STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115411	A. Building B. Wing	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Nursing Center	475 Washington Street Metter, GA 30439

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36584 Based on record reviews, staff and resident interviews, and review of the facility policies Freedom of Abuse, Neglect and Exploitation; Abuse Prevent, Fast Alerts, and Behavior Unit Admission/Discharge Policy, revised August 2021, the facility failed to protect the rights of two of nine residents (R) (R#1 and R#8) reviewed for abuse/neglect. Findings include: 1. A review of the clinical record revealed that R#1 was admitted to the facility on [DATE] and readmitted on [DATE]. R#1 was discharged from the facility on 9/7/22. A review of R#1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating the resident was cognitively intact. Further, she was assessed to require the assistance of two staff members to help her complete her Activities of Daily Living (ADL). A review of the Electronic Medical Record (EMR) revealed that R#1 had multiple co-morbidities with diagnoses of (not an all-inclusive list): Cerebral Vascular Accident (CVA), lymphedema, malignant neoplasm of right breast, chronic kidney disease Stage III, schizoaffective disorder, contracture of her left hand, hemiplegia her on left non-dominant side, diabetes, psychosis, Bipolar II, osteoporosis, Borderline Personality Disorder, peripheral vascular disease, speech/language deficits following the CVA, depression, convulsions, anemia, hypokalemia, hypotension, morbid obesity, anxiety disorder, polyneuropathy, and a history of falls. A review of the care plan last updated 8/25/22 revealed the following areas of care interventions: Verbal/physical/socially inappropriate behaviors, attention seeking, repetitive health complaints, resisting care, easily angered, impatient, fabricates the truth, multiple consensual sexual encounters with male residents, thrives on seeking male attention, history of crying episodes, and manipulative behaviors. A review of the clinical record revealed that R#2 was admitted to the facility on [DATE] and discharged on [DATE] to a behavioral hospital for stabilization. (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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the EMR revealed that R#2 had multiple co-morbidities/diagnoses, and this is not an all-inclusive list: Schizoaffective Disorder Bipolar type, anxiety disorder, dementia with behaviors, diabetes, hypertension, hypothyroidism, anemia, and Alzheimer's Disease. A review of R#2's Quarterly MDS assessment dated [DATE] revealed that the resident had a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Further, she was assessed to require over-sight and supervision from staff members to complete Activities of Daily Living (ADL). She was also coded as having behaviors directed towards others, hitting scratching and rummaging are coded as daily occurring. A review of the care plan last updated 8/25/22 (this is not an all-inclusive list): risk of elopement, behaviors taking items that don't belong to her, claims they were a gift, hoarding. Voodoo items in room, physically aggressive (for 9/6/22 resident to resident altercation was care planned), falls, nutrition, sexual behaviors, housed on the secure unit related to her behaviors, mental health services provided, cognition, pain, cardiac concerns, diabetes, risk for adverse effects from medications, self-care deficit, verbally aggressive, and verbal outbursts. A review of the electronic progress notes for R#1 dated 9/6/22, noted the following: Staff entered R#1's room to find bruising and a laceration to her head and neck area with blood on her face and sheets. R#1 stated that she had been awakened by R#2 coming into her room and punching her in the face. Resident #1 was sent to the hospital for evaluation and treatment and R#2 was placed on 1:1 with a staff member until she was transferred out of the facility for behavioral management. When R#1 returned on 9/7/22 she was given a room that was not on the locked unit. During an interview with the Administrator on 9/9/22 at 11:44 a.m., she stated she was looking into increasing the staffing on that secured unit but that the investigation was not complete related to the resident-to-resident altercation of R#1 and R#2 and that the Interdisciplinary Team (IDT) was meeting to discuss the appropriateness of the placement of each individual resident in the locked secured unit. The Administrator stated that at each care plan the IDT discusses the appropriateness of the resident being placed on the secured unit, based on the facility policy, Behavior Unit Admission/Discharge Policy. 2. A review of the clinical record revealed that R#8 was admitted to the facility on [DATE] with diagnoses of (this is not an all-inclusive list): atrial fibrillation, traumatic brain injury, Alzheimer's Disease, repeated falls, venous insufficiency peripheral, depression, obesity, and seizures. A review of the Quarterly MDS assessment dated [DATE] revealed that he was coded for delusions and daily behaviors no directed toward others. The assessment revealed that R#8 had a BIMS of out nine of 15, indicating moderate impairment. He was also assessed and coded for requiring assistance of one staff member to assist him to complete his Activities of Daily Living (ADL). A review of the facility document dated 7/29/22, revealed that on 7/29/22 Licensed Practical Nurse (LPN) GG, approached R#8 to help him up off the floor and that the resident began swinging and kicking at her. Nurse GG was witnessed by another staff member to kick R#8 in the torso, head, and neck. Nurse GG was escorted out of the facility, pictures taken of R#8, a police report made as well as the physician, Responsible Party and the Behavioral Services provider were notified. The nurse was suspended until the investigation was over then terminated. The resident stated he had no pain/injury after the assessment was completed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In review of the policy, Freedom of Abuse, Neglect and Exploitation; Abuse Prevent, Fast Alerts, under Staff to Resident Abuse it states the facility is responsible for the actions of its employees, including intentional acts of employees who are aware they are doing wrong and are in conflict with the facility's policies and procedures. This policy also states, Staff members are expected to be in control of their own behavior and understand how to work with the nursing home population. During an interview with the Administrator on 9/16/22 at 1:50 p.m., she stated that the LPN GG, was hired prior to her employment at the facility. She further stated that the current Director of Nursing (DON) and Human Resources (HR) FF was also not employed at the facility at the time that LPN GG was hired. She indicated that the previous Administrator HH, had reported this nurse to the nurse licensing board on 7/30/22.