

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115775	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Presbyterian Village - Athens		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Live Oak LN Bldg 100 Athens, GA 30606	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38988</p> <p>Based on observation, record review, interview, and review of the policy titled Skilled Nursing Facility Resident Rights and Podiatry Policy, the facility failed to ensure the Podiatrist provided care in a dignified manner for one resident (R) (R4), while providing foot care, including cutting toenails and evacuation of left great toe subungual hematoma (collection of blood and clot between the nail bed and the nail plate in the fingers or toes), in a common day area with other residents in the common area. The sample size was 9.</p> <p>Findings include:</p> <p>Review of the undated policy titled Skilled Nursing Facility Resident Rights revealed the policy outlines the rights and protections afforded to residents of the skilled nursing facility in accordance with the federal and state laws. It aims to promote a safe, respectful, and supportive environment for all residents. Respect and Dignity: Residents have the right to be treated with dignity and respect. Conclusion: This policy is designed to protect the rights and well being of all residents in the facility. It shall serve as a guide for staff to ensure that residents receive respectful, dignified, and compassionate care at all times.</p> <p>Review of the undated policy titled Podiatry Policy revealed Policy Interpretation and Implementation: Number 1. Residents will be provided with foot care and treatment in accordance with professional standards of practice. Number 4. Residents with foot disorders or medical conditions associated with foot complications will be referred to qualified professionals.</p> <p>Review of the electronic medical record (EMR) revealed that R4 was admitted to the facility with diagnoses that include but not limited to non-displaced fracture of sacrum, hypertension, mild dementia, anxiety, and depression.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE], documented R4 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderate impaired cognition.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 9/16/2024 at 10:18 am, R4 was sitting in a geri-chair in the Fireside Room common area. Podiatrist GG was sitting on the floor at the foot of R4's geri-chair, performing a procedure of cutting residents elongated toenails and debriding a subungual hematoma from left great toe. Resident was observed yelling out in pain, as Podiatrist GG continued to debride area from residents left great toe, to the point it started to bleed. There was no facility staff noted in the area, while Podiatrist GG was performing procedure. Resident continued yelling and moaning out in pain as the Podiatrist continued with the procedure. After approximately five minutes, the Director of Nursing (DON) walked by the common area as resident continued to yell out in pain. She asked Podiatrist GG to take resident to his room to complete the procedure.</p> <p>Interview on 9/16/2024 at 1:17 pm, the DON stated that when the Podiatrist visits resident in the facility, he usually will see residents in the clinic, located just outside the unit. She stated that when the clinic was being used, the Podiatrist would normally see the residents in their rooms. During further interview, the DON she was not sure why the Podiatrist didn't take the resident to his room to provide care and services for R4. She stated that cutting a residents toenails in the common sitting room was not treating the resident with respect and dignity.</p> <p>Two separate attempts to contact Podiatrist GG for an interview during the survey were unsuccessful.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38988</p> <p>Based on record review, interviews, and review of the facility's policy titled Reporting Resident Abuse, Neglect, and Exploitation, the facility failed to provide a complete and thorough investigation of an allegation of abuse for one resident (R) (R13) reviewed for abuse. The sample size was nine.</p> <p>Findings include:</p> <p>Review of the policy titled Reporting Resident Abuse, Neglect and Exploitation, dated June 2021 Procedure 31-8-83 Investigations: a. The department shall immediately initiate an investigation after the receipt of any report. The department shall direct and conduct all investigations. b. The investigation shall determine the nature, cause, and extent of the reported abuse or exploitation, an assessment of the current condition of the resident, and an assessment of needed action and services.</p> <p>Review of the Electronic Medical Record (EMR) revealed that R13 was admitted to the facility on [DATE] with diagnoses including intestinal obstruction, compression fracture lumbar vertebra, kidney failure, and atherosclerotic heart disease.</p> <p>Review of R13's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment.</p> <p>Review of the Grievance/Complaint Form dated 8/26/2024 revealed that the Social Worker (SW) was asked to speak with R13 regarding a concern about a Certified Nursing Assistant (CNA). R13 reported that she was being put to bed, and her CNA had to get someone to help her. She reported that they picked her up and shoved her into the bed. She said in that process, one of the CNA's elbows hit her in the left rib. She reported that her ribs are still sore from this process, as it occurred this past Monday. She reported that she did not want the CNA to work with her anymore as the resident felt that she was mean.</p> <p>Review of the Facility Reported incident (FRI) for R13 revealed the five-day follow up report indicated that witness statements and interviews were noted to have been conducted; however, no written statements or interview notes, from any involved parties, were included in the report, except for a written statement from CNA EE, the alleged perpetrator.</p> <p>Review of the handwritten statement dated 8/29/2024, written by CNA EE, documented putting R13 to bed with the assistance of the floor nurse. She documented that she needed assistance and that she and the nurse on the floor lifted resident under her arms and that the transfer was fast and quick.</p> <p>Interview on 9/17/2024 at 6:04 pm, the Director of Nursing (DON) was asked for the written statements and interview notes related to R13's grievance and allegation about CNA EE, being rough when putting her in the bed. She stated that she could not find any interview notes from other residents or other staff members related to this incident. She stated the Facility Incident Report Form, the summary of facility findings, and a written statement from CNA EE was all that they had.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47947</p> <p>Based on record review, review of the Plan of Correction (POC), interviews, and review of the document titled Bed Hold Letter, the facility failed to provide evidence that notice of the bed-hold policy and return was provided to the resident or residents' representative, upon transfer to the hospital for one of three sampled residents (R) (R6). This failure had the potential to contribute to possible denial of re-admission following a hospitalization for residents discharged emergently to the hospital.</p> <p>Findings include:</p> <p>Review of an undated document provided by the facility titled Bed Hold Letter, revealed that Medicare and private insurance companies will not pay to hold the bed at the nursing facility while the resident is hospitalized. The family may hold the bed by paying the private room rate. If you decide not to hold the bed, the facility will assign the bed to a new resident. Upon discharge from the hospital, the resident can be readmitted if a bed is available.</p> <p>Review of the electronic medical record (EMR) revealed R6 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, mixed receptive-expressive language disorders, hypertension (HTN), dementia, and depression.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], documented that R6 had a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated severely impaired cognition.</p> <p>Review of the Progress Note dated 8/29/2024 at 5:44 pm, documented resident developed difficulty eating dinner, with visible mouth droop with some drooling. The resident was able to squeeze the staff members hand, and able to stick her tongue out; however, when asked to smile, the resident's mouth was noted to be extremely asymmetrical. Spouse at bedside and requested resident be transported to hospital emergency room (ER). Husband followed in car.</p> <p>Review of the EMR for R6 revealed no evidence of written notification to the resident or resident's representative regarding the facility's bed hold policy or duration of the bed-hold.</p> <p>Interview on 9/17/2024 at 10:40 am, the Social Services Director (SSD) revealed that bed-hold notification was still a new process for the facility. She stated the Bed-hold Letter is included in the hospital transfer packet that is sent with the resident to the hospital. She stated she was not sure who was responsible for communicating with the resident or residents representative about the bed-hold policy. During further interview, she stated currently all bed-hold letters are filed in a binder that is kept in her office.</p> <p>Follow-up interview on 9/17/2024 at 11:15 am, the SSD confirmed that the facility does not have signed copies of Bed-Hold Letters, indicating that the resident or residents representative was presented with written notification regarding the facility's Bed-Hold process. She stated that they are still trying to figure out the process to ensure that the Bed-Hold Letter is signed by the resident or the residents' representative.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 9/17/2024 at 1:25 pm, the Director of Nursing (DON) revealed that it is the Social Services Director's responsibility to ensure that all Bed-Hold Letters are completed and signed by the resident or residents' representative. The DON confirmed that the Bed-Hold Letter for R6's 8/29/2024 transfer to the hospital was not completed with a signature from the resident or residents' representative.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47947</p> <p>Based on record review, review of the Plan of Correction (POC), staff interviews, and review of the policy titled Care Plans - Comprehensive, the facility failed to follow the plan of care for three of three sampled residents (R) (R1, R2, and R22) related to monitoring and recording meal intake.</p> <p>Findings include:</p> <p>Review of the undated policy titled Care Plans-Comprehensive revealed the policy is to establish guidelines for providing individualized patient care that is multidisciplinary, consistent, coordinated, high quality, and cost effective; to provide guidelines for initiating, customizing, and following a goal-directed plan of care based on best practice. Policy: Number 1. An individualized comprehensive care plan that includes measurable objectives and timetables to meet the residents medical, nursing, mental and psychological needs is developed for each resident. Number 2. The facility's care planning/Interdisciplinary team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Number 6. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident. Number 8. Assessments of residents are ongoing, and care plans are revised as information about the resident and the residents condition change.</p> <p>1. Review of the clinical record revealed R1was admitted to the facility on [DATE] with diagnoses including dementia, major depressive disorder, and cognitive communication deficit.</p> <p>The residents most recent quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 99, which indicated resident was not able to complete the assessment.</p> <p>Review of the care plan revised on 7/2/2024 revealed the resident has nutritional problem or potential nutritional problem related to history of unplanned weight loss, receives puree consistency and thin liquids, and requires extensive assistance with eating. Interventions to care include monitor/record/report to Physician signs and symptoms (s/sx) of malnutrition including emaciation, muscle wasting, significant weight loss of three pounds in one week, five percent (%) in one month, 7.5 % in three months, or 10% in six months; provide, serve diet as ordered and monitor intake and record every meal; Registered Dietician to evaluate and make diet change recommendations as needed (PRN).</p> <p>Review of the August and September 2024 Nutritional Task-Amount Eaten in the EMR documented R1 consumed between 51-75 % of meals. Continued review revealed there is no documentation for intake percentages from 8/29/2024 to 9/2/2024, and 9/4/2024 to 9/15/2024.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the August and September 2024 Nutritional Task-Snacks Given in the EMR revealed there is no documented evidence that R1 was given a snack between meals (as ordered on 8/29/2024) from 8/29/2024 - 9/2/2024, 9/4/2024, 9/13/2024 and 9/17/2024. For the dates 9/10/2024 - 9/11/2024, and 9/16/2024 documented Not Applicable. There is no documentation as to what Not Applicable is related to.</p> <p>2. Review of the clinical record revealed R2 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, and major depressive disorder.</p> <p>The residents most recent quarterly Minimum Data Set (MDS) dated [DATE] documented a BIMS of four, which indicated severe cognitive impairment.</p> <p>Review of the care plan revised 7/9/2024 revealed the resident has nutrition risk related to diagnoses of Lupus and is ordered a regular diet with chopped meat and thin liquids as ordered. Interventions to care include monitor/record/report to Physician signs and symptoms (s/sx) of malnutrition including emaciation, muscle wasting, significant weight loss of three pounds in one week, five percent (%) in one month, 7.5 % in three months, or 10% in six months; provide, serve diet as ordered and monitor intake and record every meal.</p> <p>Review of the September 2024 Nutritional Task-Amount Eaten in the EMR documented R2 consumed between 51-75% of meals. Continued review revealed there is no documentation for intake percentages from 9/1/2024 - 9/4/2024, 9/6/2024, 9/13/2024, and 9/17/2024.</p> <p>Review of the August and September 2024 Nutritional Task-Snacks Given in the EMR revealed there is no documented evidence that R2 was given a snack from 8/20/2024 - 8/26/2024, 8/29/2024 - 9/4/2024, 9/6/2024, 9/13/2024 and 9/17/2024. For the dates 9/10/2024 - 9/11/2024 and 9/16/2024 documented Not Applicable. There is no documentation as to what Not Applicable is related to.</p> <p>3. Review of the clinical record revealed R22 was admitted to the facility on [DATE] with diagnoses including traumatic hemorrhage of cerebrum, metabolic encephalopathy, dysphagia, hypertension, and Alzheimer's disease.</p> <p>The residents most recent quarterly Minimum Data Set (MDS) dated [DATE] revealed a BIMS score was not documented, which indicated resident was not able to complete the assessment.</p> <p>Review of the care plan revised 7/26/2024 revealed the resident has nutrition risk related to diagnoses of history of cerebral vascular accident (CVA), Alzheimer's disease, and hypertension and is ordered a mechanical soft diet with ground meat and thin liquids as ordered, history of unplanned weight loss and requires set-up with extensive assistance with eating. Interventions to care include monitor/record/report to Physician signs and symptoms (s/sx) of malnutrition including emaciation, muscle wasting, significant weight loss of three pounds in one week, five percent (%) in one month, 7.5 % in three months, or 10% in six months; provide, serve diet as ordered and monitor intake and record every meal; Registered Dietician to evaluate and make diet change recommendations as needed (PRN).</p> <p>Review of the September 2024 Nutritional Task-Amount Eaten in the EMR documented R22 consumed between 51-75% of meals. Continued review revealed there is no documentation for intake percentages from 8/15/2024 - 8/16/2024, 8/20/24 - 8/21/2024, 8/23/2024 - 8/26/2024, 8/29/2024 - 8/30/2024, 9/1/2024, 9/4/2024, 9/13/2024, and 9/17/2024.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the August and September 2024 Nutritional Task-Snacks Given in the EMR revealed there is no documented evidence that R22 was given a snack from 8/20/2024 - 8/26/2024, 8/29/2024 - 8/30/2024, 9/1/2024, 9/4/2024, 9/13/2024 and 9/17/2024. For the dates 9/10/2024 - 9/11/2024 and 9/16/2024 documented Not Applicable. There is no documentation as to what Not Applicable is related to.</p> <p>Interview on 9/17/2024 at 4:15 pm, the Assistant Director of Nursing (ADON) revealed that CNAs are responsible for entering percentage of each meal intake in the electronic system. The ADON was asked about days in the system that do not have intake percentages documented, and she stated that the missing data could be the result of agency CNAs working, and they did not know how to use the facility electronic system. During continued interview, surveyor observed two CNAs sitting at the nurses station, working on the computers, and the ADON stated they were entering information from residents' meal tickets into the electronic system.</p> <p>Interview on 9/17/2024 at 5:10 pm, the Director of Nursing (DON) revealed that CNAs are responsible for documenting the percentage of meal intakes after each meal for each resident. after . She stated that the CNAs write the intake percentage consumed of each meal on the residents tray ticket and enter information that information in the electronic system when they are ready to do their charting. The DON stated it is her expectation that all staff should be following each resident's plan of care.</p> <p>Cross Refer F684</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47947</p> <p>Based on record review and staff interviews, the facility failed to follow the Physician Orders to offer snacks between meals, for one of three sampled residents (R) (R1).</p> <p>Findings include:</p> <p>Review of the electronic medical record (EMR) revealed that R1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, major depressive disorder, gastroesophageal reflux disease (GERD), and chronic pain syndrome.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 99, which indicated resident was not able to complete the assessment.</p> <p>Review of September 2024 Order Summary Report revealed an active order dated 8/29/2024 to offer snacks between meals.</p> <p>Review of the Nutrition/Dietary Note dated 8/6/2024 revealed that R1 requires setup and assistance with eating, intake remains poor, 25-50% of meals. Numerous supplements are offered daily to compensate for intake; however, overall consumption is not adequate to stabilize weight. Resident has 12% of weight loss in 180 days.</p> <p>Review of the snack intake form revealed that no documentation was available for snack intake for dates from 8/29/2024 to 9/2/2024; two snacks documented on 9/3/2024; no documentation for 9/4/2024; three snacks documented on 9/5/202; one snack documented on 9/6/2024; one snack documented on 9/12/2024. No other snacks documented for September 2024.</p> <p>Interview on 9/16/2024 at 4:30 pm, the Dietary Manager (DM) revealed that the facility has a variety of snacks available to provide to residents between meals, including potato chips, crackers, bananas, fruit salad, puddings, apple sauce, Jello, and ice cream. She stated that after the kitchen closes, the Certified Nursing Assistants (CNAs) have access to the small refrigerator, the small freezer, and baskets of shelf stable snacks.</p> <p>Interview on 9/17/2024 at 4:15 pm, the Assistant of Director of Nursing (ADON) revealed that the Activity Director is responsible for offering snacks to residents in afternoon. She stated that the Activity Director was out today, and nobody was offering snacks to residents today. When asked about snacks on the weekends, the ADON stated that weekends are different, in that snacks are provided by families.</p> <p>Interviews on 9/17/2024 at 6:30 pm, with CNA CC and CNA DD revealed that they pass snacks when the Activity Director is not at the facility. They stated snacks are offered between each meal by going from to room, and letting residents choose what snack they would like. During further interview, they stated that many residents don't want snacks, because they already have snacks provided by their families.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38988</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice and the comprehensive person-centered care plan, for one resident (R) (R4) reviewed for pain management. Actual Harm was identified on 9/16/2024 when Podiatrist GG failed to stop and assess R4 yelling out in pain while receiving Podiatry care and treatment. The sample size was 9.</p> <p>Findings included:</p> <p>Review of the electronic medical record (EMR) revealed that R4 was admitted to the facility with diagnoses that include but not limited to non-displaced fracture of sacrum, hypertension, mild dementia, anxiety, and depression.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE], documented R4 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderate impaired cognition.</p> <p>Observation on 9/16/2024 at 10:18 am, while touring the facility, yelling was noted to be coming from down a hallway. Surveyor walked towards the yelling, to find R4 sitting in a geriatric chair in the Fireside Room common area. Sitting on the floor at R4's feet, Podiatrist GG was observed performing care and services, in the open sitting area. R4 continued to yell out in pain as Podiatrist GG proceeded to work on cutting his toenails, and digging under R4's left great toe, to debride a subungual hematoma. The Podiatrist did not stop the procedure to assess residents level of pain, but stated to the resident we have to get this infection out of your toe and continued digging until the toe started to bleed. There was no facility staff in the Fireside Room at this time, only two assistants to Podiatry GG, and three other residents. R4 continued to yell out in pain during the procedure, until the Director of Nursing (DON) asked Podiatrist GG to take the resident to his room to complete the care.</p> <p>Review of the care plan revised on 8/23/2024 revealed R4 has acute/chronic pain related to dementia, anxiety, depression, sacral fracture, and osteoporosis. Interventions to care include administer analgesia as per orders. Give before treatments or care when possible; anticipate the residents need for pain relief and respond immediately to any complaint of pain; provide the resident with reassurance that pain is time limited, try to encourage different pain-relieving methods.</p> <p>Review of the September 2024 Physician's Order (PO) revealed an order for hydrocodone-acetaminophen 10-325 milligrams (mg) one tablet by mouth every four hours as needed (PRN) for pain, with a start date of 8/6/2024.</p> <p>Review of the September 2024 Medication Administration Record (MAR) revealed that R4 had been receiving regular doses of hydrocodone-acetaminophen for pain daily. There is no evidence that the resident was medicated for pain prior to or after the podiatry procedure.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 9/16/2024 at 12:30 pm, R4 observed sitting in the restorative dining room, neat and clean. He stated he is not currently having any pain. Resident was asked about the visit by the foot doctor earlier today, and he stated that he had his toenails cut and that it hurt him. During further interview, R4 stated that he was not given any pain medicine before or after the procedure.</p> <p>Interview on 9/16/2024 at 1:00 pm, Certified Nursing Assistant (CNA) II stated that when residents complain of pain, she would immediately report it to the nurse. She was questioned how she would identify if a resident was experiencing pain, if the resident was not able to state that they were in pain? She stated that she would watch for signs of pain, such as facial expressions, crying, and yelling when being moved or transferred. She stated that R4 does yell out when staff provide care for him.</p> <p>Interview on 9/17/2024 at 4:45 pm, the DON stated that her expectation is that if residents are experiencing any pain, the staff should do an assessment to determine the cause of the pain and provide medication, if they have an order. She stated that if the residents do not have an active order for pain medications, then the nurse should call the physician, to obtain an order for something for pain.</p> <p>Two separate attempts to contact Podiatrist GG for an interview during the survey were unsuccessful.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38988</p> <p>Based on observations, record review, staff interviews, and review of the policy titled Medication Management, the facility failed to ensure that it was free of a medication error rate greater than five percent by not ensuring medications are given as ordered by the physician. A total of 25 medication opportunities were observed, with two errors, for two of six residents (R) R5 and R16, for a medication error rate of 8%.</p> <p>Findings include:</p> <p>Review of the policy titled Medication Management dated June 2021 revealed the policy is to establish protocol for medication management. Medications are administered by licensed staff including Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Medication Assistants (CMA). Procedure Number 10: Orders required for all medications: facility staff will not allow its staff to assist with, provide supervision of self-administered medications, or administer any medications, including over the counter medications, unless there is a physician's order specifying clear instructions for its use on file for the resident.</p> <p>1. Review of R5's electronic medical record (EMR) revealed resident was admitted to the facility on [DATE] with diagnoses including fracture of right lower leg, atrial fibrillation, dementia, and neuropathy.</p> <p>Observation of medication administration on 9/17/2024 at 7:45 am with Licensed Practical Nurse (LPN) FF, revealed she administered multiple medications to R5. The following observations were made: Certavite (a multivitamin and iron product used to treat or prevent vitamin deficiency) one tablet; Calcium with Vitamin D3 (a medication used to prevent or treat low blood calcium levels) one tablet; B-12 (helps break down food into energy) 1000 microgram (mcg) one tablet; Duloxetine a medication used to treat depression and anxiety) 30 milligrams (mg); Flonase (a medication used to treat Asthma) 50 mcg two sprays each nostril; Memantine (a medication used to treat moderate to severe dementia) 10 mg one tablet; Metoprolol (a medication used to treat high blood pressure) 25 mg take half tablet.</p> <p>During reconciliation with review of the September 2024 Medication Administration Record (MAR) revealed the following orders: Metoprolol Tartrate 25 mg, give 0.5 tablet by mouth every morning and at bedtime for hypertension. Further review of the MAR revealed residents blood pressure and pulse were to be obtained prior to administering the medication. LPN FF was not observed to check R5's pulse rate or obtain her blood pressure prior to administering her the metoprolol medication.</p> <p>Interview on 9/17/2024 at 11:30 am, LPN FF was asked about the protocol for checking vital signs prior to administering medications that have effects on blood pressure and heart rate. She stated that she was supposed to check R5's blood pressure before she gave her the medication. She stated she was nervous and forgot to check her vital signs.</p> <p>2. Review of R16's EMR revealed resident was admitted to the facility on [DATE] with diagnoses including chronic diastolic heart failure, hypertension, and cardiomegaly.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of medication administration on 9/17/2024 at 8:15 am with Licensed Practical Nurse (LPN) FF, revealed she administered multiple medications to R16. The following observations were made: Senna (medication used to relieve occasional constipation) one tablet; Eliquis (anticoagulant medication used to treat and prevent blood clots and to prevent stroke in people with nonvalvular atrial fibrillation) 5 mg one tablet daily; Lasix (medication used to treats fluid retention (edema) in people with congestive heart failure) 20 mg one tablet; Renavite (multivitamin specifically designed for dialysis patients) one tablet; Sodium Chloride (medication used to prevent and treat low levels of sodium) one gram (gm); Polyethylene Glycol (medication used in the management and treatment of constipation) 17 gm, mix with four - eight ounces of water daily.</p> <p>During reconciliation with review of the September 2024 MAR revealed the following orders: Polyethylene Glycol 3350 Powder, give 17 gm by mouth daily at 9:00 am, for constipation. LPN FF was not observed to retrieve the container of Polyethylene Glycol from the medication cart, measure out the prescribed dosage, or mix with the recommended four - eight ounces of water. LPN FF was asked before administering the above prepared medications to R16, if there were any other medications resident was to receive at this time, and LPN FF responded no.</p> <p>Interview on 9/17/2024 at 11:30 am, LPN FF stated that during the preparation of R16's medications, she noticed that there wasn't any Polyethylene Glycol in the cart. During further interview, LPN FF stated that she thought she told the surveyor that she would have to administer the Polyethylene Glycol at a later time, due to the medication not on the med cart.</p> <p>Interview on 9/17/2024 at 5:45 pm, the Director of Nursing (DON) stated that her expectation is that medications are administered to the residents as ordered by the physician. She stated that LPN FF was a new nurse and that this was her first survey, and that she was nervous being observed by the surveyor.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>38988</p> <p>Based on observation, staff interviews, and review of the policy titled Infection Prevention and Control Program, the facility failed to ensure staff one of two nurses observed practiced acceptable infection control practices to prevent possible cross-contamination as evidenced by not performing hand hygiene during medication administration for three of six residents (R) (R5, R3 and R16). The deficient practice had the potential to increase the possibility of cross contamination.</p> <p>Findings include:</p> <p>Review of the undated policy titled, Infection Prevention and Control Program, revealed the Infection Prevention and Control Program includes a system for prevention, identification, investigation, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals. Hand Hygiene: cleanse hands to prevent the spread of potentially deadly infections. Hand Hygiene is the single most important prevention measure healthcare workers can do to prevent infections.</p> <p>Observation on 9/17/2024 at 7:45 am, during morning medication pass, Licensed Practical Nurse (LPN) FF failed to wash her hands or use antibacterial hand rub (ABHR), prior to preparing medications for R5. She retrieved medication Kardex's from medication drawer, punched the meds into a small cup, and replaced the Kardex back in the drawer. She removed a couple of over-the-counter medications from the cart, and placed the prescribed meds into the cup. LPN FF then locked the medication cart, prepared a cup of water for the resident, and proceeded to residents room, to administer the medications. LPN FF exited R5's room without performing hand hygiene prior to leaving the room.</p> <p>Observation on 9/17/2024 at 7:59 am, after returning to the medication cart, LPN FF unlocked the medication cart and logged into the laptop computer to move onto the next resident preparing R3's medication. LPN FF did not wash her hands or use ABHR prior to preparing medications for R3. She locked the med cart and closed laptop and proceeded to R3's room to administer the prepared medications. LPN FF disposed of the medication cup and water glass and exited the room without performing hand hygiene prior to leaving the room.</p> <p>Observation on 9/17/2024 at 8:15 am, LPN FF returned to the medication cart, unlocked the cart and logged into the laptop computer to move onto next resident, preparing medications for R16. LPN FF did not wash her hands or use ABHR prior to preparing medications. She locked the med cart and closed laptop and proceeded to R16's room to administer the prepared medications. LPN FF disposed of the medication cup and water glass and exited the room without performing hand hygiene prior to leaving the room.</p> <p>Interview on 9/17/2024 at 8:30 am, LPN FF was questioned regarding the processes during the administration of medications to residents. She was asked specifically about hand hygiene, and she pointed to a bottle of hand sanitizer on top of the medication cart, and stated that she used the sanitizer after each residents medication administration. Surveyor informed LPN FF that she was followed and observed for three resident medication administrations, and was not observed to perform hand hygiene before or after preparing and administering each resident's medications.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 9/17/2024 at 5:45 pm, the Director of Nursing (DON) stated that staff are expected to use hand sanitizer or wash their hands before and after providing care to a resident. She stated that LPN FF was a new nurse and that this was her first survey, and that she was nervous about being observed by the surveyor.</p>