

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	

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 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 21213</p> <p>Based on observation, interview, review of the facility policy titled Nutrition and Weight Management Standard, and record review, the facility failed to ensure that nutritional interventions were implemented as care planned for four residents (R#6, R#12, R#13, and R#14) and surgical wound treatments were provided as care planned for one resident (R#5), from a total sample of 17 residents.</p> <p>On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator and Director of Nursing (DON) LL were informed of the Immediate Jeopardy (IJ) on [DATE] at 1:55 p.m. The noncompliance related to the first IJ was identified to have existed on [DATE]. The noncompliance related to the second IJ was identified to have existed on [DATE].</p> <p>1.) The first IJ is outlined as follows:</p> <p>Resident (R) #5 was admitted to the facility on [DATE] and required bilateral below the knee amputations (BKA's) due to severe peripheral artery disease (PAD) with occlusion on [DATE]. Upon return from hospitalization status post bilateral BKA's on [DATE], the facility failed to clarify/obtain treatment orders for the surgical wounds. R#5 was diagnosed on [DATE] at the hospital emergency room with a wound infection to the left BKA. R#5 underwent a revision to the left BKA on [DATE] and returned to the facility the same day. The facility again failed to clarify/obtain treatment orders on return from the hospital on [DATE]. There was no evidence of wound care being provided from [DATE] through [DATE]. In addition, the left BKA revision site was not accurately assessed by nursing staff on hospital return and a scheduled follow up appointment with the surgeon was not kept on [DATE]. The resident expired at the facility on [DATE]. The death certificate listed diabetes as the cause of death.</p> <p>2.) The second IJ is outlined as follows:</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
-----------------------------------------------------------------------	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>R#10, a [AGE] year-old resident with a diagnosis of cerebral palsy was dependent on staff and received all nutrition and hydration through a gastrostomy tube (g-tube). Weights for R#10 trended down from 89 pounds on [DATE] to 83 pounds on [DATE], despite repeated increases of bolus g-tube nutritional supplement formula. The last increase was on [DATE]. There was no evidence that a documented plan from the Nurse Practitioner (NP) on [DATE] for a follow-up weight and Registered Dietician (RD) evaluation in two weeks was followed. However, a nutritional assessment was completed on [DATE] when the RD acknowledged that there was no [DATE] weight but indicated that the ordered nutritional supplement formula and water flushes met the resident's needs. Despite R#10's downtrend of weight, even with incremental increases in the nutritional supplement formula, no weight was obtained, to continue to monitor his progress, after [DATE], until [DATE]. On [DATE], a weight of 75.8 pounds was documented. There is no acknowledgement of the [DATE] weight of 75.8 pounds, which reflects actual, further significant weight loss. On [DATE] there was a physician's order for biweekly weights (between ,d+[DATE] and [DATE]), and if weight decreased, resume continuous nutritional supplement feedings via g-tube. However, no weights were obtained between [DATE] through [DATE], except when surveyor inquired on [DATE].</p> <p>In addition, during an observation on [DATE] at 3:30 p.m., Licensed Practical Nurse (LPN) BB administered the incorrect amount of bolus g-tube formula to R#10 (administered 237 milliliters instead of 320 milliliters). Review of the Medication Administration Records (MAR) revealed no evidence that the physician ordered bolus nutritional supplement formula was administered as scheduled for 28 times in [DATE] and 27 times in [DATE].</p> <p>There was also repeated, systemic failure to implement pertinent interventions to address weight loss and/or nutrition and hydration risk for five residents (R#6, R#8, R#12, R#13, and R#14). R#6 and R#8 received nutrition and hydration via gastrostomy tube. R#12, R#13 and R#14 received nutrition and hydration orally.</p> <p>There was also evidence of a systemic failure related to dietary services to ensure that there was an adequate number of dietary staff and that the dietary staff had the skill set to carry out the functions of the food and nutrition services in the facility. Dietary staff failed to follow menus and individualized food plans for correct portion size to ensure residents' nutritional needs were met. R#12 and R#14 were to receive double portions of food because they were nutritionally compromised. By not receiving double portions, they were put at risk for further weight loss and/or poor nutritional status.</p> <p>The Immediate Jeopardies were related to the facility's noncompliance with the requirements at</p> <p>42 C.F.R. 483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656, Scope/Severity: K); 42 C.F.R. 483.21(b) Comprehensive Care Plans (F657, Scope/Severity: K); 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); 42 C.F.R. 483.25(g)(1)(2) Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K); 42 C.F.R. 483.60(a)(3) Sufficient Dietary Support Personnel (F802, Scope/Severity: K); 42 C.F.R. 483.60(c),(d+[DATE]), Menus and Nutritional Adequacy (F803, Scope/Severity: K); 42 C.F.R. 483.70 Administration (F835, Scope/Severity: K); 42 C.F.R. 483.70(d) Governing body (F837, Scope/Severity: K); 42 C.F.R. 483.75(g)(2) QAPI/QAA Improvement Activities (F867, Scope/Severity: K).</p> <p>Additionally. Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); and 42 C.F.R. 483.25(g)(1)(2), Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>At the time of exit on [DATE], the IJ remained ongoing.</p> <p>Findings include:</p> <p>Per the facility Policy and Procedure titled Nutrition and Weight Management Standard, weekly weights should be done on the following residents: Residents who have a 5% weight loss in 30 days, Residents who have a 7.5% weight loss in 90 days and residents who have a 10% weight loss in 180 days.</p> <p>1. Resident #6 was admitted to the facility on [DATE] and had diagnoses that included basal ganglia bleed, tracheostomy and gastrostomy tube placement, respiratory failure, dysphagia, left hemiparesis, Lupus, Cerebrovascular Accident (CVA), seizures and chronic kidney disease (CKD). Further review of the clinical record revealed that R#6 was dependent on nursing staff for nutrition and hydration via her gastrostomy tube.</p> <p>A care plan, dated [DATE], was developed that included R#6 required nutrition via a gastrostomy tube related to dysphagia. The care plan included an intervention for nursing staff to obtain weights as indicated. A review of physician's orders revealed an order since [DATE] for weights monthly. However, there was no evidence that a weight was obtained as ordered and care planned for [DATE].</p> <p>Review of the clinical record revealed an [DATE] Dietary Progress Note, from the RD, that identified a significant weight loss and possible incorrect weights for [DATE] and [DATE]. The dietary note documented an [DATE] weight of 161.3 pounds and an [DATE] weight of 185.2 pounds. With the 161.3-pound weight, that was a significant weight loss of 23.9 pounds in 90 days (12.9%). On [DATE], the RD recommended changing the gastrostomy tube nutritional supplement formula from Glucerna 1.2 at 45 ml per hour for 24 hours to Glucerna 1.5 at 45 ml per hour for 22 hours. There is no evidence that the [DATE] RD recommendation was acted on or the weight discrepancy addressed.</p> <p>On [DATE], in a Dietary Progress Note, the RD documents that there is no [DATE] weight and documented the same concerns from her [DATE] dietary note, and again recommended to change the gastrostomy tube nutritional supplement formula order to address the weight loss. However, there is no evidence the [DATE] RD recommendations were acted on until [DATE], after further weight loss. A weight obtained on [DATE] documented a further weight loss from 161.5 pounds on [DATE] to 154.6 pounds, a further loss of 6.9 pounds.</p> <p>During an interview on [DATE] at 3:00 p.m. R#6's physician confirmed that he would expect the RD recommendations to be acted on by nursing staff and provided to him or the NP to review.</p> <p>Cross reference to F692</p> <p>2. Resident #14 resided at the facility since [DATE] and had diagnoses that included dementia with behavior disturbance, protein-calorie malnutrition, dysphagia, macular degeneration, osteoarthritis, ataxic gait, cognitive communication deficit, hypertension, iron deficiency anemia, generalized anxiety disorder, and constipation.</p> <p>There was a care plan in place that R#14 had the potential for a nutritional problem. The care plan problem included that he was at risk for weight loss, had cognitive and communication impairments, was on a therapeutic diet, and required assistance with meals. The care plan included interventions for staff to provide and serve his diet as ordered and weights per policy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>However, R#14 was not served the correct diet for two lunch meals on [DATE] and [DATE] and a monthly weight was not obtained for [DATE] as ordered and care planned.</p> <p>R#14 had a diet order since [DATE] that included a no added salt, mechanical soft texture, double portion, ground meat diet. However, during an observation on [DATE] at 12:20 p.m. R#14 was observed with a lunch tray with single portions of beef stew, peppers and onions, cooked carrots, a roll, and orange cream ice cream cup. During the observation, Certified Nursing Assistant (CNA) PP stated that she usually assists R#14 to eat and that he usually eats everything. During a subsequent interview on [DATE] at 12:05 p.m. CNA PP stated that R#14 ate 85% of his lunch meal on [DATE].</p> <p>During an observation on [DATE] at 12:30 p.m. R#14 was again observed to have been served a lunch tray with only single portions of ground chicken, mixed vegetables, a biscuit, rice with gravy, apple crisp, and an orange cream ice cream cup.</p> <p>A review of monthly weights in the clinical record since [DATE] revealed weights of 121.2 pounds on [DATE], 119 pounds on [DATE], and 119 pounds on [DATE]. An additional weight obtained on [DATE], after surveyor inquiry, reflected a further weight loss to 115.6 pounds.</p> <p>A review R#14's physician's orders revealed an order since [DATE] for weights to be obtained monthly. However, a further review of the clinical record revealed no weights were obtained for [DATE] as ordered and care planned.</p> <p>Cross reference to F692</p> <p>15650</p> <p>3. Resident #12 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, unspecified protein-calorie malnutrition, chronic kidney disease, dysphagia, major depressive disorder with recurrent severe psychotic symptoms, heart failure, diabetes, anxiety and adult failure to thrive.</p> <p>The resident had a care plan since [DATE] for at risk for weight loss; history of dysphagia, requires assist with meals, on pureed diet, double portions for lunch and supper with the following interventions: double portions with lunch and supper, supplements as ordered and weights per facility protocol. The care plan was revised on [DATE] to reflect an actual weight loss and as having a history of protein malnutrition with interventions for diet with double portions as ordered, supplement as ordered, and weights as indicated.</p> <p>The resident had a physician's order since [DATE] for regular concentrated sweets diet, pureed texture with double portions for lunch and supper.</p> <p>However, during observations of the lunch meal on [DATE] at 12:26 p.m., and [DATE] at 1:00 p.m., the resident was not served double portions. Observation of the diet card that was on the resident's lunch tray revealed the portion size was specified as double portion.</p> <p>Refer to F692.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>4. Resident #13 was admitted to the facility on [DATE] with diagnoses including anemia, dysphagia, Gastroesophageal Reflux Disease (GERD), major depressive disorder, unspecified dementia with behavioral disturbance, abnormal posture, generalized anxiety disorder, osteoarthritis, and psychotic disorder.</p> <p>The resident had a care plan since [DATE] for at risk for weight loss with an intervention to weigh per physician orders or facility protocol.</p> <p>Review of the weight record for R#13 revealed the following:</p> <p>The resident had a 16.2% weight loss in one month from 101 pounds on [DATE] to 84.6 pounds on [DATE], a 17.9% weight loss in three months from 103 pounds on [DATE] to 84.6 pounds on [DATE], and a 16.1% weight loss from 103 pounds on [DATE] to 86.4 pounds on [DATE].</p> <p>The Registered Dietician evaluated the resident on [DATE] and noted a weight loss of 16.4 pounds x 30 days (16.2% loss) and a weight loss of 18.4 pounds x 90 days (17.9% severe weight loss). She further noted a BMI of 14.5 (underweight).</p> <p>On [DATE] the RD evaluated the resident and noted weights for [DATE] as 86.2 pounds and [DATE] as 84.6 pounds with a BMI of 14.8 (underweight) with a 16.3% weight loss in 180 days.</p> <p>Per review of the Weight record, there was no evidence the weights were checked every week consistently despite the resident having a significant weight loss.</p> <p>The resident's weights were only obtained once in [DATE], twice in [DATE], once in [DATE], there were no weights in September and twice in [DATE].</p> <p>Refer to F692.</p> <p>5. Resident #5 was admitted to the facility on [DATE] with diagnoses including orthopedic aftercare, peripheral vascular disease, dementia without behavioral disturbance, nondisplaced fracture base of neck of femur, muscle weakness, chronic kidney disease stage 3, cognitive communication deficit, hypertension and peripheral artery disease.</p> <p>The resident was also admitted with bilateral deep tissue injuries (DTI) to both heels that continued to deteriorate requiring bilateral below the knee amputations (BKA) due to severe peripheral artery disease on [DATE]. On [DATE] the resident returned from the hospital with discharge instructions for wound care of amputation sites. However, there were no specific wound care instructions/orders and there was no evidence staff called the physician to clarify the wound care instructions until [DATE] after a follow up appointment with the surgeon on that day.</p> <p>The resident had a [DATE] care plan for surgical wound to bilateral legs status post bilateral below knee amputation with an intervention for treatment as ordered.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On [DATE] a physician's order was obtained to clean the left and right BKA sites with wound cleanser, apply Aquacel Ag Advantage and cover with dry dressing every other day. However, review of the [DATE] and [DATE] Treatment Administration Record (TAR) revealed there was no documentation treatment had been completed to the bilateral BKA's from [DATE] until [DATE] when the order was changed to clean the left and right below knee amputation sites with wound cleanser, apply Calcium Alginate AG and cover with dry dressing every other day. Review of the [DATE] TAR indicated the wound care was only completed five of 14 scheduled times.</p> <p>Refer to F684.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0657</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213</p> <p>Based on interview and record review, the facility failed to ensure that care plans were revised to address significant weight loss for two residents (R#6 and R#8) from a total sample of 17 residents.</p> <p>On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator and Director of Nursing (DON) LL were informed of the Immediate Jeopardy (IJ) on [DATE] at 1:55 p.m. The noncompliance related to the first IJ was identified to have existed on [DATE]. The noncompliance related to the second IJ was identified to have existed on [DATE].</p> <p>1.) The first IJ is outlined as follows:</p> <p>Resident (R) #5 was admitted to the facility on [DATE] and required bilateral below the knee amputations (BKA's) due to severe peripheral artery disease (PAD) with occlusion on [DATE]. Upon return from hospitalization status post bilateral BKA's on [DATE], the facility failed to clarify/obtain treatment orders for the surgical wounds. R#5 was diagnosed on [DATE] at the hospital emergency room with a wound infection to the left BKA. R#5 underwent a revision to the left BKA on [DATE] and returned to the facility the same day. The facility again failed to clarify/obtain treatment orders on return from the hospital on [DATE]. There was no evidence of wound care being provided from [DATE] through [DATE]. In addition, the left BKA revision site was not accurately assessed by nursing staff on hospital return and a scheduled follow up appointment with the surgeon was not kept on [DATE]. The resident expired at the facility on [DATE]. The death certificate listed diabetes as the cause of death.</p> <p>2.) The second IJ is outlined as follows:</p> <p>R#10, a [AGE] year-old resident with a diagnosis of cerebral palsy was dependent on staff and received all nutrition and hydration through a gastrostomy tube (g-tube). Weights for R#10 trended down from 89 pounds on [DATE] to 83 pounds on [DATE], despite repeated increases of bolus g-tube nutritional supplement formula. The last increase was on [DATE]. There was no evidence that a documented plan from the Nurse Practitioner (NP) on [DATE] for a follow-up weight and Registered Dietician (RD) evaluation in two weeks was followed. However, a nutritional assessment was completed on [DATE] when the RD acknowledged that there was no [DATE] weight but indicated that the ordered nutritional supplement formula and water flushes met the resident's needs. Despite R#10's downtrend of weight, even with incremental increases in the nutritional supplement formula, no weight was obtained, to continue to monitor his progress, after [DATE], until [DATE]. On [DATE], a weight of 75.8 pounds was documented. There is no acknowledgement of the [DATE] weight of 75.8 pounds, which reflects actual, further significant weight loss. On [DATE] there was a physician's order for biweekly weights (between ,d+[DATE] and [DATE]), and if weight decreased, resume continuous nutritional supplement feedings via g-tube. However, no weights were obtained between [DATE] through [DATE], except when surveyor inquired on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0657</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In addition, during an observation on [DATE] at 3:30 p.m., Licensed Practical Nurse (LPN) BB administered the incorrect amount of bolus g-tube formula to R#10 (administered 237 milliliters instead of 320 milliliters). Review of the Medication Administration Records (MAR) revealed no evidence that the physician ordered bolus nutritional supplement formula was administered as scheduled for 28 times in [DATE] and 27 times in [DATE].</p> <p>There was also repeated, systemic failure to implement pertinent interventions to address weight loss and/or nutrition and hydration risk for five residents (R#6, R#8, R#12, R#13, and R#14). R#6 and R#8 received nutrition and hydration via gastrostomy tube. R#12, R#13 and R#14 received nutrition and hydration orally.</p> <p>There was also evidence of a systemic failure related to dietary services to ensure that there was an adequate number of dietary staff and that the dietary staff had the skill set to carry out the functions of the food and nutrition services in the facility. Dietary staff failed to follow menus and individualized food plans for correct portion size to ensure residents' nutritional needs were met. R#12 and R#14 were to receive double portions of food because they were nutritionally compromised. By not receiving double portions, they were put at risk for further weight loss and/or poor nutritional status.</p> <p>The Immediate Jeopardies were related to the facility's noncompliance with the requirements at</p> <p>42 C.F.R. 483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656, Scope/Severity: K); 42 C.F.R. 483.21(b) Comprehensive Care Plans (F657, Scope/Severity: K); 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); 42 C.F.R. 483.25(g)(1)(2) Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K); 42 C.F.R. 483.60(a)(3) Sufficient Dietary Support Personnel (F802, Scope/Severity: K); 42 C.F.R. 483.60(c),(d+[DATE]), Menus and Nutritional Adequacy (F803, Scope/Severity: K); 42 C.F.R. 483.70 Administration (F835, Scope/Severity: K); 42 C.F.R. 483.70(d) Governing body (F837, Scope/Severity: K); 42 C.F.R. 483.75(g)(2) QAPI/QAA Improvement Activities (F867, Scope/Severity: K).</p> <p>Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); and 42 C.F.R. 483.25(g)(1)(2), Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K).</p> <p>At the time of exit on [DATE], the IJ remained ongoing.</p> <p>Findings include:</p> <p>1. Resident #6 was admitted to the facility on [DATE] and had diagnoses that included basal ganglia bleed, tracheostomy and gastrostomy tube placement, respiratory failure, dysphagia, left hemiparesis, Lupus, Cerebrovascular Accident (CVA), seizures and chronic kidney disease (CKD). Further review of the clinical record revealed that R#6 was dependent on nursing staff for nutrition and hydration via her gastrostomy tube.</p> <p>Quarterly Minimum Data Set (MDS) assessments, dated [DATE] and [DATE] were completed by nursing staff. The assessments both documented no significant weight loss of 5% or more in a month or 10% or more in six months. A significant weight loss was identified between the two MDS assessments in an [DATE] RD assessment. However, the comprehensive care plan was not revised to include R#6's significant weight loss.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0657</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the clinical record revealed an [DATE] Dietary Progress Note, from the RD, that identified a significant weight loss and possible incorrect weight from [DATE] and [DATE]. The dietary note documented an [DATE] weight of 161.3 pounds and an [DATE] weight of 185.2 pounds. With the 161.3-pound weight, that was a significant weight loss of 23.9 pounds in 90 days (12.9%). The RD recommended changing the gastrostomy tube nutritional supplement formula from Glucerna 1.2 at 45 ml per hour for 24 hours to Glucerna 1.5 at 45 ml per hour for 22 hours.</p> <p>On [DATE], in a Dietary Progress Note, the RD documents that there is no [DATE] weight and documented the same concerns from her [DATE] dietary note, and again recommended to change the gastrostomy tube nutritional supplement formula order to address the weight loss.</p> <p>A weight obtained on [DATE] documented a further weight loss from 161.5 pounds on [DATE] to 154.6 pounds, a further loss of 6.9 pounds.</p> <p>2. Resident #8 was admitted to the facility on [DATE] and had diagnoses that included history of respiratory failure, pneumonia, dysphagia, encephalopathy, cerebral infarction, atherosclerotic heart disease, hypertension, heart failure, gastroesophageal reflux disease, anemia, contractures, hemiplegia affecting left non-dominant side, protein-calorie malnutrition, diabetes, and aphasia. A review of the clinical record revealed that R#8 received all nutrition and hydration via gastrostomy tube.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated [DATE] and an Annual MDS assessment, dated [DATE] were completed by nursing staff. The assessments both documented a significant weight loss of 5% or more in a month or 10% or more in six months. However, the comprehensive care plan was not revised to include R#8's significant weight loss.</p> <p>The Registered Dietician assessed R#8 on [DATE] and documented in a Dietary Progress Note that he triggered for a severe weight loss. His BMI at 136.6 pounds was 18.5 (normal). The notes included the weight fluctuation from 148 pounds on [DATE] to 165 pounds on [DATE] to 136.6 pounds on [DATE]. The RD recommended weekly weights for four weeks to determine accurate weight.</p> <p>The NP documented weight loss on [DATE] and included a plan to continue the current gastrostomy tube feedings and water flushes and weights weekly. The RD assessed R#8 again on [DATE] and documented, in a Dietary Progress Note, a [DATE] weight of 134.2 pounds and calculated the BMI at 18.2 (now underweight) and 11.1% weight loss in 180 days. The RD recommended increasing the gastrostomy tube nutritional supplement formula from Osmolite 60 ml per hour to 70 ml per hour. Further review of the clinical record revealed that the RD recommendation to increase the Osmolite was ordered on [DATE].</p> <p>Additional weights obtained for [DATE] and [DATE]: ,d+[DATE] (134#), ,d+[DATE] (135.8), ,d+[DATE] (135.8), ,d+[DATE] (135.9), and ,d+[DATE] (135.9) indicated R#8 remained within an underweight BMI of 18.4 (based off the [DATE] weight of 135.9#).</p> <p>During an interview on [DATE] at 10:25 a.m. DON LL (as of [DATE]) stated that the facility's weight system was broken; the facility needed systems and education.</p> <p>Cross reference to F692</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 15650</p> <p>Based on record review, review of the facility policy titled Skin Management Standard, and staff interviews, the facility failed to clarify and obtain treatment orders after one resident (R) (#5) had a bilateral below knee amputation (BKA), failed to provide treatment to the BKA, failed to accurately assess R#5's surgical wound with a drain and failed to ensure the resident went to a scheduled follow-up appointment with the surgeon from a sample of two residents with surgical wounds.</p> <p>On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator and Director of Nursing (DON) LL were informed of the Immediate Jeopardy (IJ) on [DATE] at 1:55 p.m. The noncompliance related to the first IJ was identified to have existed on [DATE]. The noncompliance related to the second IJ was identified to have existed on [DATE].</p> <p>1.) The first IJ is outlined as follows:</p> <p>Resident (R) #5 was admitted to the facility on [DATE] and required bilateral below the knee amputations (BKA's) due to severe peripheral artery disease (PAD) with occlusion on [DATE]. Upon return from hospitalization status post bilateral BKA's on [DATE], the facility failed to clarify/obtain treatment orders for the surgical wounds. R#5 was diagnosed on [DATE] at the hospital emergency room with a wound infection to the left BKA. R#5 underwent a revision to the left BKA on [DATE] and returned to the facility the same day. The facility again failed to clarify/obtain treatment orders on return from the hospital on [DATE]. There was no evidence of wound care being provided from [DATE] through [DATE]. In addition, the left BKA revision site was not accurately assessed by nursing staff on hospital return and a scheduled follow up appointment with the surgeon was not kept on [DATE]. The resident expired at the facility on [DATE]. The death certificate listed diabetes as the cause of death.</p> <p>2.) The second IJ is outlined as follows:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R#10, a [AGE] year-old resident with a diagnosis of cerebral palsy was dependent on staff and received all nutrition and hydration through a gastrostomy tube (g-tube). Weights for R#10 trended down from 89 pounds on [DATE] to 83 pounds on [DATE], despite repeated increases of bolus g-tube nutritional supplement formula. The last increase was on [DATE]. There was no evidence that a documented plan from the Nurse Practitioner (NP) on [DATE] for a follow-up weight and Registered Dietician (RD) evaluation in two weeks was followed. However, a nutritional assessment was completed on [DATE] when the RD acknowledged that there was no [DATE] weight but indicated that the ordered nutritional supplement formula and water flushes met the resident's needs. Despite R#10's downtrend of weight, even with incremental increases in the nutritional supplement formula, no weight was obtained, to continue to monitor his progress, after [DATE], until [DATE]. On [DATE], a weight of 75.8 pounds was documented. There is no acknowledgement of the [DATE] weight of 75.8 pounds, which reflects actual, further significant weight loss. On [DATE] there was a physician's order for biweekly weights (between ,d+[DATE] and [DATE]), and if weight decreased, resume continuous nutritional supplement feedings via g-tube. However, no weights were obtained between [DATE] through [DATE], except when surveyor inquired on [DATE].</p> <p>In addition, during an observation on [DATE] at 3:30 p.m., Licensed Practical Nurse (LPN) BB administered the incorrect amount of bolus g-tube formula to R#10 (administered 237 milliliters instead of 320 milliliters). Review of the Medication Administration Records (MAR) revealed no evidence that the physician ordered bolus nutritional supplement formula was administered as scheduled for 28 times in [DATE] and 27 times in [DATE].</p> <p>There was also repeated, systemic failure to implement pertinent interventions to address weight loss and/or nutrition and hydration risk for five residents (R#6, R#8, R#12, R#13, and R#14). R#6 and R#8 received nutrition and hydration via gastrostomy tube. R#12, R#13 and R#14 received nutrition and hydration orally.</p> <p>There was also evidence of a systemic failure related to dietary services to ensure that there was an adequate number of dietary staff and that the dietary staff had the skill set to carry out the functions of the food and nutrition services in the facility. Dietary staff failed to follow menus and individualized food plans for correct portion size to ensure residents' nutritional needs were met. R#12 and R#14 were to receive double portions of food because they were nutritionally compromised. By not receiving double portions, they were put at risk for further weight loss and/or poor nutritional status.</p> <p>The Immediate Jeopardies were related to the facility's noncompliance with the requirements at</p> <p>42 C.F.R. 483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656, Scope/Severity: K); 42 C.F.R. 483.21(b) Comprehensive Care Plans (F657, Scope/Severity: K); 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); 42 C.F.R. 483.25(g)(1)(2) Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K); 42 C.F.R. 483.60(a)(3) Sufficient Dietary Support Personnel (F802, Scope/Severity: K); 42 C.F.R. 483.60(c),(d+[DATE]), Menus and Nutritional Adequacy (F803, Scope/Severity: K); 42 C.F.R. 483.70 Administration (F835, Scope/Severity: K); 42 C.F.R. 483.70(d) Governing body (F837, Scope/Severity: K); 42 C.F.R. 483.75(g)(2) QAPI/QAA Improvement Activities (F867, Scope/Severity: K).</p> <p>Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); and 42 C.F.R. 483.25(g)(1)(2), Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>At the time of exit on [DATE], the IJ remained ongoing.</p> <p>Findings include:</p> <p>Review of an undated policy titled Skin Management Standard noted a section titled Intact Surgical Wounds had the following protocol:</p> <ol style="list-style-type: none"> 1. Clean with approved wound cleanser. 2. Apply dressing per physician order. 3. Change dressing as directed by physician. 4. Sites left uncovered per physician order should be monitored daily until healed. <p>Review of the clinical record revealed R#5 was admitted to the facility on [DATE] with diagnoses including orthopedic aftercare, peripheral vascular disease, dementia without behavioral disturbance, nondisplaced fracture base of neck of femur, muscle weakness, chronic kidney disease stage 3, cognitive communication deficit, hypertension and peripheral artery disease.</p> <p>The resident was also admitted with bilateral deep tissue injuries (DTI) to both heels that continued to deteriorate requiring bilateral below the knee amputations (BKA) due to severe peripheral artery disease on [DATE]. On [DATE] the resident returned from the hospital with discharge instructions for wound care of amputation sites. However, there were no specific wound care instructions/orders and there was no evidence staff called the physician to clarify the wound care instructions until [DATE] after a follow up appointment with the surgeon on that day.</p> <p>The [DATE] Surgeon Progress Note documented the left BKA stump had central wound dehiscence and exposed bone with a revision of the left stump scheduled for [DATE]. On [DATE] a physician's order was obtained to clean the left and right BKA sites with wound cleanser, apply Aquacel Ag Advantage and cover with dry dressing every other day. However, review of the [DATE] and [DATE] Treatment Administration Record (TAR) revealed there was no documentation treatment had been completed to the bilateral BKA's from [DATE] to [DATE] when the order was changed to clean the left and right below knee amputation sites with wound cleanser, apply Calcium Alginate AG and cover with dry dressing every other day. Review of the [DATE] TAR indicated the wound care was only completed five of 14 scheduled times.</p> <p>The [DATE] Nursing Progress Note documented treatments completed, left stump noted to be macerated with thick greenish yellow discharge, bone protruding and had a foul odor. The note further indicated the nurse was sending the resident to the emergency room for evaluation per nursing judgment.</p> <p>Review of the [DATE] Emergency Department Note revealed an infection of the left BKA stump with purulent drainage from the BKA wound. The resident was treated with an intravenous antibiotic while in the emergency room and was sent back to the facility with a prescription for an oral antibiotic, Bactrim DS 800 milligrams/160 milligrams twice a day for seven days.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R#5 had surgery to the left stump as scheduled. Review of the [DATE] Operative Report revealed a Pre-Op diagnosis of necrotic left BKA stump with the procedure being a revision of left BKA stump. The Operative Note also indicated the surgeon closed the wound using sutures and staples over a Penrose drain.</p> <p>The resident was discharged back to the facility the same day on [DATE] with discharge instructions to follow up at the surgeon's office on [DATE] at 3:10 p.m. Further review of the discharge instructions revealed there were no wound care instructions for how to care for the operative site nor did it include instructions for the care of the Penrose drain. There was no evidence staff called the physician or the hospital to clarify or obtain wound care orders for the surgical site or for the Penrose drain. There was also no evidence the resident went to the follow up appointment scheduled for [DATE].</p> <p>During an interview with the Registered Nurse at the surgeon's office on [DATE] at 2:15 p.m., she confirmed the resident never showed up for the follow up appointment on [DATE] at 3:10 p.m. She also stated that the Operative note stated a Penrose drain was in place and patients usually have a follow-up appointment ten to fourteen days later to remove the drain.</p> <p>During an interview with Treatment Nurse HH on [DATE] at 12:30 p.m., she stated the resident did not have a Penrose drain when she returned from the hospital on [DATE]. She stated the resident had retention straps under the suture line. She described the retention straps as looking like an electrical cord that was off-white in color, the length of the suture line. This would also fit the description of a drain.</p> <p>During an interview with Licensed Practical Nurse BB on [DATE] at 11:00 a.m., she stated when the resident returned from surgery on [DATE], the resident's stump was wrapped with bandages and she did not remove them. She stated on the days she did wound care to the stump, there was not a drain in place, only a retention strap.</p> <p>During an interview with Director of Nursing LL on [DATE] at 3:45 p.m., she stated she would expect the staff to call the physician to clarify the discharge instructions for surgical wound to the amputation sites when the resident returned from the hospital on [DATE] and [DATE]. She stated she talked to the Registered Nurse at the surgeon's office today who told her she spoke to the surgeon's Physician's Assistant who said the resident did have drains in place on [DATE] and would have continued treatment with Aquacel AG three times a week.</p> <p>During a subsequent interview with Director of Nursing LL on [DATE] at 10:45 a.m., she stated that she questioned if Treatment Nurse HH thought the drain was retention straps and really did not know what drains looked like.</p> <p>The [DATE] Wound/Skin Note documented the left BKA had 15 staples with a retention strap in place. Review of the clinical record revealed no documentation that specified a drain in the left BKA.</p> <p>The [DATE] Wound Note indicated the left BKA remained dry with 15 staples intact with retention strap, scant amount of serosanguinous drainage, no odor, warmth, swelling or redness. It further noted there was moderate amount of pain associated with surgical site.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The [DATE] Wound Note documented the left BKA presents with mushy feeling and some serosanguinous drainage. No odor, warmth or swelling. Remains with retention strap in place, painful during wound care. Doctor's office called and appointment for [DATE] scheduled.</p> <p>The resident expired on [DATE].</p> <p>The Death Certificate noted the immediate cause of death as diabetes.</p> <p>During an interview with the Medical Director on [DATE] at 3:10 p.m., he stated when the resident returned from the hospital on [DATE] with no specific orders for treatment to the bilateral BKA's, he would expect the wound nurse to get involved. He stated they could call a doctor and get orders for treatment. He stated a fresh stump would especially need daily dressing changes. Although the Medical Director would not specify if not doing treatments to the bilateral BKA's would have caused infection or a further decline to the left BKA, he stated not doing treatments would certainly not help prevent infection. After the Medical Director read the [DATE] Operative Report, he stated a drain would need some attention and monitoring and he would expect the staff to call for treatment orders. He stated he was not sure about a retention strap in place but stated retention sutures could be used to keep the suture line intact. He stated the retention sutures used at this hospital were orange in color. The Medical Director then showed the surveyor a picture of retention sutures that were going across a suture line, not parallel as described by Treatment Nurse HH. He stated normally a drain would stay in place about a week.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213</p> <p>Based on observation, interview, record review and review of facility policy titled Nutrition and Weight Management Standard, the facility failed to ensure that significant weight loss was addressed timely for three residents (R) (R#6, R#10, and R#13), failed to act on Registered Dietician (RD) recommendations for five residents (R#6, R#8, R#12, R#13, and R#14), failed to ensure one resident received adequate hydration (R#6), failed to ensure that one resident received the physician ordered amount of nutritional supplement formula via gastrostomy tube (R#10), and failed to ensure that two residents (R#12 and R#14) received the correct food portions at meals from a total sample of 17 residents.</p> <p>On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator and Director of Nursing (DON) LL were informed of the Immediate Jeopardy (IJ) on [DATE] at 1:55 p.m. The noncompliance related to the first IJ was identified to have existed on [DATE]. The noncompliance related to the second IJ was identified to have existed on [DATE].</p> <p>1.) The first IJ is outlined as follows:</p> <p>Resident (R) #5 was admitted to the facility on [DATE] and required bilateral below the knee amputations (BKA's) due to severe peripheral artery disease (PAD) with occlusion on [DATE]. Upon return from hospitalization status post bilateral BKA's on [DATE], the facility failed to clarify/obtain treatment orders for the surgical wounds. R#5 was diagnosed on [DATE] at the hospital emergency room with a wound infection to the left BKA. R#5 underwent a revision to the left BKA on [DATE] and returned to the facility the same day. The facility again failed to clarify/obtain treatment orders on return from the hospital on [DATE]. There was no evidence of wound care being provided from [DATE] through [DATE]. In addition, the left BKA revision site was not accurately assessed by nursing staff on hospital return and a scheduled follow up appointment with the surgeon was not kept on [DATE]. The resident expired at the facility on [DATE]. The death certificate listed diabetes as the cause of death.</p> <p>2.) The second IJ is outlined as follows:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>R#10, a [AGE] year-old resident with a diagnosis of cerebral palsy was dependent on staff and received all nutrition and hydration through a gastrostomy tube (g-tube). Weights for R#10 trended down from 89 pounds on [DATE] to 83 pounds on [DATE], despite repeated increases of bolus g-tube nutritional supplement formula. The last increase was on [DATE]. There was no evidence that a documented plan from the Nurse Practitioner (NP) on [DATE] for a follow-up weight and Registered Dietician (RD) evaluation in two weeks was followed. However, a nutritional assessment was completed on [DATE] when the RD acknowledged that there was no [DATE] weight but indicated that the ordered nutritional supplement formula and water flushes met the resident's needs. Despite R#10's downtrend of weight, even with incremental increases in the nutritional supplement formula, no weight was obtained, to continue to monitor his progress, after [DATE], until [DATE]. On [DATE], a weight of 75.8 pounds was documented. There is no acknowledgement of the [DATE] weight of 75.8 pounds, which reflects actual, further significant weight loss. On [DATE] there was a physician's order for biweekly weights (between ,d+[DATE] and [DATE]), and if weight decreased, resume continuous nutritional supplement feedings via g-tube. However, no weights were obtained between [DATE] through [DATE], except when surveyor inquired on [DATE].</p> <p>In addition, during an observation on [DATE] at 3:30 p.m., Licensed Practical Nurse (LPN) BB administered the incorrect amount of bolus g-tube formula to R#10 (administered 237 milliliters instead of 320 milliliters). Review of the Medication Administration Records (MAR) revealed no evidence that the physician ordered bolus nutritional supplement formula was administered as scheduled for 28 times in [DATE] and 27 times in [DATE].</p> <p>There was also repeated, systemic failure to implement pertinent interventions to address weight loss and/or nutrition and hydration risk for five residents (R#6, R#8, R#12, R#13, and R#14). R#6 and R#8 received nutrition and hydration via gastrostomy tube. R#12, R#13 and R#14 received nutrition and hydration orally.</p> <p>There was also evidence of a systemic failure related to dietary services to ensure that there was an adequate number of dietary staff and that the dietary staff had the skill set to carry out the functions of the food and nutrition services in the facility. Dietary staff failed to follow menus and individualized food plans for correct portion size to ensure residents' nutritional needs were met. R#12 and R#14 were to receive double portions of food because they were nutritionally compromised. By not receiving double portions, they were put at risk for further weight loss and/or poor nutritional status.</p> <p>The Immediate Jeopardies were related to the facility's noncompliance with the requirements at</p> <p>42 C.F.R. 483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656, Scope/Severity: K); 42 C.F.R. 483.21(b) Comprehensive Care Plans (F657, Scope/Severity: K); 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); 42 C.F.R. 483.25(g)(1)(2) Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K); 42 C.F.R. 483.60(a)(3) Sufficient Dietary Support Personnel (F802, Scope/Severity: K); 42 C.F.R. 483.60(c),(d+[DATE]), Menus and Nutritional Adequacy (F803, Scope/Severity: K); 42 C.F.R. 483.70 Administration (F835, Scope/Severity: K); 42 C.F.R. 483.70(d) Governing body (F837, Scope/Severity: K); 42 C.F.R. 483.75(g)(2) QAPI/QAA Improvement Activities (F867, Scope/Severity: K).</p> <p>Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); and 42 C.F.R. 483.25(g)(1)(2), Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>At the time of exit on [DATE], the IJ remained ongoing.</p> <p>Findings include:</p> <p>1. Review of the clinical record revealed R#10 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy, dysphagia, insomnia, protein-calorie malnutrition, muscle weakness, quadriplegia, anxiety disorder, major depressive disorder, spastic quadriplegic cerebral palsy, and abnormal posture. He received all nutrition and hydration via a gastrostomy tube. The NP also included a baseline of failure to thrive in her notes.</p> <p>A review of the clinical record, including weights, NP notes and orders revealed orders since [DATE] of incrementally increasing R#10's gastrostomy tube feedings to address weight loss and to promote tolerance of the increase in nutrition supplement volume. On [DATE], weight was 89 pounds. On [DATE], weight was 88 pounds. On [DATE] the nutritional supplement formula was changed from continuous to a bolus of 200 milliliters (ml) of 2cal (nutritional formula) four times per day with 100 ml water flush. On [DATE], weight was 86.6 pounds. On [DATE] the 2cal nutritional supplement formula was increased to 240 ml with 100 ml water flush four times per day. On [DATE] weight was 83 pounds. On [DATE] the 2cal formula was increased to 240 ml five times per day. On [DATE], weight was 83 pounds. On [DATE] an RD assessment documented that at 83 pounds, the Body Mass Index (BMI) was 16.3 (underweight) and that R#10's weights were continuing to trend down. On [DATE] the 2cal formula was increased to 320 ml five times a day.</p> <p>On [DATE] the NP noted the 83-pound weight (from August) and recapped the 2cal formula increase to 320cc five times per day (from [DATE]). The Plan section of the note included to follow-up weight and RD evaluation in two weeks. The NP note also includes discussed with nursing. However, there is no evidence the plan to obtain a follow-up weight and RD evaluation was acted on and/or carried out.</p> <p>A review of the clinical record revealed no further nutritional assessment of R#10 until [DATE]. On [DATE], the RD documented that there were no [DATE] weights and again documented the 83-pound weight from [DATE] and the BMI of 16.3 (underweight). Her nutritional calculations determine that the resident's ordered feedings and flushes meet his needs.</p> <p>Despite R#10's weight loss and the NP increasing the gastrostomy tube feedings (last on [DATE]), no weights were obtained to continue to monitor his progress after [DATE], until [DATE]. On [DATE] the weight was documented as 75.8 pounds, a further decline of 7.6 pounds from 83 pounds (on [DATE]), which was a 9.1% weight loss in two months.</p> <p>On [DATE] the NP documented conflicting information in her notes. Her note incorrectly included that the resident gained 4 pounds in 6 weeks and had a current weight of 102 pounds. However, her note also included that no weight was documented since the change of the formula schedule (which was on [DATE]). The plan section of the note included to weigh R#10 biweekly, discussed with the DON, and continue bolus formula feedings five times per day, and if weight declines, change R#10 back to a continuous rate (instead of bolus). There is no documented acknowledgement of the 75.8-pound weight obtained on [DATE] that already reflected a further significant weight loss.</p> <p>During an interview on [DATE] at 3:40 p.m. DON LL stated that she was not aware of the plan to weigh R#10 biweekly.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 1:20 p.m., RD MM stated that she was at the facility on [DATE] and reviewed weights and discussed with the DON. RD MM stated that the weight of 75.8 pounds, dated [DATE] in the electronic clinical record, was not in the system (when she reviewed weights on [DATE]). She stated she was unsure if someone added the weight in later and back dated it. RD MM provided the [DATE] computer generated weight report she had received, and the weight report did not include the [DATE] weight of 75.8 pounds for R#10. However, RD MM stated that she did discuss R#10 with the NP that week.</p> <p>After the NP Note on [DATE] with conflicting information, an order was entered into R#10's electronic clinical record on [DATE], by the NP as follows: patient scheduled for biweekly weights. Needs weight ASAP (as soon as possible), if weight has decreased, resume continuous feedings. However, further review of the clinical record revealed no weights were obtained ASAP, or after [DATE], until after surveyor inquiry on [DATE].</p> <p>During an observation on [DATE] at 5:15 p.m. LPN BB weighed R#10 and obtained a weight of 76.6 pounds. After the weight obtained on [DATE], no further weights were obtained and documented during the [DATE] through [DATE] scheduled time frame of the biweekly order.</p> <p>There was no further assessment of R#10's nutritional status after the RD assessment on [DATE], even after the further decline in weight to 75.8 pounds on [DATE], until after surveyor inquiry on [DATE]. On [DATE] the RD assessed R#10 and documented the [DATE] weight of 75.8 pounds, a BMI of 14.8 (underweight), a 7.6-pound (9.1%) loss in 90 days, and a 12.2 pound (13.90%) loss in 180 days (severe weight loss). The RD Note included a new recommendation for R#10 to receive, via gastrostomy tube, a continuous rate 2cal nutritional supplement formula at 40 ml per hour for 22 hours and 150 ml of water flushes every 4 hours and weekly weights until stable.</p> <p>In addition to R#10's weight loss not being thoroughly monitored and addressed after [DATE], R#10 was observed to receive an insufficient amount of nutritional supplement formula.</p> <p>R#10 had the order since [DATE] for 320 ml of 2cal nutritional supplement formula to be administered five times a day with 100 ml of water four times per day. During an interview on [DATE] at 3:30 p.m. with R#10's nurse, LPN BB incorrectly stated that R#10 received five cartons of 2cal per day. Observation of a carton of 2cal revealed it is only 237 ml. After the interview with LPN BB on [DATE] at 3:30 p.m., a new order was entered into R#10's electronic record by LPN BB, timed at 4:00 p.m., that documented for R#10 to get 327 ml (was previously 320 ml) of 2cal formula five times per day with 100 ml water flush.</p> <p>During an observation on [DATE] from 4:08 p.m. to 4:28 p.m., surveyor observed LPN BB administer one carton of 2cal (237ml) with 100 ml of water, which was the incorrect amount of 2cal based on the current physician's orders. During interviews on [DATE] at 4:50 p.m. and 5:05 p.m., LPN BB stated that she updated the order (at 4:00 p.m.) to clarify that the water flush was supposed to be five times per day, not four times per day and that she had thought she read the order wrong (interpreted the 320 ml to mean 237 ml - reversed the numbers), which is why she only administered one carton of 2cal.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In addition to R#10's weight loss not being thoroughly monitored and addressed after [DATE] and R#10 being observed receiving the incorrect amount of nutritional supplement formula via gastrostomy tube, there was incomplete documentation of the 2cal nutritional supplement formula being administered during the time frame of significant weight loss.</p> <p>Review of the clinical record revealed #10's weights showed a decrease in weight from 83 pounds (on [DATE]) to 75.8 pounds (on [DATE]), despite an increase in 2cal nutritional supplement formula on [DATE]. A review of the [DATE] and [DATE] Medication Administration Records (MAR's) revealed multiple blank entries that did not document that the ordered feedings were administered as scheduled by licensed nursing staff. For [DATE], after the last increase in the 2cal nutritional supplement formula on [DATE], 28 of the 93 times the supplement was scheduled to be administered, were blank. For [DATE] of the 150 times the supplement was scheduled to be administered were blank.</p> <p>During an interview on [DATE] at 3:00 p.m. R#10's weight loss from 83 pounds to 75.8 pounds was discussed with his physician. When the surveyor asked if there would be a reason R#10's weight would decrease to 75.8 pounds even though his nutritional supplement formula was increased, the physician stated he did not know; he was not aware of anything new going on with R#10 and that R#10 was dependent (on staff) for nutrition and hydration. He further stated that a 9 % weight loss needed to be addressed and he would expect the facility to carry out the NP's orders for weights.</p> <p>2. Resident #6 was admitted to the facility on [DATE]. A review of NP Notes revealed that R#6 was transferred to the facility for tracheostomy downsizing and had diagnoses that included basal ganglia bleed, tracheostomy and gastrostomy tube placement, respiratory failure, dysphagia, left hemiparesis, Lupus, Cerebrovascular Accident (CVA), seizures and chronic kidney disease (CKD). Further review of the clinical record revealed that R#6 was dependent on nursing staff for nutrition and hydration via her gastrostomy tube.</p> <p>R#6 had a physician's order for a bolus of 120 ml of water to be administered every four hours via pump and gastrostomy tube from [DATE] through [DATE]. In further review of the clinical record, including physician's orders and MAR's there was also another bolus flush order for 150 ml of water every four hours, starting on [DATE]. Therefore, both bolus water flush orders (120 ml every four hours and 150 ml every four hours) would have been active at the same time, as of [DATE]. However, in reviewing the [DATE] MAR, the [DATE] water flush order (for 150 ml every four hours) was only initialed as being administered on [DATE] and [DATE]. After that the order is not initialed, by licensed nursing staff, on the MAR as being carried out. The 120 ml every four hours water flush order (ordered on [DATE]) is initialed as being completed for the month ([DATE]). After [DATE], the 150 ml every four hours water flush order does not appear on any more MAR's and the 120 ml water flush order stopped after [DATE].</p> <p>On [DATE], the 120 ml every four hours bolus water flush order (ordered on [DATE]) was discontinued by the NP. A review of the order revealed an administrative note on the discontinued order that documented that the flush was discontinued and increased to 150 ml. However, no order for 150 ml of water was entered into R#6's electronic clinical record after [DATE], until after surveyor inquiry on [DATE], at which time, the [DATE] 150cc flush order was revised by licensed nursing staff and reappeared on the [DATE] MAR.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Even though there was no evidence of a 150 ml every four hours water flush order being written and implemented after the 120 ml every four hours water flush order was discontinued on [DATE], the RD calculated it into determining that R#6's fluid needs were met in the [DATE] and [DATE] assessments.</p> <p>During an interview on [DATE] at 1:20 p.m. the RD stated that she pulls the order summaries report and looks at that for current orders. If there is no water flush order, she will note that and recommend one. She stated she does not know why it would not be on the MARS, she does not look at them, but she would have noted no flush order if the order summary report did not include one.</p> <p>In absence of a bolus water flush order (after [DATE] until surveyor inquiry on [DATE]), R#6 did have a medication flush order of 30 ml of water before and after medication and 5 ml of water between medications. A review of a [DATE] email from the RD to the DON, revealed that based on information provided by the DON and the current orders in the clinical record, R#6 would receive 485 ml of water from her current medications plus 751 ml of water from her current enteral nutrition order for a total of 1236 ml of water. Her current fluid needs range was 1400- 1750 ml of water therefore the medication flush order and free water (from the enteral nutrition order) would meet 88% of her fluid needs. The RD's response also included that she would aim for ,d+[DATE] % of fluid needs met.</p> <p>During an interview on [DATE] at 3:00 p.m. when R#6's physician was questioned if 88% of fluids needs being met was adequate, he responded that he personally would prefer it to be right at 100%, but he did not know of any harm it caused R#6. He stated however, over a period of time it could lead to dehydration.</p> <p>In addition to there being no evidence of a bolus water flush being administered after [DATE] until surveyor inquiry on [DATE], R#6 experienced a significant weight loss and possible weight discrepancy that were not addressed timely.</p> <p>During an interview on [DATE] at 3:40 p.m. when questioned about the facility's process for obtaining and responding to RD recommendations, the DON stated that the RD does a review, goes home, and completes a report, faxes it back to the facility, the recommendations are put in the physician's folder, and the recommendations are carried out if he or the NP agrees with to them.</p> <p>During an interview on [DATE] at 4:40 p.m. Unit Manager AA stated that after the RD comes in, she types of recommendations and sends them to the facility. Then, the NP reviews to see if she agrees with the recommendations. Unit Manager AA stated that the RD recommendations are written up on individual forms for each resident. If the NP agrees with them, the nurses write an order, print out a copy of the order (from the electronic clinical record), attach it to the recommendation form and put it in the DON's box. Unit Manager AA stated if the NP does not agree with the RD recommendation, the NP will write that on the form, and it goes in the DON's box and are filed in her office.</p> <p>Review of the clinical record for R#6 revealed an [DATE] Dietary Progress Note, from the RD, that identified a significant weight loss and possible incorrect weights on [DATE] and [DATE]. The dietary note documented an [DATE] weight of 161.3 pounds and an [DATE] weight of 185.2 pounds. With the 161.3-pound weight, that was a significant weight loss of 23.9 pounds in 90 days (12.9%). On [DATE], the RD recommended changing the gastrostomy tube nutritional supplement formula from Glucerna 1.2 at 45 ml per hour for 24 hours to Glucerna 1.5 at 45 ml per hour for 22 hours. There is no evidence that the [DATE] RD recommendation was acted on or the weight discrepancy addressed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On [DATE], in a Dietary Progress Note, the RD documented that there is no [DATE] weight and documented the same concerns from her [DATE] dietary note, and again recommended to change the gastrostomy tube nutritional supplement formula order to address the weight loss. However, there is no evidence the [DATE] RD recommendations were acted on until [DATE], after further weight loss. A weight obtained on [DATE] documented a further weight loss from 161.5 pounds on [DATE] to 154.6 pounds, a further loss of 6.9 pounds.</p> <p>During an interview on [DATE] at 3:00 p.m. R#6's physician confirmed that he would expect the RD recommendations to be acted on by nursing staff and provided to him or the NP to review.</p> <p>In addition to there being no evidence of a bolus water flush being administered after [DATE] until surveyor inquiry on [DATE], and R#6 experiencing a significant weight loss and possible weight discrepancy that were not addressed timely, R#6 was observed on [DATE] to not be receiving water at the correct rate via gastrostomy tube.</p> <p>Review of the clinical record revealed a bolus water flush of 150 ml every four hours was ordered since [DATE]. However, during an observation on [DATE] at 10:30 a.m. the water flush rate was set incorrectly on the gastrostomy pump at 40 ml per hour (which would be a total of 160 ml of water in four hours), not 150 ml every four hours as ordered.</p> <p>3. Resident #8 was admitted to the facility on [DATE]. Review of the clinical record revealed R#8 had diagnoses that included history of respiratory failure, pneumonia, dysphagia, encephalopathy, cerebral infarction, atherosclerotic heart disease, hypertension, heart failure, gastroesophageal reflux disease, anemia, contractures, hemiplegia affecting left non-dominant side, protein-calorie malnutrition, diabetes, and aphasia. R#8 received all nutrition and hydration via gastrostomy tube.</p> <p>Review of the clinical record revealed R#8 had a weight fluctuation from April to [DATE]. The [DATE] weight was 148 pounds, the [DATE] weight was 165 pounds, and the [DATE] weight was 136.6 pounds. A Nurse's Note entry on [DATE] documented addressing the notable weight increase from 148 pounds on [DATE] to 165 pounds on [DATE], that the weight was taken twice to verify, and the resident would be weighed weekly for four weeks for accuracy. However, a review of the clinical records revealed no further weights after [DATE] until [DATE], at which time R#8's weight was 136.6 pounds.</p> <p>During an interview on [DATE] at 2:00 p.m. DON LL stated she was unable to locate any additional weights.</p> <p>The RD assessed R#8 on [DATE] and documented in a Dietary Progress Note that he triggered for a severe weight loss. His BMI at 136.6 pounds was 18.5 (normal). The notes included the weight fluctuation from 148 pounds on [DATE] to 165 pounds on [DATE] to 136.6 pounds on [DATE]. The RD recommended weekly weights for four weeks to determine accurate weight.</p> <p>After the RD recommendation on [DATE] for weekly weights for four weeks, weights of 136.6 pounds on [DATE] and 134.2 pounds on [DATE] were documented. However, there was no evidence additional weekly weights were obtained until [DATE], at which time R#8 remained at 134.2 pounds.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The NP documented the weight loss on [DATE] and included a plan to continue the current gastrostomy tube feedings and water flushes and weights weekly. The RD assessed R#8 again on [DATE] and documented, in a Dietary Progress Note, the [DATE] weight of 134.2 pounds and calculated the BMI at 18.2 (now underweight) and 11.1% weight loss in 180 days. The RD recommended increasing the gastrostomy tube nutritional supplement formula from Osmolite 60 ml per hour to 70 ml per hour. Further review of the clinical record revealed that the RD recommendation to increase the Osmolite was ordered on [DATE].</p> <p>On [DATE] an order was written by the NP for weekly weights to be obtained every Wednesday for weight loss, for 30 days (start date [DATE] through [DATE]). However, the weekly weight order was not carried out consistently. Clinical record review revealed weights were obtained on [DATE], [DATE] and [DATE] but not again until [DATE], [DATE] and [DATE].</p> <p>Additional weights obtained on [DATE] (134), [DATE] (135.8), [DATE] (135.8), [DATE] (135.9), and [DATE] (135.9) indicated R#8 remained within an underweight BMI of 18.4 (based off the [DATE] weight of 135.9).</p> <p>During interviews on [DATE] at 10:25 a.m. and [DATE] at 2:00 p.m., DON LL, who was new to the facility as of [DATE], stated that restorative staff had been obtaining weights but had previously been pulled to the floor, so weights were not being obtained. She stated the system was broken and that the facility needed systems and education.</p> <p>4. Resident #14 was admitted to the facility on [DATE]. Review of the clinical record revealed R#14 had diagnoses that included dementia with behavior disturbance, protein-calorie malnutrition, dysphagia, macular degeneration, osteoarthritis, ataxic gait, cognitive communication deficit, hypertension, iron deficiency anemia, generalized anxiety disorder, and constipation.</p> <p>R#14 had a physician's order since [DATE] for 120 ml of a house nutritional supplement to be administered three times daily. A review of the clinical record revealed a [DATE] Dietary Progress Note by the RD that documented a [DATE] weight of 118.2 pounds, BMI 20.3 (normal), a weight loss of 15.8 pounds in 90 days (11.8%), 17.6 pound weight loss in 180 days (13.1% severe weight loss) and that weight continued to trend down for 30 days. On [DATE] weight was 122 pounds and on [DATE] weight was 118.2 pounds. The note included that R#14 was fed by nursing staff at mealtime. The RD recommended to increase the house nutritional supplement to 120 ml four times daily.</p> <p>However, further review of the clinical record revealed no evidence that the RD recommendation to increase the nutritional supplement for significant weight loss was addressed.</p> <p>R#14 had a diet order since [DATE] that included a no added salt, mechanical soft texture, double portion, ground meat diet. However, during an observation on [DATE] at 12:20 p.m. R#14 was observed with a lunch tray with single portions of beef stew, peppers and onions, cooked carrots, a roll and orange cream ice cream cup. During the observation, Certified Nursing Assistant (CNA) PP stated that she usually assists R#14 to eat and that he usually eats everything. During a subsequent interview on [DATE] at 12:05 p.m. CNA stated that R#14 ate 85% of his lunch meal on [DATE].</p> <p>During an observation on [DATE] at 12:30 p.m. R#14 was again observed to have been served a lunch tray with only single portions of ground chicken, mixed vegetables, a biscuit, rice with gravy, apple crisp, and an orange cream ice cream cup.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A review of monthly weights for R#14 in the clinical record since [DATE] revealed weights of 121.2 pounds on [DATE], 119 pounds on [DATE], and 119 pounds on [DATE]. An additional weight obtained on [DATE], after surveyor inquiry, reflected a further weight loss to 115.6 pounds.</p> <p>15650</p> <p>5. Review of the clinical record revealed R#12 was admitted to the facility on [DATE] diagnoses including bipolar disorder, unspecified protein-calorie malnutrition, chronic kidney disease, dysphagia, major depressive disorder with recurrent severe psychotic symptoms, heart failure, diabetes, anxiety, and adult failure to thrive.</p> <p>The resident had a physician's order since [DATE] for regular concentrated sweets diet, pureed texture with double portions for lunch and supper.</p> <p>However, during observations of the lunch meal on [DATE] at 12:26 p.m., and [DATE] at 1:00 p.m., R#12 was not served double portions. Observation of the diet card that was on the resident's lunch tray revealed the portion size was specified as double portion.</p> <p>During an observation of the meal service tray line on [DATE] at 12:25 p.m., the dietary staff was observed serving only regular portions on the resident's plate. Although the dietary aide called out a puree diet to staff plating the food, she did not include double portions.</p> <p>During an interview with Cook NN on [DATE] at 2:45 p.m., she was not aware the resident was supposed to have double portions.</p> <p>Review of the 2021 Weight Record for R#12 revealed the following weights in pounds:</p> <p>[DATE]- 143, [DATE]-133, [DATE]- 128, [DATE]- 114, [DATE]- 116, [DATE]- 111, [DATE]- 114.6, [DATE]- 115, [DATE]- 115, [DATE]- 116, [DATE]- 119, [DATE]- 116, [DATE]- 113.6, [DATE]- 108, [DATE]- 105.2, no [DATE] weights, [DATE]- 97.8, and [DATE]- 96.</p> <p>The resident was evaluated by the RD on [DATE], [DATE] and [DATE] who noted weight loss and a BMI of 21.9. There were no recommendations given and noted the resident was receiving double portions at lunch and supper and Med Pass 2.0 120 cubic centimeters (cc) three times a day.</p> <p>The NP noted on [DATE] the resident had a gastrointestinal bleed with significant weight loss. She noted unexplained weight loss was worsening and continue Med Pass 120 cc three times a day. She further noted the resident was receiving double portions.</p> <p>There was not a [DATE] RD evaluation for R#12. However, on [DATE] the RD noted a weight of 113.6 for [DATE] with a BMI of 21.5. She further calculated a 29.4-pound weight loss x 180 days (20.6% severe wt. loss) and recommended sugar free ice cream with lunch and supper.</p> <p>Per review of the Physician Recommendation Sheet for R#12 dated [DATE] with the recommendation for the ice cream, there was no evidence this was communicated to the physician as the recommendation was not acted on by noting either a reject or accept.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Observation of the resident's lunch meals on [DATE] at 12:26 p.m., [DATE] at 1:00 p.m. and [DATE] at 1:00 p.m., R#12 was not served ice cream.</p> <p>The NP noted on [DATE] that the resident's weight was 108 pounds with chronic weight loss since [DATE]. She noted failure to thrive and worsening weight loss of unknown etiology. Med Pass 120 cc three times a day and ice cream with lunch and supper.</p> <p>On [DATE] the NP noted the resident's weight has not stabilized despite aggressive interventions.</p> <p>Review of the clinical record revealed no RD evaluation done in [DATE].</p> <p>On [DATE] the NP noted a follow up evaluation of weight loss. Continue double portions.</p> <p>The [DATE] RD evaluation noted a weight of 105.2 on [DATE] with a BMI of 19.9. Indicated a loss of 10.8 pounds x 90 days (9.3%) and 22.8 pounds x 180 days (17.8% severe wt. loss). The RD recommended to increase House Supplement 120 cc to four times a day. However, review of the [DATE] MAR revealed the resident continued to receive Med Pas 120 cc three times a day. The [DATE] MAR noted the resident continued to receive Med Pass 120 cc three times a day through [DATE] after the RD recommended again to increase the Med Pass 120 cc to four times a day.</p> <p>The NP noted on [DATE] worsening weight loss, weight 97.8 pounds. She further noted the colonoscopy was completed [DATE] with no acute process found. No etiology for weight loss identified.</p> <p>In summary, despite R#12 having ongoing significant weight loss since February 2021, there was no evidence the facility responded or acted on the RD recommendations for Sugar Free ice cream on [DATE] and no evidence the facility responded or acted on the RD recommendation on [DATE] to increase the Med pass 120 cc to four times per day until [DATE]. The resident was also observed to be served regular portions of food instead of double portions. The resident was also not w[TRUNCATED]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	

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 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>15650</p> <p>Based on observation and staff interviews, the facility failed to ensure that the staff designated as director of food and nutrition services was a certified dietary or food service manager or had a similar food service management certification or degree. There were 65 of 70 residents that received an oral diet.</p> <p>Findings include:</p> <p>During an observation of the lunch service on 11/1/21 at 11:05 a.m. there were only two kitchen staff present and working in the kitchen. During an interview with Cook NN at that time, she stated they have not had a Dietary Manager (DM) in about three months, and she has been the one who orders food and does the schedule.</p> <p>During an interview with Registered Dietician MM on 11/1/21 at 11:05 a.m., she stated that Cook NN was acting as the DM. She also stated she is getting the application and paperwork together for Cook NN to take the certification course.</p> <p>During an interview on 11/2/21 at 10:45 a.m. and review of staff schedule, the Administrator stated he had an additional Registered Dietician (RD) and Certified Dietary Manager (CDM) (from a sister facility) coming in to assist in getting caught up. In August 2021, the CDM was at the facility on 8/10/21, 8/17/21 and 8/24/21. In September 2021, an RD was at the facility on 9/8/21, 9/15/21, 9/22/21 and 9/28/21. In October 2021, the RD was at the facility on 10/5/21, 10/19/21 and 10/26/21.</p> <p>In addition, review of facility documentation revealed the RD was working at the facility on 11/1/21, 11/9/21, 11/10/21, and 11/11/21.</p> <p>Further interview with the Administrator on 11/4/21 at 3:35 p.m. revealed they have been looking for a CDM since July 2021.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0802</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15650</p> <p>Based on observation and staff interviews, the facility failed to ensure there was adequate dietary support personnel to prepare, cook and serve meals to 65 of 70 residents receiving an oral diet.</p> <p>On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator and Director of Nursing (DON) LL were informed of the Immediate Jeopardy (IJ) on [DATE] at 1:55 p.m. The noncompliance related to the first IJ was identified to have existed on [DATE]. The noncompliance related to the second IJ was identified to have existed on [DATE].</p> <p>1.) The first IJ is outlined as follows:</p> <p>Resident (R) #5 was admitted to the facility on [DATE] and required bilateral below the knee amputations (BKA's) due to severe peripheral artery disease (PAD) with occlusion on [DATE]. Upon return from hospitalization status post bilateral BKA's on [DATE], the facility failed to clarify/obtain treatment orders for the surgical wounds. R#5 was diagnosed on [DATE] at the hospital emergency room with a wound infection to the left BKA. R#5 underwent a revision to the left BKA on [DATE] and returned to the facility the same day. The facility again failed to clarify/obtain treatment orders on return from the hospital on [DATE]. There was no evidence of wound care being provided from [DATE] through [DATE]. In addition, the left BKA revision site was not accurately assessed by nursing staff on hospital return and a scheduled follow up appointment with the surgeon was not kept on [DATE]. The resident expired at the facility on [DATE]. The death certificate listed diabetes as the cause of death.</p> <p>2.) The second IJ is outlined as follows:</p> <p>R#10, a [AGE] year-old resident with a diagnosis of cerebral palsy was dependent on staff and received all nutrition and hydration through a gastrostomy tube (g-tube). Weights for R#10 trended down from 89 pounds on [DATE] to 83 pounds on [DATE], despite repeated increases of bolus g-tube nutritional supplement formula. The last increase was on [DATE]. There was no evidence that a documented plan from the Nurse Practitioner (NP) on [DATE] for a follow-up weight and Registered Dietician (RD) evaluation in two weeks was followed. However, a nutritional assessment was completed on [DATE] when the RD acknowledged that there was no [DATE] weight but indicated that the ordered nutritional supplement formula and water flushes met the resident's needs. Despite R#10's downtrend of weight, even with incremental increases in the nutritional supplement formula, no weight was obtained, to continue to monitor his progress, after [DATE], until [DATE]. On [DATE], a weight of 75.8 pounds was documented. There is no acknowledgement of the [DATE] weight of 75.8 pounds, which reflects actual, further significant weight loss. On [DATE] there was a physician's order for biweekly weights (between ,d+[DATE] and [DATE]), and if weight decreased, resume continuous nutritional supplement feedings via g-tube. However, no weights were obtained between [DATE] through [DATE], except when surveyor inquired on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0802</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In addition, during an observation on [DATE] at 3:30 p.m., Licensed Practical Nurse (LPN) BB administered the incorrect amount of bolus g-tube formula to R#10 (administered 237 milliliters instead of 320 milliliters). Review of the Medication Administration Records (MAR) revealed no evidence that the physician ordered bolus nutritional supplement formula was administered as scheduled for 28 times in [DATE] and 27 times in [DATE].</p> <p>There was also repeated, systemic failure to implement pertinent interventions to address weight loss and/or nutrition and hydration risk for five residents (R#6, R#8, R#12, R#13, and R#14). R#6 and R#8 received nutrition and hydration via gastrostomy tube. R#12, R#13 and R#14 received nutrition and hydration orally.</p> <p>There was also evidence of a systemic failure related to dietary services to ensure that there was an adequate number of dietary staff and that the dietary staff had the skill set to carry out the functions of the food and nutrition services in the facility. Dietary staff failed to follow menus and individualized food plans for correct portion size to ensure residents' nutritional needs were met. R#12 and R#14 were to receive double portions of food because they were nutritionally compromised. By not receiving double portions, they were put at risk for further weight loss and/or poor nutritional status.</p> <p>The Immediate Jeopardies were related to the facility's noncompliance with the requirements at</p> <p>42 C.F.R. 483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656, Scope/Severity: K); 42 C.F.R. 483.21(b) Comprehensive Care Plans (F657, Scope/Severity: K); 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); 42 C.F.R. 483.25(g)(1)(2) Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K); 42 C.F.R. 483.60(a)(3) Sufficient Dietary Support Personnel (F802, Scope/Severity: K); 42 C.F.R. 483.60(c),(d+[DATE]), Menus and Nutritional Adequacy (F803, Scope/Severity: K); 42 C.F.R. 483.70 Administration (F835, Scope/Severity: K); 42 C.F.R. 483.70(d) Governing body (F837, Scope/Severity: K); 42 C.F.R. 483.75(g)(2) QAPI/QAA Improvement Activities (F867, Scope/Severity: K).</p> <p>Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); and 42 C.F.R. 483.25(g)(1)(2), Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K).</p> <p>At the time of exit on [DATE], the IJ remained ongoing.</p> <p>Findings include:</p> <p>Observation and interview during the lunch meal service on [DATE] at 12:05 p.m., revealed two dietary staff working in the kitchen. Cook NN stated they have been working with two dietary staff on the day shift for the past three months. She stated three people would be better because they have to prepare, cook, serve and clean. She stated they also have been without a Dietary Manager for three months. She stated corporate told them two was enough to work in the kitchen. She stated since they have been without a Dietary Manager, she must place the food orders, do the schedule, print tray cards and cook.</p> <p>Registered Dietician MM stated on [DATE] at 12:15 p.m. that ideally, they need three staff in the kitchen, especially since Cook NN has been acting as the Dietary Manager and having to order food.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0802</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview with Dietary Aide OO on [DATE] at 4:25 p.m., she stated when there are only two people working in the kitchen, you just have to cut corners. She stated for example, the menu for supper today included pineapple upside down cake but there was not time to cook it because she was asked to help with lunch today. She and the night shift cook usually work from 11:45 a.m. to 7:15 p.m. When they come in, they normally set up the drinks for lunch then she organizes the tray cards and starts making desserts for supper. They also use plastic plates, bowls, and plastic silverware because it is easier and less to wash. She stated they have been short of help for the past two to three months.</p> <p>During an interview with Dietary Aide RR on [DATE] at 1:00 p.m., she stated corporate told them about three months ago that two people were enough to work in the kitchen on day shift. She stated day shift has to do breakfast and lunch and wash dishes and that it was just too much. At times they don't have time to make dessert for lunch or supper. She stated she has talked to the Administrator about it several times and he tells her Just work with me, I'm trying to get people in.</p> <p>21213</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15650</p> <p>Based on observation, staff interview and review of the Week One Menu, the facility failed to ensure dietary staff were serving the correct portion sizes of pureed food and regular diets according to the menu and failed to serve double portions to two residents (R) (#12 and #14) who had a history of weight loss. There were 65 residents with oral diets.</p> <p>On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator and Director of Nursing (DON) LL were informed of the Immediate Jeopardy (IJ) on [DATE] at 1:55 p.m. The noncompliance related to the first IJ was identified to have existed on [DATE]. The noncompliance related to the second IJ was identified to have existed on [DATE].</p> <p>1.) The first IJ is outlined as follows:</p> <p>Resident (R) #5 was admitted to the facility on [DATE] and required bilateral below the knee amputations (BKA's) due to severe peripheral artery disease (PAD) with occlusion on [DATE]. Upon return from hospitalization status post bilateral BKA's on [DATE], the facility failed to clarify/obtain treatment orders for the surgical wounds. R#5 was diagnosed on [DATE] at the hospital emergency room with a wound infection to the left BKA. R#5 underwent a revision to the left BKA on [DATE] and returned to the facility the same day. The facility again failed to clarify/obtain treatment orders on return from the hospital on [DATE]. There was no evidence of wound care being provided from [DATE] through [DATE]. In addition, the left BKA revision site was not accurately assessed by nursing staff on hospital return and a scheduled follow up appointment with the surgeon was not kept on [DATE]. The resident expired at the facility on [DATE]. The death certificate listed diabetes as the cause of death.</p> <p>2.) The second IJ is outlined as follows:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>R#10, a [AGE] year-old resident with a diagnosis of cerebral palsy was dependent on staff and received all nutrition and hydration through a gastrostomy tube (g-tube). Weights for R#10 trended down from 89 pounds on [DATE] to 83 pounds on [DATE], despite repeated increases of bolus g-tube nutritional supplement formula. The last increase was on [DATE]. There was no evidence that a documented plan from the Nurse Practitioner (NP) on [DATE] for a follow-up weight and Registered Dietician (RD) evaluation in two weeks was followed. However, a nutritional assessment was completed on [DATE] when the RD acknowledged that there was no [DATE] weight but indicated that the ordered nutritional supplement formula and water flushes met the resident's needs. Despite R#10's downtrend of weight, even with incremental increases in the nutritional supplement formula, no weight was obtained, to continue to monitor his progress, after [DATE], until [DATE]. On [DATE], a weight of 75.8 pounds was documented. There is no acknowledgement of the [DATE] weight of 75.8 pounds, which reflects actual, further significant weight loss. On [DATE] there was a physician's order for biweekly weights (between ,d+[DATE] and [DATE]), and if weight decreased, resume continuous nutritional supplement feedings via g-tube. However, no weights were obtained between [DATE] through [DATE], except when surveyor inquired on [DATE].</p> <p>In addition, during an observation on [DATE] at 3:30 p.m., Licensed Practical Nurse (LPN) BB administered the incorrect amount of bolus g-tube formula to R#10 (administered 237 milliliters instead of 320 milliliters). Review of the Medication Administration Records (MAR) revealed no evidence that the physician ordered bolus nutritional supplement formula was administered as scheduled for 28 times in [DATE] and 27 times in [DATE].</p> <p>There was also repeated, systemic failure to implement pertinent interventions to address weight loss and/or nutrition and hydration risk for five residents (R#6, R#8, R#12, R#13, and R#14). R#6 and R#8 received nutrition and hydration via gastrostomy tube. R#12, R#13 and R#14 received nutrition and hydration orally.</p> <p>There was also evidence of a systemic failure related to dietary services to ensure that there was an adequate number of dietary staff and that the dietary staff had the skill set to carry out the functions of the food and nutrition services in the facility. Dietary staff failed to follow menus and individualized food plans for correct portion size to ensure residents' nutritional needs were met. R#12 and R#14 were to receive double portions of food because they were nutritionally compromised. By not receiving double portions, they were put at risk for further weight loss and/or poor nutritional status.</p> <p>The Immediate Jeopardies were related to the facility's noncompliance with the requirements at</p> <p>42 C.F.R. 483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656, Scope/Severity: K); 42 C.F.R. 483.21(b) Comprehensive Care Plans (F657, Scope/Severity: K); 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); 42 C.F.R. 483.25(g)(1)(2) Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K); 42 C.F.R. 483.60(a)(3) Sufficient Dietary Support Personnel (F802, Scope/Severity: K); 42 C.F.R. 483.60(c),(d+[DATE]), Menus and Nutritional Adequacy (F803, Scope/Severity: K); 42 C.F.R. 483.70 Administration (F835, Scope/Severity: K); 42 C.F.R. 483.70(d) Governing body (F837, Scope/Severity: K); 42 C.F.R. 483.75(g)(2) QAPI/QAA Improvement Activities (F867, Scope/Severity: K).</p> <p>Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); and 42 C.F.R. 483.25(g)(1)(2), Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>At the time of exit on [DATE], the IJ remained ongoing.</p> <p>Findings include:</p> <p>1. Review of the planned menu for Monday, Week One, documented that one cup of spaghetti and meat sauce were planned for residents receiving a regular diet and a pureed diet.</p> <p>However, during an observation of the lunch meal service on [DATE] at 12:25 p.m., dietary staff NN was observed serving three ounces (.d+[DATE] cup) of the meat sauce and three ounces of the pureed spaghetti.</p> <p>During an interview with Registered Dietician MM on [DATE] at 1:50 p.m., she stated staff should have served four ounces (.d+[DATE] cup) of the meat sauce and four ounces of spaghetti noodles.</p> <p>2. R#12 had a physician's order since [DATE] for regular concentrated sweets diet, pureed texture with double portions for lunch and supper.</p> <p>However, during observations of the lunch meal on [DATE] at 12:26 p.m., and [DATE] at 1:00 p.m., the resident was not served double portions. Observation of the diet card that was on the resident's lunch tray revealed the portion size was specified as double portion.</p> <p>During an observation of the meal service tray line on [DATE] at 12:25 p.m., the dietary staff was observed serving only regular portions on the resident's plate. Although the dietary aide called out a puree diet to staff plating the food, she did not include double portions.</p> <p>During an interview with Cook NN on [DATE] at 2:45 p.m., she was not aware the resident was supposed to have double portions.</p> <p>21213</p> <p>3. R#14 had a diet order since [DATE] that included a no added salt, mechanical soft texture, double portion, ground meat diet. However, during an observation on [DATE] at 12:20 p.m., R#14 was observed with a lunch tray with single portions of beef stew, peppers and onions, cooked carrots, a roll, and orange cream ice cream cup. During the observation, Certified Nursing Assistant (CNA) PP stated that she usually assists R#14 to eat and that he usually eats everything. During a subsequent interview on [DATE] at 12:05 p.m. CNA PP stated that R#14 ate 85% of his lunch meal on [DATE].</p> <p>During an observation on [DATE] at 12:30 p.m., R#14 was again observed to have been served a lunch tray with only single portions of ground chicken, mixed vegetables, a biscuit, rice with gravy, apple crisp, and an orange cream ice cream cup.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213</p> <p>Based on record review, review of the Job Summary's for Nursing Home Administrator and Director of Nursing, and staff interviews, facility administration failed to effectively oversee the facility's nutrition system for residents receiving nutrition and hydration via non-oral and oral routes.</p> <p>On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator and Director of Nursing (DON) LL were informed of the Immediate Jeopardy (IJ) on [DATE] at 1:55 p.m. The noncompliance related to the first IJ was identified to have existed on [DATE]. The noncompliance related to the second IJ was identified to have existed on [DATE].</p> <p>1.) The first IJ is outlined as follows:</p> <p>Resident (R) #5 was admitted to the facility on [DATE] and required bilateral below the knee amputations (BKA's) due to severe peripheral artery disease (PAD) with occlusion on [DATE]. Upon return from hospitalization status post bilateral BKA's on [DATE], the facility failed to clarify/obtain treatment orders for the surgical wounds. R#5 was diagnosed on [DATE] at the hospital emergency room with a wound infection to the left BKA. R#5 underwent a revision to the left BKA on [DATE] and returned to the facility the same day. The facility again failed to clarify/obtain treatment orders on return from the hospital on [DATE]. There was no evidence of wound care being provided from [DATE] through [DATE]. In addition, the left BKA revision site was not accurately assessed by nursing staff on hospital return and a scheduled follow up appointment with the surgeon was not kept on [DATE]. The resident expired at the facility on [DATE]. The death certificate listed diabetes as the cause of death.</p> <p>2.) The second IJ is outlined as follows:</p> <p>R#10, a [AGE] year-old resident with a diagnosis of cerebral palsy was dependent on staff and received all nutrition and hydration through a gastrostomy tube (g-tube). Weights for R#10 trended down from 89 pounds on [DATE] to 83 pounds on [DATE], despite repeated increases of bolus g-tube nutritional supplement formula. The last increase was on [DATE]. There was no evidence that a documented plan from the Nurse Practitioner (NP) on [DATE] for a follow-up weight and Registered Dietician (RD) evaluation in two weeks was followed. However, a nutritional assessment was completed on [DATE] when the RD acknowledged that there was no [DATE] weight but indicated that the ordered nutritional supplement formula and water flushes met the resident's needs. Despite R#10's downtrend of weight, even with incremental increases in the nutritional supplement formula, no weight was obtained, to continue to monitor his progress, after [DATE], until [DATE]. On [DATE], a weight of 75.8 pounds was documented. There is no acknowledgement of the [DATE] weight of 75.8 pounds, which reflects actual, further significant weight loss. On [DATE] there was a physician's order for biweekly weights (between ,d+[DATE] and [DATE]), and if weight decreased, resume continuous nutritional supplement feedings via g-tube. However, no weights were obtained between [DATE] through [DATE], except when surveyor inquired on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>In addition, during an observation on [DATE] at 3:30 p.m., Licensed Practical Nurse (LPN) BB administered the incorrect amount of bolus g-tube formula to R#10 (administered 237 milliliters instead of 320 milliliters). Review of the Medication Administration Records (MAR) revealed no evidence that the physician ordered bolus nutritional supplement formula was administered as scheduled for 28 times in [DATE] and 27 times in [DATE].</p> <p>There was also repeated, systemic failure to implement pertinent interventions to address weight loss and/or nutrition and hydration risk for five residents (R#6, R#8, R#12, R#13, and R#14). R#6 and R#8 received nutrition and hydration via gastrostomy tube. R#12, R#13 and R#14 received nutrition and hydration orally.</p> <p>There was also evidence of a systemic failure related to dietary services to ensure that there was an adequate number of dietary staff and that the dietary staff had the skill set to carry out the functions of the food and nutrition services in the facility. Dietary staff failed to follow menus and individualized food plans for correct portion size to ensure residents' nutritional needs were met. R#12 and R#14 were to receive double portions of food because they were nutritionally compromised. By not receiving double portions, they were put at risk for further weight loss and/or poor nutritional status.</p> <p>The Immediate Jeopardies were related to the facility's noncompliance with the requirements at</p> <p>42 C.F.R. 483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656, Scope/Severity: K); 42 C.F.R. 483.21(b) Comprehensive Care Plans (F657, Scope/Severity: K); 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); 42 C.F.R. 483.25(g)(1)(2) Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K); 42 C.F.R. 483.60(a)(3) Sufficient Dietary Support Personnel (F802, Scope/Severity: K); 42 C.F.R. 483.60(c),(d+[DATE]), Menus and Nutritional Adequacy (F803, Scope/Severity: K); 42 C.F.R. 483.70 Administration (F835, Scope/Severity: K); 42 C.F.R. 483.70(d) Governing body (F837, Scope/Severity: K); 42 C.F.R. 483.75(g)(2) QAPI/QAA Improvement Activities (F867, Scope/Severity: K).</p> <p>Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); and 42 C.F.R. 483.25(g)(1)(2), Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K).</p> <p>At the time of exit on [DATE], the IJ remained ongoing.</p> <p>Findings include</p> <p>The facility had a Job Summary for the Licensed Nursing Home Administrator. The job summary included that the primary purpose of the Nursing Home Administrator position was to oversee the day-to-day operation of the facility and to review organizational performance. The job duties included to oversee that nursing services, social service programs, activity programs, food service programs and medical services were planned, implemented, and evaluated to meet resident needs to maximize resident quality of life and quality of care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility had a Job Summary for the Director of Nursing (DON). The job summary included that the primary purpose of the DON position was to plan, organize, develop, and direct the overall operation of the Nursing Department to ensure that the highest degree of quality care is maintained at all times. The job duties and responsibilities included administrative functions, committee meeting functions, personnel functions, nursing care functions, safety and sanitation, equipment and supply functions, care plan and assessment functions, budgeting and planning functions, resident rights responsibilities, working conditions, and staff development functions.</p> <p>A review of the list of management changes at the facility revealed that the facility had four different DON's since [DATE], three of them being since [DATE]. The facility DON's with their dates of service were as follows: DON JJ ([DATE]-[DATE]), DON II ([DATE]-[DATE]), and DON LL since [DATE]. Regional Nurse Consultant (RNC) KK served as interim DON between DON's II and LL. The Administrator began at the facility on [DATE].</p> <p>Facility Administration, including the Administrator and prior DON's, failed to consistently and effectively oversee areas of the facility that were included in their job descriptions.</p> <p>1. Administration failed to ensure that nutritional interventions were implemented as care planned for four residents (R#6, R#12, R#13, and R#14).</p> <p>Cross refer to F656.</p> <p>2. Administration failed to ensure that care plans were revised to address significant weight loss for two residents (R#6 and R#8).</p> <p>Cross refer to F657.</p> <p>3. Administration failed to ensure that significant weight loss was addressed timely for three residents (R#6, R#10, and R#13), failed to ensure RD recommendations were acted on for five residents (R#6, R#8, R#12, R#13, and R#14), failed to ensure one resident received adequate hydration (R#6), failed to ensure that one resident received the physician ordered amount of nutritional supplement formula via gastrostomy tube (R#10), and failed to ensure that two residents (R#12 and R#14) received the correct food portions at meals.</p> <p>Cross refer to F692.</p> <p>4. Administration failed to ensure there was adequate dietary support personnel to prepare, cook and serve meals to 70 residents.</p> <p>Cross refer to F802.</p> <p>5. Administration failed to ensure dietary staff were serving the correct portion sizes of pureed food and regular diets according to the menu and failed to serve double portions to two residents (R#12 and R#14) who had a history of weight loss.</p> <p>Cross refer to F803.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>6. Administration failed to ensures concerns were identified and QAPI plans implemented related to leadership and the weight management process including not following Registered Dietician (RD) recommendations, significant weight loss not addressed timely, weights not obtained routinely, water flushes and nutritional supplements not administered via gastrostomy tubes as ordered, food portions not served as planned and/or ordered, inadequate dietary staff, and nutrition care plans not revised and/or implemented.</p> <p>Cross refer to F867.</p> <p>During an interview on [DATE] at 10:25 a.m. DON LL (as of [DATE]) stated that the facility's weight system was broken; the facility needed systems and education.</p> <p>During an interview on [DATE] at 10:45 a.m. the Administrator stated he was aware weights were not being obtained and addressed it at the [DATE] QA (Quality Assurance) meeting. However, he was not aware resident weights were not obtained the following month in [DATE]. He stated that he found out RD recommendations were not being acted on and had an additional RD and Certified Dietary Manager (CDM) coming in to assist in getting caught up because the RD that was usually at the facility had been out. The Administrator stated that he started at the facility on [DATE] and had a DON who was out more than she was at the facility and then he had an interim DON after that toward the end of [DATE] (before DON LL started on [DATE]).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	

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 0837</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15650</p> <p>Based on observation, staff interviews and review of the facility policy titled, Quality Assurance Performance Improvement Management the facility's Governing Body failed to ensure the QAPI program was effective in identifying, developing, and implementing corrective actions to address concerns with nutrition and weight management; and failed to oversee dietary staffing to ensure adequate dietary staff to prepare, cook and serve meals. The census was 70.</p> <p>On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator and Director of Nursing (DON) LL were informed of the Immediate Jeopardy (IJ) on [DATE] at 1:55 p.m. The noncompliance related to the first IJ was identified to have existed on [DATE]. The noncompliance related to the second IJ was identified to have existed on [DATE].</p> <p>1.) The first IJ is outlined as follows:</p> <p>Resident (R) #5 was admitted to the facility on [DATE] and required bilateral below the knee amputations (BKA's) due to severe peripheral artery disease (PAD) with occlusion on [DATE]. Upon return from hospitalization status post bilateral BKA's on [DATE], the facility failed to clarify/obtain treatment orders for the surgical wounds. R#5 was diagnosed on [DATE] at the hospital emergency room with a wound infection to the left BKA. R#5 underwent a revision to the left BKA on [DATE] and returned to the facility the same day. The facility again failed to clarify/obtain treatment orders on return from the hospital on [DATE]. There was no evidence of wound care being provided from [DATE] through [DATE]. In addition, the left BKA revision site was not accurately assessed by nursing staff on hospital return and a scheduled follow up appointment with the surgeon was not kept on [DATE]. The resident expired at the facility on [DATE]. The death certificate listed diabetes as the cause of death.</p> <p>2.) The second IJ is outlined as follows:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0837</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>R#10, a [AGE] year-old resident with a diagnosis of cerebral palsy was dependent on staff and received all nutrition and hydration through a gastrostomy tube (g-tube). Weights for R#10 trended down from 89 pounds on [DATE] to 83 pounds on [DATE], despite repeated increases of bolus g-tube nutritional supplement formula. The last increase was on [DATE]. There was no evidence that a documented plan from the Nurse Practitioner (NP) on [DATE] for a follow-up weight and Registered Dietician (RD) evaluation in two weeks was followed. However, a nutritional assessment was completed on [DATE] when the RD acknowledged that there was no [DATE] weight but indicated that the ordered nutritional supplement formula and water flushes met the resident's needs. Despite R#10's downtrend of weight, even with incremental increases in the nutritional supplement formula, no weight was obtained, to continue to monitor his progress, after [DATE], until [DATE]. On [DATE], a weight of 75.8 pounds was documented. There is no acknowledgement of the [DATE] weight of 75.8 pounds, which reflects actual, further significant weight loss. On [DATE] there was a physician's order for biweekly weights (between ,d+[DATE] and [DATE]), and if weight decreased, resume continuous nutritional supplement feedings via g-tube. However, no weights were obtained between [DATE] through [DATE], except when surveyor inquired on [DATE].</p> <p>In addition, during an observation on [DATE] at 3:30 p.m., Licensed Practical Nurse (LPN) BB administered the incorrect amount of bolus g-tube formula to R#10 (administered 237 milliliters instead of 320 milliliters). Review of the Medication Administration Records (MAR) revealed no evidence that the physician ordered bolus nutritional supplement formula was administered as scheduled for 28 times in [DATE] and 27 times in [DATE].</p> <p>There was also repeated, systemic failure to implement pertinent interventions to address weight loss and/or nutrition and hydration risk for five residents (R#6, R#8, R#12, R#13, and R#14). R#6 and R#8 received nutrition and hydration via gastrostomy tube. R#12, R#13 and R#14 received nutrition and hydration orally.</p> <p>There was also evidence of a systemic failure related to dietary services to ensure that there was an adequate number of dietary staff and that the dietary staff had the skill set to carry out the functions of the food and nutrition services in the facility. Dietary staff failed to follow menus and individualized food plans for correct portion size to ensure residents' nutritional needs were met. R#12 and R#14 were to receive double portions of food because they were nutritionally compromised. By not receiving double portions, they were put at risk for further weight loss and/or poor nutritional status.</p> <p>The Immediate Jeopardies were related to the facility's noncompliance with the requirements at</p> <p>42 C.F.R. 483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656, Scope/Severity: K); 42 C.F.R. 483.21(b) Comprehensive Care Plans (F657, Scope/Severity: K); 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); 42 C.F.R. 483.25(g)(1)(2) Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K); 42 C.F.R. 483.60(a)(3) Sufficient Dietary Support Personnel (F802, Scope/Severity: K); 42 C.F.R. 483.60(c),(d+[DATE]), Menus and Nutritional Adequacy (F803, Scope/Severity: K); 42 C.F.R. 483.70 Administration (F835, Scope/Severity: K); 42 C.F.R. 483.70(d) Governing body (F837, Scope/Severity: K); 42 C.F.R. 483.75(g)(2) QAPI/QAA Improvement Activities (F867, Scope/Severity: K).</p> <p>Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); and 42 C.F.R. 483.25(g)(1)(2), Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0837</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>At the time of exit on [DATE], the IJ remained ongoing.</p> <p>Findings include:</p> <p>A review of the facility policy titled Quality Assurance Performance Improvement Management dated [DATE] documented, in part, the following: Authority: The Governing Body of this facility shall be ultimately responsible for the QAPI Performance Improvement Program. The Administrator represents the Governing Body of this facility.</p> <p>Review of the QAPI Committee Meeting Agenda/ Minutes revealed meetings held on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] with the Administrator present for all meetings except the [DATE] meeting. No other members of the governing body were present for any of the above meetings. During the [DATE] meeting, weights were discussed. However, there was no discussion regarding dietary staffing.</p> <p>During interview and observation of the lunch meal service on [DATE] at 12:05 p.m., there were two dietary staff observed working in the kitchen. Cook NN stated they have been working with two dietary staff on the day shift for the past three months. She stated three people would be better because they have to prepare, cook, serve and clean. She stated they also have been without a Dietary Manager for three months. She stated corporate told them two was enough to work in the kitchen. She stated since they have been without a Dietary Manager, she must place the food orders, do the schedule, print tray cards and cook.</p> <p>Registered Dietician MM stated on [DATE] at 12:15 p.m. that ideally, they need three staff in the kitchen, especially since Cook NN has been acting as the Dietary Manager and having to order food.</p> <p>During an interview with the Administrator on [DATE] at 3:10 p.m. and 3:35 p.m., he stated when he started employment at the facility in [DATE], the kitchen was already staffed with two people. He stated the kitchen staff have not complained to him about only having two people in kitchen and did not know who from corporate told them they could only have two staff in the kitchen.</p> <p>During an interview with Dietary Aide RR on [DATE] at 1:00 p.m., she stated corporate told them about three months ago that two people were enough to work in the kitchen on day shift. She stated day shift has to do breakfast and lunch and wash dishes and that it was just too much. At times they don't have time to make dessert for lunch or supper. She stated she has talked to the Administrator about it several times and he tells her just work with me, I'm trying to get people in.</p> <p>Refer to F802.</p> <p>21213</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213</p> <p>Based on record review, staff interviews, and review facility policy titled Quality Assurance Performance Improvement (QAPI) Management, the facility failed to identify concerns and effectively implement QAPI plans related to leadership and the weight management process including not following Registered Dietician (RD) recommendations, significant weight loss not addressed timely, weights not obtained routinely, water flushes and nutritional supplements not administered via gastrostomy tubes as ordered, food portions not served as planned and/or ordered, inadequate dietary staff, and nutrition care plans not revised and/or implemented. The facility census was 70 residents.</p> <p>On [DATE] a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents.</p> <p>The facility's Administrator and Director of Nursing (DON) LL were informed of the Immediate Jeopardy (IJ) on [DATE] at 1:55 p.m. The noncompliance related to the first IJ was identified to have existed on [DATE]. The noncompliance related to the second IJ was identified to have existed on [DATE].</p> <p>1.) The first IJ is outlined as follows:</p> <p>Resident (R) #5 was admitted to the facility on [DATE] and required bilateral below the knee amputations (BKA's) due to severe peripheral artery disease (PAD) with occlusion on [DATE]. Upon return from hospitalization status post bilateral BKA's on [DATE], the facility failed to clarify/obtain treatment orders for the surgical wounds. R#5 was diagnosed on [DATE] at the hospital emergency room with a wound infection to the left BKA. R#5 underwent a revision to the left BKA on [DATE] and returned to the facility the same day. The facility again failed to clarify/obtain treatment orders on return from the hospital on [DATE]. There was no evidence of wound care being provided from [DATE] through [DATE]. In addition, the left BKA revision site was not accurately assessed by nursing staff on hospital return and a scheduled follow up appointment with the surgeon was not kept on [DATE]. The resident expired at the facility on [DATE]. The death certificate listed diabetes as the cause of death.</p> <p>2.) The second IJ is outlined as follows:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>R#10, a [AGE] year-old resident with a diagnosis of cerebral palsy was dependent on staff and received all nutrition and hydration through a gastrostomy tube (g-tube). Weights for R#10 trended down from 89 pounds on [DATE] to 83 pounds on [DATE], despite repeated increases of bolus g-tube nutritional supplement formula. The last increase was on [DATE]. There was no evidence that a documented plan from the Nurse Practitioner (NP) on [DATE] for a follow-up weight and Registered Dietician (RD) evaluation in two weeks was followed. However, a nutritional assessment was completed on [DATE] when the RD acknowledged that there was no [DATE] weight but indicated that the ordered nutritional supplement formula and water flushes met the resident's needs. Despite R#10's downtrend of weight, even with incremental increases in the nutritional supplement formula, no weight was obtained, to continue to monitor his progress, after [DATE], until [DATE]. On [DATE], a weight of 75.8 pounds was documented. There is no acknowledgement of the [DATE] weight of 75.8 pounds, which reflects actual, further significant weight loss. On [DATE] there was a physician's order for biweekly weights (between ,d+[DATE] and [DATE]), and if weight decreased, resume continuous nutritional supplement feedings via g-tube. However, no weights were obtained between [DATE] through [DATE], except when surveyor inquired on [DATE].</p> <p>In addition, during an observation on [DATE] at 3:30 p.m., Licensed Practical Nurse (LPN) BB administered the incorrect amount of bolus g-tube formula to R#10 (administered 237 milliliters instead of 320 milliliters). Review of the Medication Administration Records (MAR) revealed no evidence that the physician ordered bolus nutritional supplement formula was administered as scheduled for 28 times in [DATE] and 27 times in [DATE].</p> <p>There was also repeated, systemic failure to implement pertinent interventions to address weight loss and/or nutrition and hydration risk for five residents (R#6, R#8, R#12, R#13, and R#14). R#6 and R#8 received nutrition and hydration via gastrostomy tube. R#12, R#13 and R#14 received nutrition and hydration orally.</p> <p>There was also evidence of a systemic failure related to dietary services to ensure that there was an adequate number of dietary staff and that the dietary staff had the skill set to carry out the functions of the food and nutrition services in the facility. Dietary staff failed to follow menus and individualized food plans for correct portion size to ensure residents' nutritional needs were met. R#12 and R#14 were to receive double portions of food because they were nutritionally compromised. By not receiving double portions, they were put at risk for further weight loss and/or poor nutritional status.</p> <p>The Immediate Jeopardies were related to the facility's noncompliance with the requirements at</p> <p>42 C.F.R. 483.21(b)(1) Develop/Implement Comprehensive Care Plan (F656, Scope/Severity: K); 42 C.F.R. 483.21(b) Comprehensive Care Plans (F657, Scope/Severity: K); 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); 42 C.F.R. 483.25(g)(1)(2) Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K); 42 C.F.R. 483.60(a)(3) Sufficient Dietary Support Personnel (F802, Scope/Severity: K); 42 C.F.R. 483.60(c),(d+[DATE]), Menus and Nutritional Adequacy (F803, Scope/Severity: K); 42 C.F.R. 483.70 Administration (F835, Scope/Severity: K); 42 C.F.R. 483.70(d) Governing body (F837, Scope/Severity: K); 42 C.F.R. 483.75(g)(2) QAPI/QAA Improvement Activities (F867, Scope/Severity: K).</p> <p>Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25 Quality of Care (F684, Scope/Severity: J); and 42 C.F.R. 483.25(g)(1)(2), Nutrition/Hydration Status and Maintenance (F692, Scope/Severity: K).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>At the time of exit on [DATE], the IJ remained ongoing.</p> <p>Findings include:</p> <p>The facility had a Quality Assurance Performance Improvement Management policy, dated [DATE]. The policy's overview included that the Quality Assurance Performance Improvement (QAPI) program provided an opportunity for the facility to assess current practices and procedures in order to determine a plan for improvement in the quality of care. The purpose of the QAPI program was to develop, implement, and maintain an ongoing program designed to monitor and evaluate customer satisfaction and the quality of resident care, pursue methods to improve quality care and other facility services, and to resolve identified problems. The policy also included that the QAPI committee would meet at least monthly and more often as needed.</p> <p>A review of QAPI Committee Meeting Agenda/Minutes form sign-in section revealed that the following staff members were part of the committee: Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Social Services Director, Activities Director, Minimum Data Set (MDS) Coordinator, Admissions Director, Dietary Manager, Housekeeping Supervisor, Maintenance Director, Unit Managers and Business Office Manager. Further review of the sign-in section of the QAPI committee meeting form, from previously held meetings, revealed that additional facility staff, including therapy, central supply, medical records and additional nursing staff also attended the meetings at times. The facility had held QAPI meetings on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE].</p> <p>During an interview on [DATE] at 3:00 p.m. the Administrator confirmed that he oversees the QA committee meetings. He stated that the committee meets monthly, but that they had not had a meeting in [DATE] due to the presence of the surveyors. He stated that their most recent meeting was on [DATE].</p> <p>During an interview on [DATE] at 10:45 a.m. the Administrator stated he was aware weights were not being obtained, and he had addressed it at the [DATE] QA meeting. However, he was not aware resident weights were not obtained the following month in [DATE]. He stated that he found out RD recommendations were not being acted on and had an additional RD and Certified Dietary Manager (CDM) coming in to assist in getting caught up because the RD that was usually at the facility had been out. A review of the [DATE] QAPI Committee Meeting Agenda/Minutes form revealed notes under the nursing section that documented all residents needed weights ASAP (as soon as possible) and that weekly weights were discussed on weight loss and residents with gastrostomy tubes.</p> <p>During an interview on [DATE] at 10:25 a.m. DON LL (as of [DATE]) stated that the facility's weight system was broken; the facility needed systems and education.</p> <p>Despite discussing the need for weights on all residents and weekly weights on residents with weight loss and gastrostomy tubes, the facility's QAPI process failed to follow up to ensure the weights were obtained as discussed. In addition, the facility's QAPI process failed to identify multiple additional nutrition system concerns for residents receiving nutrition and hydration via oral and non-oral routes including RD recommendations not acted on, significant weight loss not addressed timely, water flushes and nutritional supplements not administered via gastrostomy tubes as ordered, food portions not served as ordered, inadequate dietary staff, and nutrition care plans not revised and/or implemented for R#6, R#8, R#10, R#12, R#13, and R#14.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	

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 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Cross refer to F692.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2021
NAME OF PROVIDER OR SUPPLIER Providence Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 South Green Street Thomaston, GA 30286	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>21213</p> <p>Based on observations, interview, and review of facility in-service education records, facility staff failed to wear Personal Protective Equipment in accordance with facility practice to decrease exposure and spread of COVID-19 on three of five halls and at one of two nursing stations.</p> <p>Findings include:</p> <p>A review of in-service education records revealed that staff had been educated on wearing face masks while in the facility. Inservice education, dated 5/1/21 and 5/23/21, documented that masks were to be worn at all times when in the halls, residents' rooms and at the nurses' stations. The education records further documented that mask wearing was mandatory.</p> <p>However, on 10/4/21 three facility staff were observed not wearing face masks appropriately while in the hallways and/or at the nurses' stations.</p> <p>On 10/4/21 at 11:40 a.m. Dietary Staff CC was observed walking by the 100/200 hall nurse's station and down the 200 hallway to Unit Manager AA's office without wearing a face mask. Immediately following the observation, Dietary Staff CC was interviewed about the absence of a face mask and she stated that she left it in her car. Unit Manager AA provided her with a new mask.</p> <p>During an observation on 10/4/21 at 1:50 p.m. Licensed Practical Nurse (LPN) DD was observed seated at the 400/500 hall nurse's station with a face mask on top of her head, not covering her nose and mouth, and the Activity Director was observed in the 300 hallway working on the large activity calendar with her face mask detached from the right ear exposing her mouth and nose. During further interview on 10/4/21 at 1:55 p.m. Unit Manager AA (who was also oversaw infection control) stated that all staff were supposed to have a mask on.</p> <p>Following the observations of staff not wearing a face mask appropriately on 10/4/21, an additional education in-service was held on 10/4/21. Review of the in-service education record provided revealed that all staff were to wear a mask/face covering while in the facility at all times. The education further documented that masks may only be removed while eating and at least six feet away from others, outside at least 6 feet aware from others, or in an office alone.</p> <p>However, on 10/5/21 Housekeeping Staff EE was observed at 10:50 a.m. on the 300 hallway with his face mask pulled down exposing his nose and again at 1:55 p.m. on the 500 hallway with his face mask pulled down exposing his nose and mouth.</p> <p>At the time of exit on 11/16/21, there were no residents with COVID-19.</p>		