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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11A186 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/13/2026 |
| NAME OF PROVIDER OR SUPPLIER Georgia Regional Atlanta Ltc | | STREET ADDRESS, CITY, STATE, ZIP CODE 3073 Panthersville Rd, Snf Bldg. #17 Decatur, GA 30034 | |
| 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 0689 Level of Harm - Actual harm Residents Affected - Few | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to follow the plan of care, resulting in an accident for one of nine sampled residents (R)(R1) related to transferring with a mechanical lift. Harm was identified to have occurred on 2/6/2026, when two staff members were transferring the resident with the mechanical lift, and the resident fell, requiring transfer to an acute care hospital. The resident sustained a closed nondisplaced fracture of the sixth cervical vertebra from the fall. It was determined that the resident required three-person assistance with transferring with the mechanical lift. Findings included: A review of the written statement related to the incident that occurred on 2/6/2026 from Certified Nursing Assistant (CNA) TT revealed the following: After she assisted R1 with dressing, they (her and CNA CC) placed the sling underneath him (R1). She stated that they attached the sling to the mechanical lift and began lifting R1 from the bed. Once he was fully lifted, she proceeded to move the [NAME] lift from the bed to the chair. During the transfer from bed to chair, the bottom right hook became detached, and R1 fell out of the sling and onto the floor. A review of the written statement dated 2/6/2026 from CNA AC indicated that R1 was dressed, the sling was placed underneath him, and was attached to the mechanical lift. It was noted that the CNA TT proceeded to lift R1 on the mechanical lift to the chair while (CNA AC) was holding the chair. During the transfer of R1, the bottom right hook became detached, and R1 fell to the floor. A review of the Hospital emergency room After Visit Summary dated 2/6/2026 noted that R1 sustained a closed nondisplaced fracture of the sixth cervical vertebra. The summary further noted that R1 was to wear a C-collar when out of bed and to follow up with outpatient. Inpatient consult to Orthopedic Surgery Reason: GLF: Linear lucency of the C6 spinous process. It was noted that Consult has been discussed with the MD on call, orthopedic spine attending. Diagnosis: 1. Other closed nondisplaced fracture of the sixth cervical vertebra, initial encounter (CMS-HCC). During an interview on 2/12/2026 at 11:45 am with Physical Therapist (PT) FF and Occupational Therapist HH, it was revealed that they do functional training for residents. They revealed that a 24-hour support plan is initiated for all residents and updated as needed. PT FF revealed that R1 has a below-the-knee amputation (BKA) and is unable to transfer himself, so he required manual or mechanical lift with the assistance of three staff members. PT FF revealed that the staff is trained on the 24-hour report, she trains the staff in transferring, and that the staff was trained on how to position themselves during transferring R1. A review of the 24-Hour Support Plan dated 1/13/2026 revealed that R1 required a 3-person manual transfer from bed to wheelchair or a 3-person mechanical lift transfer. A review of the Care Plan dated 12/4/2025 revealed that R1 is a paraplegic with bilateral BKA. Measures goals included that R1 would sustain no injury from a fall through the next review. The Plan of Approach/Interventions included that staff would aid R1 with all transfers; a 3-person assist with all transfers. During an interview on 2/12/2026 at 12:25 pm, the Administrator and Nurse Manager II revealed that two people were transferring R1 from</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: 11A186 | Facility ID: If continuation sheet Page 1 of 2 |

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| F 0689 Level of Harm - Actual harm Residents Affected - Few | his bed to his wheelchair with the mechanical lift, and R1 slipped off his sling, hitting his head and shoulder. She revealed that R1 was sent out to the hospital and returned to the facility the same day with a neck brace. She revealed that R1 sustained a closed nondisplaced fracture of the sixth cervical vertebra from the fall. She revealed that the staff involved in the incident had been employed since May 2025 and had done other transfers with no incidents. She revealed that CNA TT had been reassigned to the Kitchen during the investigation. She revealed that the other CNA (CNA AC) who was assisting during the transfer had resigned. During an interview on 2/13/2026 at 8:45 am, CNA TT revealed that on 2/6/2026, she and CNA AC were preparing to lift R1. She stated that she adjusted the height of the mechanical lift to lift R1, and the pad straps were attached to the lift on each side. She said she did not recheck the strap connection when the lift was readjusted because they were in place correctly. She revealed that while transferring R1 from his bed to his wheelchair, the lower right strap came loose, and R1 fell on the floor. She revealed that she, another CNA, and another Nurse picked the resident up. She confirmed that the resident required three people for transferring, but it was only two of them who transferred the resident. During an interview on 2/13/2026 at 9:30 am, R1 revealed that the staff was transferring him from his bed to his chair when the strap came loose at the bottom, and he fell out. He revealed he was sent to the hospital and was diagnosed with a neck injury, and he has to wear a neck brace while he is up. He revealed that he was being transferred by two CNAs. A review of Lifting and Transferring Individual, 03-911 policy dated 2/12/2026, indicated that mechanical lift transfer is where a mechanical lift is used with a sling to move individuals from one surface to another. The Lifting and Transfer Techniques indicated the following: Staff members engage best practice approaches and lifting and transferring techniques included in training (orientation and annually), including but not limited to, preparing the individual. A review of the Mechanical Lifting Procedure, 03-912 policy revision dated 2/12/2026, indicated that, at a minimum, two staff members are required to operate the mechanical lift. One staff member is responsible for operating the lift, and the second staff member is responsible for guiding and supporting the individual. A third person may be used to support the individual's head/neck if they do not have head control and their head is at risk of falling below the sling level. | | |