagnosis of schizophrenia and was to be given her antipsychotic medication as ordered. Target behaviors and side effects related to the medication were to be monitored each shift. The care plan did not indicate specific behaviors to be monitored related to the administration of the medication.Review of R16's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/15/2025 and found in the EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. R16 had received antipsychotic medication and displayed no behaviors during the reference dates.Review of R16's Order Summary Report, dated 11/21/2025 and found in the EMR under the Orders tab, indicated an order, with an original order date of 07/15/25 for Haldol (an antipsychotic medication) five milligrams (mg) by mouth every night at bedtime for schizophrenia. There were no orders for the tracking of specified behaviors or potential side effects related to the administration of the resident's Haldol.Review of R16's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 11/1/2025 through 11/21/2025 and found in the EMR under the Orders tab, revealed nothing to indicate specific behaviors or side effects related to the administration of the resident's antipsychotic medications were being monitored.2. Review of the admission Record found in the EMR under the Profile tab revealed R47 was admitted to the facility on [DATE]. The resident's diagnoses included history of stroke, depression, anxiety, insomnia, and vascular dementia with agitation. The record indicated the resident received hospice services.Review of R47's Care Plan, dated 7/7/2023 and found in the EMR under the Care Plan tab, indicated the resident received antidepressant, antianxiety, and antipsychotic medication for behavior management to address his anxiety, depression, and agitation. The care plan indicated, Administer psychotropic medications as ordered by physician, Monitor for side effects and effectiveness every shift, Monitor/document/report as needed any adverse reactions of psychotropic medications, including unsteady gait, tardive dyskinesia, [extrapyramidal symptoms] EPS [shuffling gait, rigid muscles, shaking], frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, and behavior symptoms not usual to the person. The care plan indicated that R47 was to be monitored for behaviors associated with his depression, anxiety, and agitation.Review of R47's quarterly MDS, with an Assessment Reference Date (ARD) of 9/15/2025 and found in the EMR under the MDS tab, revealed the resident had a BIMS score of three out of 15, which indicated the resident was severely cognitively impaired. R47 received antidepressant, antianxiety, and antipsychotic medications and displayed behaviors during the reference period.Review of R47's Order Summary Report, dated 11/21/2025 and found in the EMR under the Orders tab, revealed orders with original order dates: -8/21/2024 trazodone (an antidepressant medication) 50 mg every night at bedtime for insomnia-5/20/2025 Ativan (an antianxiety medication) (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one mg every two hours as needed for anxiety-10/6/2025 Haldol (an antipsychotic medication) two mg every two hours as needed for agitation-9/8/2025 Monitor for behaviors each shift, including restlessness, agitation, hitting, increase in complaints, continuous yelling out, delusions, hallucinations, psychosis, aggression, and refusing care.-11/21/2023 Monitor for side effects related to depression, including dry mouth, dizziness, increased sedation, constipation, gastrointestinal upset, nausea/vomiting, decreased appetite, gait disturbances, and restlessness.The order set did not indicate an order for monitoring side effects related to the resident's antianxiety or antipsychotic medication administration.Review of R47's MAR and TAR, dated 11/1/2025 through 11/21/2025 and found in the EMR under the Orders tab, revealed nothing to indicate side effects related to the administration of the resident's antianxiety or antipsychotic medications were monitored.During an interview with the Director of Nursing (DON) on 11/20/2025 at 1:56 pm, she confirmed behaviors and side effects related to the administration of R16's antipsychotic medication and side effects related to the administration of R47's antianxiety and antipsychotic medications were not monitored. She stated her expectation was potential side effects and target behaviors related to the administration of all psychotropic medication were monitored each shift and documented on each resident's MAR/TAR. Review of the facility's Use of Psychotropic Medication Policy, reviewed most recently in June 2025, indicated, It is the intent of this policy to ensure residents only receive psychotropic medication when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint and Psychotropic medications are to be used only when a practitioner determines the medication[s] is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication[s] is beneficial to the resident, and demonstrated by monitoring and documentation of the resident's response to the medication[s].

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed protect residents from abuse by ensuring timely reporting of an allegation of financial abuse for one (Resident (R) 5) out of three residents reviewed for abuse. The facility's failure to ensure timely reporting of the allegation of abuse created the potential for this and other residents to experience ongoing effects related to abuse. A total of 23 residents were reviewed in the sample.Findings include:Review of the facility's Compliance with Reporting Allegation of Abuse/Neglect/Exploitation Policy, dated 12/22/2023, indicated, It is the policy of the facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes and The Administrator or designee will notify the appropriate agencies immediately; as soon as possible, but no later than 24 hours after the discovery of the incident.Review of the admission Record found in the Electronic Medical Record (EMR) under the Profile tab revealed R5 was admitted to the facility on [DATE]. The resident's diagnoses included history of stroke and Alzheimer's disease. The document indicated that the resident's Responsible Party (RP) was Family Member (FM) 3.Review of R5's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/7/2025 and found in the EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired.Review of R5's financial documentation, dated 10/2/2023 through 11/21/2025 and provided by the facility, revealed although FM3 was R5's Responsible Party and was named as the resident's Rep Payee (the person who received R5's Social Security payments issued each month by the government), FM3 did not respond to any of the facility's attempts to reach her during that time period to provide payment for R5's services while at the facility or provide R5 with personal spending money to meet his needs. The documentation revealed R5 did not have access to any of his money and had not had access since 10/2/2023.During an interview with the Director of Nursing (DON) on 11/20/2025 at 1:48 pm, she confirmed FM3 was still listed as R5's RP and was still the resident's Rep Payee. She stated the facility had been unable to reach FM3 for a long time. She stated FM3 still received R5's Social Security checks but would not respond to the facility to ensure R5 received his own money. The DON stated she thought R5 was being taken advantage of financially by FM3. During an interview with the Social Services Director (SSD) on 11/20/2025 at 2:33 pm, she stated R5 was admitted to the facility in August of 2023. She stated R5 initially received rehabilitation services under his Medicare benefits, but it became clear that the resident required long-term care services. She stated FM3 was involved in R5's care until October of 2023 when the facility requested financial information to ensure qualification for Medicaid financial assistance and requested R5's access to his money to ensure continued care, treatment, and quality of life. The SSD confirmed FM3 never provided the documentation to ensure R5 could qualify for Medicaid and to ensure he had access to his funds to pay his bills and provide for any additional basic necessities not covered by general room and board. The SSD stated she had reported her concerns regarding potential financial abuse of R5 by FM3 to the previous Administrator in December of 2023, but nothing had been done. The SSD indicated she reported her concerns to Adult Protective Services (APS) during that time as well but confirmed R5 still did not have access to his own money almost two years later.During an interview with the Business Office Manager (BOM) on 11/20/2025 at 2:57 pm, she stated she had been employed by the facility for a year and had concerns about R5 being financially abused by FM3 since shortly after being hired. The BOM stated she had been trying to assist R5 to obtain access to his bank funds, but due to the resident's poor cognition, she had been unable to do so. She stated the previous (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator had been aware of her concerns, but as far as she knew, the concerns were not reported to the State Agency or investigated by the facility.During an interview with the Administrator on 11/20/2025 at 3:31 pm, he stated he had been employed by the facility for about two months. He confirmed he was aware of the concerns related to R5 potentially being financially abused by FM3. He stated the concerns had been reported to APS and the local Police Department since he had become aware of the concerns and stated the local Police Department was investigating the report. The Administrator stated he was concerned R5 was being financially abused by FM3 but had not reported the potential abuse to the local State Agency as required by the facility's abuse policies and procedures. The Administrator stated the potential financial abuse of R5 by FM3 should have been reported to the State Agency as soon as the facility became aware of the potential abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to protect residents from abuse by ensuring a thorough investigation into allegations of potential abuse was conducted for two out of three residents (Resident (R) 5 and R3) reviewed for abuse. The facility's failure to ensure thorough investigation of potential financial abuse for R5, and of an injury for R3, created the potential for these and other residents to experience ongoing effects related to abuse. A total of 23 residents were reviewed in the sample.Findings include:Review of the facility policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 12/22/2023, revealed V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: . 4. identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse. neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.1. Review of R5's admission Record, found in the Electronic Medical Record (EMR) under the Profile tab revealed R5 was admitted to the facility on [DATE]. The resident's diagnoses included history of stroke and Alzheimer's disease. The document indicated that the resident's Responsible Party (RP) was Family Member (FM) 3.Review of R5's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/7/2025 and found in the EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired.Review of R5's financial documentation, dated 10/2/2023 through 11/21/2025 and provided by the facility, revealed although FM3 was R5's Responsible Party and was named as the resident's Rep Payee (the person who received R5's Social Security payments issued each month by the government), FM3 did not respond to any of the facility's attempts to reach her during that time period to provide payment for R5's services while at the facility or provide R5 with personal spending money to meet his needs. The documentation revealed R5 did not have access to any of his money and had not had access since 10/2/2023.Review of the facility's internal investigation documentation for 10/1/2023 through 11/20/2025 revealed nothing to indicate the facility initiated an investigation related to potential financial abuse of R5 by FM3.During an interview with the Administrator on 11/20/2025 at 3:31 pm, he stated he had not initiated an internal investigation into the potential abuse as required by the facility's abuse policies and procedures. The Administrator stated the potential financial abuse of R5 by FM3 should have been investigated internally by the facility as soon as the facility became aware of the potential abuse.2. Review of R3's five-day Medicare MDS with an ARD date of 7/30/2025, located in the MDS tab of the EMR, revealed an admission date of 7/25/2025 and a BIMS score of 14 out of 15, indicating R3's cognition was intact. R3 had diagnoses of paroxysmal atrial fibrillation, heart failure, and diabetes mellitus.During an interview on 11/20/2025 at 2:40 pm, the Director of Therapy (DOT) was asked about R3's lower extremity bleeding during a therapy session in July 2025. The DOT stated R3 had vascular and swelling issues in her lower left extremity before coming to the therapy session, and the bleeding was the bursting of a vessel. When asked if the incident was investigated, the DOT stated she documented in the daily therapy note on her computer but did not write a statement.During an interview on 11/20/2025 at 8:23 am, the DON was asked for the investigation related to R3's LLE injury on 7/28/2025. The DON stated the incident report for R3's LLE injury was also the investigation and stated she obtained CNA1's statement. The DON stated there was no incident report or investigation for R3's ruptured hematoma during therapy on 7/29/2025 as a note was added to the incident report referencing the bleeding episode.During an interview on 11/21/2025 at 12:19 pm, the DON stated the nurse that completed the incident report would have (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed R3 and documented in the progress notes. The DON reviewed the EMR for R3's statement and stated, It's not here, but the nurse would have interviewed R3. The DON was asked about the facility policy instructing staff to interview all persons involved in an allegation. The DON acknowledged that by not interviewing R3, pertinent details may have been missed. The DON was asked if the nurse (Licensed Practical Nurse (LPN)2) who CNA1 reported the incident to had completed a statement. The DON stated LPN2 documented her statement in the incident report. During an interview on 11/21/2025 at 1:23 pm, LPN2 stated that CNA1 reported bumping R3's lower leg causing her hematoma. LPN2 stated soon after the incident was reported, R3 complained of leg pain. LPN2 stated that R3 was interviewable but as far as she knew, no statement was obtained. LPN2 stated she did not talk with R3 about the incident. LPN2 stated the next shift would have followed up with an investigation. LPN2 was asked if she wrote or gave a statement besides what she wrote about the incident in the incident report. LPN2 stated, No and said no one asked her to give a statement.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure one resident (Resident (R) 55) and their representative out of one resident reviewed for hospitalization out of a total sample of 23 residents received a written bed hold policy and transfer notice. This failure had the potential to result in the resident and/or their representative not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired, and had the potential to cause confusion or distress regarding re-admission to the facility.Findings include:Upon request, the facility failed to provide any policies related to the process of transferring a resident to the hospital.Review of R55's Census Record located under the Resident tab in the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] and had been transferred to the hospital four times in the past ten months.Review of R55's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/2025 and located under the MDS tab of the EMR revealed a Brief Interview of Mental Status (BIMS) score of four out of 15, indicating severe cognitive impairment. R55's diagnoses included multiple sclerosis, personal history of traumatic brain injury, and cerebral infarct (stroke).Review of R55's Misc [Miscellaneous] tab of the EMR revealed no bed hold or notice of transfer forms related to the hospitalizations.During an interview on 11/20/2025 at 1:30 pm, Licensed Practical Nurse (LPN) 1 stated she had never filled out a transfer/discharge notice and was not aware one needed to be filled out and provided to the residents and their representatives.During an interview on 11/20/2025 at 2:41 pm, the Administrator stated that the Social Services Director (SSD) was responsible for providing the transfer notice and bed hold policy to the residents and resident representatives.During an interview on 11/20/2025 at 2:51 pm, the SSD stated she did not provide residents or their representatives with a written transfer/discharge notice or the bed hold information. The SSD stated she was not the person responsible for that task.During an interview on 11/20/2025 at 3:15 pm, the Business Office Manager (BOM) stated that the facility did not send bed hold policies or written transfer notices to the resident or resident representative because they made a courtesy phone call to the resident representative at the time of transfer to the hospital.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interview, and facility policy review, the facility failed to ensure a consistent program of activities was in place for one (Resident (R) 16) out of three residents reviewed for activities. The facility's failure to ensure activities were consistently provided per, and documented according to, R16's assessed preferences created the potential for the resident to experience negative psychosocial effects related to social isolation. A total of 23 residents were reviewed in the sample.Findings include:Review of the facility's Activities Policy, dated 7/9/2020, indicated, It is the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident.Review of the admission Record found in the electronic medical record (EMR) under the Profile tab revealed R16 was admitted to the facility on [DATE]. The resident's diagnoses included Parkinson's disease and schizophrenia.Review of R16's Care Plan, dated 8/30/2025 and found in the EMR under the Care Plan tab, revealed the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits and immobility. Interventions included, Ensure that the activities the resident is attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed [such as large print, holders if resident lacks hand strength, task segmentation], Compatible with individual needs and abilities; and Age appropriate; and Introduce the resident to residents with similar background, interests and encourage/facilitate interaction; and Invite the resident to scheduled activities and The resident needs assistance/escort to activity functions.Review of R16's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/2025, found in the EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact.Review of R16's Activities - Initial Review Assessment, dated 11/12/2025 and found in the EMR under the Assessment Tab, indicated R16 enjoyed praying and worshiping, spending time with family, being outside, and listening to Christian music. The assessment indicated the resident wished to participate in activities while in the facility, including group activities, outings, 1:1 (one to one) visits with staff, and independent activities. The assessment indicated R16 required assistance from staff to get to activities.Review of R16's Individual Resident Activities Participation Log dated 10/19/2025 through 11/21/2025 revealed no documentation to show the resident attended any activities during that time. (The log was blank).During observations on 11/19/2025 at 1:29 pm and 4:11 pm, on 11/20/2025 at 10:19 am, 2:13 pm and 4:33 pm, and on 11/21/2025 at 9:48 am, R16 was observed in her room or seated in front of the nurses' station while group activities were ongoing. The resident was not observed to be engaged with other residents or staff or participating in any kind of activity during the observations.R16 declined an interview during the survey.During an interview with the Activities Director (AD) on 11/21/2025 at 9:23 am, she confirmed R16 enjoyed participating in facility group activities, especially BINGO and music related activities; however, R16 had not been in activities much that week. She stated all activity participation was expected to be documented in each resident's Activities Participation Log. The AD confirmed there was no documentation to show R16 had participated in any activities since 10/19/2025 and stated it was usually the job of the activity assistant to complete participation logs; however, she had not had an assistant since the beginning of November 2025. The AD stated her expectation was activities should be offered to all residents based on their individual preferences, and participation in activities was to be documented on each resident's activity log.Review of the facility's Activities Department Calendar, dated November 2025 and posted throughout the facility, revealed activities offered during the survey timeframe included chair pilates, card games, crafts, Good Morning Vibes, BINGO, bowling, cornhole, puzzles, balloon tennis, and happy hour/movie time.

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	115772	A. Building B. Wing	11/21/2025

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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to ensure physician orders for the use of an indwelling urinary catheter device were in place for one (Resident (R) 1) of two residents reviewed for urinary catheters. The facility's failure to ensure orders were in place for R1's suprapubic urinary catheter created the potential for the resident to go without appropriate catheter-related care and services. A total of 23 residents were reviewed in the sample.Findings include:Review of the facility's Appropriate Use of Indwelling Catheters Policy, dated September 2024, indicated, The use of an indwelling urinary catheter will be in accordance with physician's orders, which will include the diagnosis or clinical condition making the use of the catheter necessary, size of the catheter, and frequency of change [if applicable]. Review of the admission Record found in the Electronic Medical Record (EMR) under the Profile tab revealed R1 was admitted to the facility on [DATE]. The resident's diagnoses included neurogenic bladder.Review of R1's Medicare 5-Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/28/2025 and found in the EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident was severely cognitively impaired. The record indicated the resident had an internal urinary catheter in place at the time of the assessment.Review of R1's Care Plan, dated 8/28/2025 and found in the EMR under the Care Plan tab, revealed the resident had a urinary suprapubic catheter in place in his bladder related to his diagnosis of neurogenic bladder. The document indicated the catheter was to be positioned below the level of the resident's bladder, and the resident was to be monitored for potential signs and symptoms of discomfort or infection related to the catheter.Review of R1's Physician's Order Report, dated 11/21/2025 and found in the EMR under the Orders tab, revealed orders for the maintenance and care of the resident's suprapubic catheter but revealed no orders for the resident's actual catheter (including the size or type of the indwelling catheter).During an interview with the Director of Nursing (DON) on 11/20/2025 at 2:03 pm, she confirmed she was unable to locate an order for R1's suprapubic catheter in the resident's record and stated her expectation was that an order for the actual catheter (size and type) was in place for the use of any indwelling catheter.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observations, resident, resident family member, and staff interviews, record review, and facility policy review, the facility failed to ensure clinical criteria were met prior to prescribing and administering an antibiotic for a urinary tract infection (UTI) for one (Resident (R) 79) of one resident reviewed for antibiotic use out of a total sample of 23 residents. This failure had the potential to cause antibiotic resistance, increased risk of Clostridioides difficile infection, and adverse drug reactions.Findings include:Review of the facility policy titled Antibiotic Stewardship Program, dated 9/22/2025, revealed 4. The program includes antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: i. Nursing staff shall assess residents who are suspected to have an infection and notify the physician. ii. Laboratory testing shall be in accordance with current standards of practice. iii. The facility uses the [CDC's [Centers for Disease Control] NHSN [National Healthcare Safety Network] Surveillance Definitions, updated McGeer criteria [evidence-based guidelines], or other surveillance tool] to define infections. iv. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics.Review of R79's five-day Medicare Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/2025, located in the MDS tab of the electronic medical record (EMR), revealed an admission date of 11/7/2025. R79 had a Brief Interview for Mental Status (BIMS) score of nine out of 15, indicating R79's cognition was moderately impaired, and had diagnoses of metabolic encephalopathy, non-Alzheimer's dementia, and urinary tract infection (UTI) (last 30 days).Review of R79's Urine Culture, report dated 11/17/2025, located in the EMR under the Results tab revealed Culture, Urine source clean catch, Isolate Organism Enterococcus faecalis with a colony count of 60,000 cfu/ml [colony-forming units per milliliter]-70,000 cfu/ml.Review of R79's Physician Orders, dated 11/18/2025, located in the EMR under the Order tab, revealed Linezolid [an oxazolidinone antibiotic used to treat serious bacterial infections] Oral Tablet 600 MG [milligram] [Linezolid] Give 1 tablet by mouth every 12 hours for UTI for 7 Days.Review of R79's Care Plan dated 11/18/2025, located in the EMR under the Care Plan tab, revealed R79 has a UTI. An intervention included Administer antibiotic medications as ordered by physician. Monitor/document side effects and effectiveness Q [every]-shift.Review of R79's Revised McGeer Criteria for Infection Surveillance Checklist, dated 11/20/2025, provided by the facility, revealed a large X was placed over both sections 1 and 2 that included UTI without indwelling catheter Must fulfill both 1 AND 2 indicating these sections were not applicable. The sections included: 1. At least one of the following sign or symptom: Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate _Fever or leukocytosis, and ˆ [at least] 1 of the following: _Acute costovertebral angle pain or tenderness _ Suprapubic pain _ Gross hematuria _ New or marked increase in incontinence _ New or marked increase in urgency _ New or marked increase in frequency _ If no fever or leukocytosis, then ˆ 2 of the following: _ Suprapubic pain _ Gross hematuria _ New or marked increase in incontinence _ New or marked increase in urgency _ New or marked increase in frequency.2. At least one of the following microbiologic criteria _ ˆ [greater than or equal to] 105 cfu/mL of no more than 2 species of organisms in a voided urine sample _ ˆ 102 cfu/mL of any organism[s] in a specimen collected by an in-and-out catheter. A large X was placed to indicate UTI criteria not met.During a concurrent observation and interview on 11/18/2025 at 1:27 pm, R79 was seated in his wheelchair, dressed and groomed, with a Family Member (FM) 2 at his side. FM2 stated R79 had just completed an antibiotic for a UTI in the hospital before he was admitted to the facility. FM2 stated R79 had a change in his demeanor but was not experiencing symptoms such as burning or frequency of urination. R79 stated he felt fine.During an interview on 11/20/2025 at 9:30 am, the Infection Preventionist (IP) was asked why a urine analysis was completed for R79. The IP stated it was because FM2 asked the nurse practitioner (NP) to have it completed due to odd statements R79 made. The IP stated the urine analysis and culture qualified as a UTI and so an antibiotic was prescribed. The IP stated they used McGeer criteria, and an (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	organism grew from the urine sample. The IP was asked if the colony count should be 100,000 or greater according to McGeer. The IP reviewed the urine culture and stated, No. The IP stated R79 was on an antibiotic in the hospital also for a UTI, but the new round of antibiotics was started in the facility. During a follow up interview on 11/20/2025 at 10:42 am, the IP changed her statement and stated R79 did not meet the McGeer criteria for a UTI as he was not symptomatic, and the urine culture results did not meet the indicated level. The IP went on to say the physician instructed nursing to give the last dose on 11/21/2025 instead of 11/24/2025.During an interview on 11/20/2025 at 12:54 pm, R79 and FM2 confirmed R79 was just prescribed another antibiotic for seven days at the facility for a UTI. FM2 stated R79 had no symptoms.During an interview on 11/20/2025 at 1:43 pm, The NP was asked how R79's UTI was handled. The NP stated R79 had a new encephalopathy diagnosis, and FM2 was concerned he might have an UTI due to his behaviors, saying odd things. The NP stated FM2 asked her to retest F79's urine. The NP stated her intention was not to have the sample of urine cultured but that nursing did a culture. The NP stated the physician started an antibiotic after he saw the test results online. When the NP was asked if R79 should have been prescribed an antibiotic based on the culture results, she responded, No, he should not have been on an antibiotic.During an interview on 11/21/2025 at 12:25 pm, the Director of Nursing (DON) was asked if the IP made the physician aware that R79 did not meet criteria for a UTI. The DON stated the physician reviewed the laboratory report, and after the IP followed up with the physician on 11/20/2025, the physician reduced the duration of the antibiotic from seven days to three days.During a telephone interview on 11/21/2025 at 2:14 pm, Medical Doctor (MD) 1 was asked if he was informed R79 did not meet the McGeer criteria for a UTI. MD1 acknowledged R79's colony count was 60,000 but stated the family wanted to try an antibiotic because R79 was acting confused. MD1 stated R79's symptoms included, only the one thing [confusion] which was why he reduced the antibiotic duration from seven days to three days. MD1 stated, But it was based on the family's request to try it one more time. MD1 stated he was aware of antibiotic stewardship and that R79 had just completed a round of antibiotics in the hospital.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, and facility policy review, the facility failed to ensure a medication error rate of less than five percent. Errors were made during the administration of medication for two of seven residents (Resident (R) 85 and R92) observed for medication administration. A total of two errors were made out of 25 opportunities for error, which resulted in an eight percent medication error rate. Medication errors have the potential to result in adverse health outcomes.Findings include:Review of the facility's Medication Administration Policy, dated April 2025, indicated, Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation. 1. Review of the admission Record found in the Electronic Medical Record (EMR) under the Profile tab revealed R85 was admitted to the facility on [DATE]. The resident's diagnoses included atrial fibrillation and history of stroke.Review of R85's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/5/2025 and found in the EMR under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident was moderately cognitively impaired.Review of R85's Physician's Order Report, dated 11/21/2025 and found in the EMR under the Orders tab, revealed orders, with an original order date of 10/30/25, for the resident to receive aspirin (chewable) 81 milligrams (mg) by mouth one time daily for his diagnoses of atrial fibrillation and history of stroke.Review of R85's Medication Administration Record (MAR) dated 11/1/2025 through 11/21/2025 revealed the resident was receiving his aspirin as ordered.Observation on 11/20/2025 at 9:00 am revealed R85 received his medication from Licensed Practical Nurse (LPN) 1. R85 was given enteric coated aspirin rather than the ordered chewable aspirin.During an interview with LPN1 on 11/20/2025 at 9:03 am, she confirmed she had given the resident enteric coated aspirin and stated that although both chewable and enteric coated aspirin were available in the medication cart, she usually administered the enteric coated aspirin to R85.2. Review of the admission Record found in the EMR under the Profile tab revealed R92 was admitted to the facility on [DATE]. The resident's diagnoses included history of pancreatic cancer, acute kidney failure, and morbid obesity.Review of an admission Note, dated 11/13/2025 and found in the EMR under the Notes tab, revealed the resident was alert and oriented times three (oriented to person, place, and time).Review of R92s Physician's Order Report, dated 11/21/2025 and found in the EMR under the Orders tab, revealed orders, with an original order date of 11/20/2025, for the resident to receive multivitamin with-minerals one tablet by mouth one time a day for a supplement. Review of R92's Medication Administration Record (MAR) dated 11/20/2025 through 11/21/25 revealed the resident was receiving his multivitamin with minerals as ordered.Observation on 11/20/2025 at 9:55 am revealed R92 received his medication from Registered Nurse (RN) 1. R92 was given a multivitamin without minerals instead of the ordered multivitamin with minerals.During an interview with RN1 on 11/20/2025 at 10:00 am, she confirmed she had administered a multivitamin without minerals to R92 rather than the ordered multivitamin with minerals. She stated the multivitamin with minerals was not available in the medication cart but stated she should have given the multivitamin with minerals according to the resident's physician's orders.During an interview with the Director of Nursing (DON) on 11/21/2025 at 12:41 pm, she stated her expectation was for medications to be administered according to physician's orders.