STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115537	A. Building B. Wing	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spalding Post Acute LLC	415 Airport Road Griffin, GA 30224

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, and review of facility policy titled Resident's Rights, the facility failed to ensure each resident's dignity was maintained related to wearing hospital gowns in bed during the day for 10 residents (Resident (R) 22, R37, R41, R80, R84, R154, R155, R156, R157, and R158) of 11 residents reviewed for dignity. Findings include: 1. Review of R80's Face Sheet located under the Misc. [miscellaneous] tab of the electronic medical record (EMR) revealed R80 was admitted to the facility on [DATE]. Review of R80's Quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 01/14/22 revealed R80 did not have a score for the Brief Interview for Mental Status (BIMS). The MDS revealed R80 was totally dependent on staff for dressing. Review of R80's 10/19/21 Care Plan, located in the EMR under the Care Plan tab, reflected a care plan for ADLs (activities of daily living) assistance with the goal of R80 will have all her ADL care needs met as evidenced by being clean, odor free and appropriately groomed and dressed daily through next review. On 02/07/22 at 10:05 AM, R80 was observed in her room in bed. R80 was awake and she was wearing a hospital gown. At 12:30 PM, R80 was observed again in her room in bed eating lunch and wearing a hospital gown. On 02/09/22 at approximately 12:45 PM, R80 was observed in her room in bed awake eating lunch and wearing a hospital gown. When R80 was asked about wearing hospital gowns, R80 stated she had clothes and pointed to two bins next to her bed. R80 said she would like to wear her normal clothes instead of a hospital gown if she could. On 02/10/22 at 8:25 AM, R80 was observed in her room in bed awake and wearing a hospital gown. At this time Certified Nurse Aide (CNA) 3 confirmed she was R80's CNA. CNA3 was asked about R80 wearing a hospital gown and CNA3 stated she did not think R80 had any clothes. But when R80 pointed to the bins at her bedside, CNA3 stated she did not know why residents were wearing hospital gowns as she has not worked with R80 in a while as she is agency staff. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R41's Face Sheet located under the Misc. tab of the EMR revealed R80 was admitted to the facility on [DATE]. Review of R41's Discharge MDS located in the EMR under the MDS tab with an ARD of 01/18/22 revealed R41 did not have a score for the BIMS and was checked as severely impaired for cognition. The MDS also revealed R41 was totally dependent on staff for dressing. Review of R41's 08/28/21 Care Plan, located under the Care Plan tab in the EMR, reflected a care plan for ADL assistance with the goal of R80 will have all his ADL care needs met as evidenced by being clean, odor free and appropriately groomed and dressed daily through next review. On 02/7/22 at 10:50 AM, 12:32 PM, and 4:30 PM, R41 was observed in his room in bed wearing a hospital gown while connected to a gastrostomy feeding tube. On 02/08/22 at 2:15 PM, R41 was observed in his bed wearing a hospital gown while connected to a gastrostomy feeding tube. On 02/09/22 at 8:30 AM, R41 was observed in his bed wearing a hospital gown while connected to a gastrostomy feeding tube. At 12:54 PM, R41 was observed in his bed wearing a hospital gown connected to a gastrostomy feeding tube. At this time R41's closet was observed with no clothes with his name on them. On 02/10/22 at 8:43 AM, R41 was observed in bed asleep wearing a hospital gown connected to a gastrostomy feeding tube. At this time CNA2 was asked about R41 being dressed in a hospital gown. She confirmed she was R41's CNA and stated she was not sure why R41 was dressed in a hospital gown, but she thought it could have been because R41 just came back from the COVID-19 hall. She went on to say residents who wear hospital gowns either want to wear a gown, they do not have clothes, or their clothes were in the laundry. On 02/10/22 at 2:15 PM, the Social Work Assistant was interviewed about R41's hospital gown. She states R41 had clothes in bags, but they had not been washed and hung up yet. 3. Review of R22's Admission Record located under the Profile tab of the EMR revealed R22 was admitted to the facility on [DATE]. Review of R22's significant change MDS located in the EMR under the MDS tab with an ARD of 11/21/21 revealed R22 had BIMS score of six out of 15, which indicated the resident was cognitively impaired. The MDS revealed R22 was totally dependent on staff for dressing. Review of R22's 04/23/21Care Plan, located under the Care Plan tab, reflected a care plan for ADL assistance with the goal of [R22's name] will have all her ADL care needs anticipated and met as evidenced by being clean, dry, odor free and appropriately groomed and dressed daily through next review. On 02/07/22 at 12:50 PM, R22 was observed in her room sitting in a Geri-chair eating lunch and wearing a hospital gown. On 02/08/22 at 10:05 AM, R22 was observed in her room in bed awake and wearing a hospital gown. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/10/22 at 8:25 AM, R22 was observed in her room in bed wearing a hospital gown. On 02/10/22 at 1:15 PM, the Social Work Assistance (SWA) stated R22 did have clothes for staff to dress her in. 4. Review of the EMR revealed the Admission Record under the Profile tab indicated that R84 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Observation on 02/07/22 at 10:39 AM revealed R84 was not in his room. Interview at this time with Licensed Practical Nurse (LPN) 7 revealed R84 left earlier this morning for dialysis. Observation of R84's room revealed R84 had no clothes in the closet. 5. Review of the EMR revealed the Admission Record under the Profile tab indicated that R156 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Observation on 02/07/22 at 10:50 AM revealed R156 was in bed wearing a hospital gown and there were no clothes in the closet. 6. Review of the EMR revealed the Admission Record under the Profile tab indicated that R37 was originally admitted to the facility on [DATE]. Observation on 02/07/22 at 10:58 AM revealed R37 was in bed wearing a hospital gown and there were no clothes in the closet. 7. Review of the EMR revealed the Admission Record under the Profile tab indicated that R155 was originally admitted to the facility on [DATE]. Observation on 02/07/22 at 11:02 AM revealed R155 was in bed wearing a hospital gown and there were no clothes in his closet. 8. Review of the EMR revealed the Admission Record under the Profile tab indicated that R157 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Observation on 02/07/22 at 12:15 PM revealed R157 was in bed wearing a hospital gown and there were no clothes in the closet. 9. Review of the EMR revealed the Admission Record under the Profile tab indicated that R158 was originally admitted to the facility on [DATE]. Observation on 02/07/22 at 12:30 PM revealed R158 was in bed wearing a hospital gown and there were no clothes in closet. Interview with LPN7 at this time revealed that R158 was positive for COVID-19 and was a transfer from another facility that did not keep residents that were COVID-19 positive. 10. Review of the EMR revealed the Admission Record under the Profile tab indicated that R154 was originally admitted to the facility on [DATE]. Observation on 02/07/22 at 1:50 PM revealed R154 was in bed wearing a hospital gown and in the closet was a coat but there were no other clothes. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Social Worker (SW) on 02/09/22 at 9:10 AM, the surveyor asked the SW if she was aware that residents on the PUI (person under investigation)/COVID unit were wearing hospital gowns and that they had no clothes in the closet. The SW stated that she was not aware that residents on this unit did not have clothes. She stated that when a resident was admitted to the facility, the nurse aides were responsible for completing the Inventory Sheet and if the resident did not have any clothes, the nurse aides would let the SW know. The SW stated that she would go to laundry and see if any of the donated clothing would fit the resident, she would contact the resident's family and that she could go to Walmart and purchase clothing for the resident. On 02/09/22 at 9:10 AM, the SW went to the PUI/COVID unit with the surveyor and confirmed that the residents were wearing hospital gowns and did not have clothing in their closet. While in R155's room, R155 indicated that in the plastic bag he brought from the hospital, he had one shirt and one pair of pants but that they needed to be washed. The SW stated to R155 that she would see that these clothes were washed and returned to him this evening. R155 stated that he would like to wear clothes instead of the hospital gown. Review of the facility's policy for Resident Rights, dated 2020, reflected IV. Respect and dignity. Every resident has a right to be treated with respect and dignity, including: .B. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40417 Based on interviews, record reviews, and facility policy review, the facility failed to ensure a code status (advance directive) was consistently recorded accurately throughout the clinical record for one resident (Resident (R) 31) of 10 residents reviewed for advanced directives. The facility's deficient practice had potential to affect treatment provided by the facility, to R31 (incorrect with R31's wishes or desires) in an emergent situation. Findings include: Review of facility-provided undated policy titled Code Status Orders revealed .All patients require a code status order as soon as possible upon admission/re-admission .Purpose To ensure that the patient's desired resuscitation wishes are documented in the medical record .document the resident's wishes in the medical record . Review of facility-provided policy titled ELECTRONIC MEDICAL RECORDS dated 11/2021 revealed . Electronic medical records may be used in lieu of paper records . Review of R31's electronic medical record (EMR) under the Clinical tab, Clinical Resident Profile revealed R31 had an admitted [DATE] with a re-entry date of 02/04/22 to the facility. Review of R31's EMR Clinical tab, under the Profile tab, and the heading Code Status, revealed no information for R31's code status. The Orders tab revealed no information regarding code status. The Care Plan tab revealed no information regarding the R31's code status. Interview on 02/07/22 at 12:45 PM revealed, License Practical Nurse (LPN) 4 confirmed staff at the facility would access the EMR under the profile tab to obtain a resident's code status information (if resident were to be found unresponsive). LPN4 confirmed the facility did not have hard charts for residents residing at the facility. Interview on 02/07/22 at 12:47 PM revealed, LPN5 confirmed staff at the facility would access the EMR under the profile tab to obtain a resident's code status information (if resident were to be found unresponsive). LPN5 confirmed the facility did not have hard charts for residents residing at the facility. During an interview on 02/10/22 at 11:30 AM, Certified Nursing Assistant (CNA) 1 stated, I do not know what code status he [R31] was. CNA1 confirmed and verified the facility did not have hard charts for the facility's residents. CNA1 confirmed the staff would access the resident's EMR to obtain code status information. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/10/22 at 02:22 PM, the Director of Nursing (DON) confirmed the facility staff would access resident's information on the EMR (under the profile tab), to obtain and or verify resident's code status information. DON verified and confirmed R31's EMR did not have code status information documented under profile, orders, Medication Administration Record (MAR) or care plan. The DON confirmed and verified the facility failed to ensure R31's code status information was entered on R31's EMR (therefore unavailable for staff access). The DON also confirmed the facility's failure to ensure the resident's EMR contained the correct code status information had the potential for resident's wishes or desires for treatment (in an emergent situation) to be administered incorrectly. DON stated R31's code status was not entered on his medical record when he was readmitted to the facility on [DATE]. During an interview on 02/10/22 at 6:19 PM, the Social Service Director (SSD) confirmed she entered information on the facility's residents' EMR regarding code status. SSD confirmed she reviewed the facility's residents' code status information, yearly and as needed. SSD confirmed and verified R31's EMR under profile tab should have contained his code status information for staff to access.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40417 Based on interviews, record reviews and facility policy review, the facility failed to ensure residents were free from misappropriation for three of three sampled residents reviewed for misappropriation (Resident (R) 21, R35, and R48). The residents' narcotic medications were diverted. The failure had the potential to affect any resident who resided at the facility. Findings include: Review of facility's policy titled .Freedom from Abuse, Neglect, and Exploration Policy and Procedure dated 2019 revealed, .facilitate resident's rights to be free from abuse, neglect misappropriation of resident property . Requested employee file for Licensed Practical Nurse (LPN) 9, who was allegedly involved with misappropriation for review. LPN9's employee file was requested; however, the facility did not provide the file for review. Review of a facility-provided document, on the facility's letter head with .RE: [reference] .5-Day follow . no date was included, revealed .investigation report regarding misappropriation of funds incident which occurred on 09/21/21 . The heading Complaint revealed .three of the residents were missing narcotic medication (sic) in the narcotic drawer . The heading Findings revealed . The investigation substantiate (sic) that drug diversion (sic) occurred thus misappropriation of residents funds took place ., regarding R21, R35, and R48. Review of a facility-provided document, on the facility's letter head with .RE: [reference] .5-Day follow . no date was included, revealed .This is 5 days follow up investigation report on the misappropriation of funds/meds missing incident which took place on 10/13/21 . The heading Complaint revealed . The heading revealed . [R35's name] Oxycodone [a narcotic pain medication] 5 mg narcotic .The narcotic card showed in the back that the blister were (sic) opened and the medication was taken out of the blister pack. There was another medication placed back into the medication blister pack and taped back . The heading Findings revealed . The investigation substantiate (sic) that drug diversion occurred thus misappropriation of residents funds took place . The follow up revealed LPN9 was the alleged perpetrator. Review of R21's Admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed R21 was admitted to the facility on [DATE]. The Med Diag [diagnosis] tab revealed multiple diagnoses to include chronic pain. Review of electronic medical record (EMR) labeled R35 revealed R35 was admitted to the facility on [DATE]. The Med Diag tab revealed multiple diagnoses to include chronic pain. Review of electronic medical record (EMR) labeled R48 revealed R48 was admitted to the facility on [DATE]. The Med Diag tab revealed multiple diagnoses to include chronic pain. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's former Director of Nursing (DON) involved with conducting the facility's investigations for misappropriation of resident's personal property (diversion of medication) on 09/21/21 and 10/13/21 was no longer employed at the facility. The alleged employee (LPN 9) was no longer employed at the facility. During an interview was on 02/10/22 at 2:58 PM, the facility's current DON, confirmed resident's narcotic medications for destruction, were stored in a lock box, in a locked file cabinet, in her locked office, when removed from use for residents at the facility. An interview was conducted on 02/10/22 at 7:00 PM, the Assistant Director of Nursing (ADON) confirmed and verified the facility terminated alleged LPN 9 regarding the incident on 10/13/21 for the allegation related to misappropriation of resident's property (narcotic medications). ADON stated, I do not know how the decision to terminate was involved. ADON confirmed, narcotic medication card had pill replaced in blister pack and resealed with tape. ADON was unsure if LPN 9 was reported to Georgia Board of Nursing. ADON stated, I heard there was an incident prior to that incident, when I was hired by the facility. An interview was conducted on 02/10/22 at 7:44 PM, the Administrator confirmed and verified the facility substantiated the allegations of misappropriation of R 21's, R 35's, and R48's narcotic medications (drug diversion) on 09/21/21 and on 10/13/21 for R35. The Administrator also confirmed full medication cart audit performed on 09/21/21. The Administrator further confirmed the audit revealed missing narcotics as follows: R21's 50 plus tablets of Hydrocodone, R35's 90 plus tablets of Oxycodone 5 mg tablets and R48's 120 tablets of Hydrocodone, from the locked narcotic drawer on the medication cart. Continued interview with the Administrator revealed the second incident (10/13/21), of drug diversion (misappropriation), R35's oxycodone narcotic card was resealed with tape. The Administrator stated, pharmacy evaluated the pill behind the tape in the blister back of R35's oxycodone medication card and determined the pill was not oxycodone. The Administrator confirmed the first incident (09/21/21) alleged LPN9's drug screen results was positive for marijuana but not for the oxycodone. The Administrator stated, the facility did not fire LPN9 at that time. When asked about a policy, the Administrator stated he was unsure if the facility had a policy regarding positive drug screen for employees. The Administrator stated the second incidence of missing narcotics occurred on 10/13/21 and confirmed LPN9 was terminated from employment at the facility due alleged involvement with both incidents of drug diversion. The Administrator stated LPN9 was working at the facility when both incidents occurred. The Administrator confirmed and verified both incidents of misappropriation of R21's, R35's and R48's personal belongs of narcotic medications (drug diversion) for dates 09/21/21 and 10/13/21 were reported to the proper authorities.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 36190 Based on record review, interview, and policy review, the facility failed to develop policies for abuse, neglect, exploration, or misappropriation of resident property that included screening of potential employees, related to obtaining reference checks prior to new employees starting work at the facility, for seven of nine newly hired employees' records reviewed. This had the potential to affect all 114 residents who resided in the facility. The findings include: 1. Review of the Administrator's employee file revealed a hire date of 08/01/21. No evidence was found in the employee file that reference checks had been conducted or any attempt to obtain information from previous employers and/or current employers. On 02/20/22 at 7:42 PM, the Administrator stated her hire information was kept at the corporate level. The Administrator did not provide the survey team with any documented evidence of reference checks or any information from previous employers prior to the exit. 2. Review of Licensed Practical Nurse (LPN) 4's employee file revealed a hire date of 12/29/21. No evidence was found in the employee file that reference checks had been conducted or any attempt to obtain information from previous employers and/or current employers. 3. Review of Registered Nurse (RN) 1's employee file revealed a hire date of 11/22/21. No evidence was found in the employee file that reference checks had been conducted or any attempt to obtain information from previous employers and/or current employers. 4. Review of LPN6's employee file revealed a hire date of 01/04/22. No evidence was found in the employee file that reference checks had been conducted or any attempt to obtain information from previous employers and/or current employers. 5. Review of the Staff Development's employee file revealed a hire date of 01/17/22. No evidence was found in the employee file that reference checks had been conducted or any attempt to obtain information from previous employers and/or current employers. 6. Review of RN2's employee file revealed a hire date of 01/26/22. No evidence was found in the employee file that reference checks had been conducted or any attempt to obtain information from previous employers and/or current employers. 7. Review of LPN7's employee file revealed a hire date of 01/02/19. No evidence was found in the employee file that reference checks had been conducted or any attempt to obtain information from previous employers and/or current employers. On 02/10/22 at 6:00 PM, the Human Resource Manager confirmed no reference checks were in the above employees' files. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/10/22 at 7:42 PM, the Administrator confirmed reference checks had not been performed on new hires. She stated she had to terminate the past human resource employee and the new Human Resource Manager would be doing the reference and previous employee checks going forward. Review of the facility's policy for Abuse Prohibition, dated 08/2019, reflected .2. The Center will screen potential employees for a history of abuse, neglect or mistreating patients, including checking with the appropriate licensing boards and registries. 2.1 The Center will not employ individuals who: 2.l.1 have been found guilty by a court of law of abusing, neglecting, or mistreating others; or 2.1.2 had a finding entered in the state nurse aide registry concerning abuse, neglect, mistreatment of others, or misappropriation of property. 2.1.2.1 Knowledge of actions by a court of law against an employee, which would indicate unfitness for service will be reported to the state nurse aide registry or licensing authority. Nothing was found in the policy about obtaining information from former employers whether favorable or unfavorable for prospective employees.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37245 Based on record review, interview, and facility policy review, the facility failed to ensure care plan interventions regarding emergency tracheostomy care were developed for one of five residents (Resident (R) 5) sampled for tracheostomy care. Additionally, the facility failed to ensure care plan interventions regarding emergency tracheostomy care were implemented for three of five residents (R23, R27, and R31) sampled for tracheostomy care. On 2/8/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on 2/8/2022 at 6:46 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/7/2022. The IJ is outlined as follows: The facility failed to ensure four of five residents with a tracheostomy had the necessary supplies in the event of a life-threatening emergency and failed to train facility nursing staff on the need and use of emergency tracheostomy kits at the bedside. The facility had five residents with tracheostomies. Upon observations on 2/7/2022 and 2/8/2022, four of the five residents, R5, R23, R27, and R31 did not have necessary emergency tracheostomy supplies at bedside and additional supplies were not located in the facility. In addition, interviews on 2/7/2022 and 2/8/2022 with nursing staff caring for the residents with tracheostomies (Licensed Practical Nurse (LPN)1, LPN2, and LPN3) revealed a lack of knowledge and training regarding emergency tracheostomy supplies. The IJ was related to the facility's noncompliance with the program requirements as follows: 42 CFR 483.21(b)(1) -- Develop/Implement Comprehensive Care Plan (F656 Scope/Severity (S/S): K), 42 CFR 483.25(i) -- Respiratory/Tracheostomy Care and Suctioning (F695 S/S: K), 42 CFR 483.35(a)(3)(4)(c) -- Competent Nursing Staff (F726 S/S: K), and 42 CFR 483.70 - Administration (F835 S/S: K). Additionally, Substandard Quality of Care was identified with the requirements at 42 CFR 483.25(i) -- Respiratory/Tracheostomy Care and Suctioning (F695 S/S: K). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Acceptable Removal Plan was received on 2/10/2022. The removal plan included placing tracheostomy supplies at the bedside in the resident's room and extra tracheostomy supplies in the nursing supply room, in-servicing nursing staff on location of tracheostomy supplies and tracheostomy care, care plan revision, and re-education of administration staff. Through interviews with facility staff, observation of tracheostomy supplies, clinical record review of revised care plans, and review of staff in-services, the survey team verified all elements of the facility's IJ Removal Plan, and the immediacy of the deficient practice was removed on 2/10/2022. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the provision of care for residents with tracheostomies. Findings include: Review of facility-provided policy titled, Person-Centered Care Plan, dated 06/21/19 revealed, . A comprehensive, individualized care plan will be developed within 7 days after completion of the comprehensive assessment for each patient that includes measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are identified in the comprehensive assessments. Care plans will be . communicated to appropriate staff . Review of the facility-provided policy titled, Tracheostomy Care-Suctioning dated 09/19/20 revealed, . The facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. Review of facility-provided undated policy titled, Oxygen Administration revealed, .The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there is a physician order for this procedure .Review the resident's care plan to assess any special needs of the resident . 1. Review of R5's undated Face Sheet provided by the facility revealed R5 was admitted to the facility on [DATE]. R5 was admitted with a tracheostomy. Review of R5's current Care Plan, located in the electronic medical record (EMR) under the Care Plan tab, revealed R5 had a tracheostomy and addressed tracheostomy general care; however, the care plan did not address emergency care and supplies for R5's tracheostomy. 2. Review of R23's undated Face Sheet, provided by the facility revealed R23 was admitted to the facility on [DATE] with a tracheostomy. Review of R23's current Care Plan, located in the EMR under the Care Plan tab, revealed R23 had a tracheostomy and addressed emergency tracheostomy care as follows: Tube out procedures: Keep extra trach [tracheostomy] tube and obturator at bedside. If tube is coughed out, open stoma with hemostat. If tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate HOB 45 degrees and stay with resident. Obtain medical help immediately. R23's care plan did not include the location of emergency supplies. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observations on 02/07/22 at 2:15 PM and 2:42 PM revealed an ambu (self-inflating bag resuscitator) bag hanging on R23's closet door and a red cloth bag hanging on the closet door. An interview and observation on 02/08/22 at 9:16 AM with the ADON revealed R23 had an emergency kit (red cloth bag) that was missing sterile gloves, lubricating jelly, and obturator. 3. Review of R27's undated Face Sheet, provided by the facility revealed R27 was admitted to the facility on [DATE] with a tracheostomy. Review of R27's current Care Plan, located in the EMR under the Care Plan tab, revealed R27 had a tracheostomy, and the care plan addressed emergency tracheostomy care as follows: Tube out procedures: Keep extra trach tube and obturator at bedside. If tube is coughed out, open stoma with hemostat. If tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate HOB 45 degrees and stay with resident. Obtain medical help immediately. R27's care plan did not include the location of emergency supplies. Observations on 02/07/22 at 2:12 PM, 3:22 PM, and 4:44 PM (with LPN3) revealed no emergency supplies available in R27's room. 4. Review of R31's electronic medical record (EMR), labeled R31, under the tab Clinical revealed R31 was admitted to the facility on [DATE] with a re-admitted [DATE]. R31 was readmitted with a tracheostomy. The Care Plan tab of R31's EMR revealed, R31's care plan included tracheostomy care (He does exhibit anxiety related to his trach, suctioning and trach care at times) as follows: Administer oxygen as ordered . Change Trach tube/inner cannula as ordered by physician .Provide education related to trach and trach care needs .Trach care as ordered . and addressed tracheostomy emergency .Tube out procedures: Keep extra trach tube and obturator at bedside. If tube is coughed out, open stoma with hemostat. If tube cannot be reinserted, monitor/document for signs of respiratory distress. If able to breathe spontaneously, elevate HOB 45 degrees and stay with resident. Obtain medical help immediately. There was no information regarding trach cannula size. Review of R31's Physician Orders, located in R31's EMR under the Orders tab revealed, R31's orders did not include any tracheostomy information including, physician orders for tracheostomy size, no physician orders for tracheostomy care management or emergency management. Review of R31's Medication Administration Record (MAR) for the month of February 2022, contained no information regarding trach management, suctioning, cleaning or changing inner cannula, trach cannula size, trach emergency management or oxygen administration through trach mask. Attempted to review, the Treatment Administration Record (TAR), the results obtained were No Order data found for TREATMENT ADMINISTRATION RECORD. An observation was conducted on 02/07/22 at 12:38 PM, entered R31's room (during the initial tour) there were no emergency tracheostomy supplies visible in R31's room. During an interview on 02/09/22 at 1:58 PM, the Medical Director confirmed the residents' EMR under care plans should include all aspects of care for trach on resident's care plan including trach care management, the size of the trach, suctioning procedure and trach emergency management care. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on 02/10/22 at 9:09 PM with MDS Coordinator (MDSC) 1 regarding R5, R23, R27, and R31. MDSC1 stated the tracheostomy care plans should have included, but not limited to, the following: risk for complications, location of emergency supplies, doctor orders, emergency process if tracheostomy becomes dislodged. MDSC1 stated R5 did not have comprehensive care plan that addressed the emergency process regarding tracheostomy care. MDSC1 also stated R23, R27, and R31's care plan had not been implemented. An interview was conducted on 02/10/22 at 9:11 PM with the MDSC2 regarding R5, R23, R27, and R31. MDSC2 confirmed R5's tracheostomy care plan was not comprehensive. Cross refer to F695. 40417

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 09262 Based on observation, interview and record review, the facility failed to provide activities of daily living (ADLs) for residents who were unable to provide their own ADLS such as trimming of finger and toenails and receiving showers for three residents (Resident (R) 37, R154, and R156) in the sample of 34. Findings include: 1. Observation on 02/07/22 at 10:58 AM revealed R37 had long fingernails on each hand and a dark substance underneath the nails. During an interview on 02/07/22 at 2:10 PM, Registered Nurse (RN) 1 confirmed that R37's fingernails were long, and that underneath the nail was a dark substance that needed to be cleaned. 2. Observation on 02/07/22 at 1:50 PM revealed that R154 had long fingernails. During an interview on 02/07/22 at 3:18 PM, RN3 confirmed that R154's fingernails were long and in need of trimming. 3. Observation on 02/07/22 at 4:08 PM during wound treatment of R156's pressure ulcers revealed that R156 had long toenails and that R156's hair appeared oily and unkept. During an interview on 02/07/22 at 4:08 PM, RN1 confirmed that R156 had long toes nails and that she would be added to the podiatrist list the next time he comes to the facility. During an interview with the Assistant Director of Nursing (ADON) on 02/10/22 at 02:42 PM, the ADON provided the surveyor R156's shower sheets dated 01/19/22 through 02/04/22 revealed that R156 last received a shower on 01/31/22. The ADON indicated residents are to receive two showers per week. During an interview on 02/10/22 at 12:57 PM, the Social Worker (SW) confirmed that the podiatrist was last here on 02/03/22 and would return on 02/15/22, at which time he would return and trim finger and toenails for all of the new residents, any residents that staff put on the list. The SW confirmed that the residents on the PUI (persons under investigation)/COVID unit where R37, R154 and R156 reside were not seen by the Podiatrist on 02/03/22.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37245 Based on observation, record review, interview, and review of facility policies titled NSG Trach Care and Tracheostomy Emergency Bedside Supplies, the facility failed to have emergency tracheostomy supplies readily available at the bedside for four of five residents (Resident (R) 5, R23, R27, and R31) sampled for tracheostomy care. On 2/8/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on 2/8/2022 at 6:46 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/7/2022. The IJ is outlined as follows: The facility failed to ensure four of five residents with a tracheostomy had the necessary supplies in the event of a life-threatening emergency and failed to train facility nursing staff on the need and use of emergency tracheostomy kits at the bedside. The facility had five residents with tracheostomies. Upon observations on 2/7/2022 and 2/8/2022, four of the five residents, R5, R23, R27, and R31 did not have necessary emergency tracheostomy supplies at bedside and additional supplies were not located in the facility. In addition, interviews on 2/7/2022 and 2/8/2022 with nursing staff caring for the residents with tracheostomies (Licensed Practical Nurse (LPN)1, LPN2, and LPN3) revealed a lack of knowledge and training regarding emergency tracheostomy supplies. The IJ was related to the facility's noncompliance with the program requirements as follows: 42 CFR 483.21(b)(1) -- Develop/Implement Comprehensive Care Plan (F656 Scope/Severity (S/S): K), 42 CFR 483.25(i) -- Respiratory/Tracheostomy Care and Suctioning (F695 S/S: K), 42 CFR 483.35(a)(3)(4)(c) -- Competent Nursing Staff (F726 S/S: K), and 42 CFR 483.70 - Administration (F835 S/S: K). Additionally, Substandard Quality of Care was identified with the requirements at 42 CFR 483.25(i) -- Respiratory/Tracheostomy Care and Suctioning (F695 S/S: K). (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Acceptable Removal Plan was received on 2/10/2022. The removal plan included placing tracheostomy supplies at the bedside in the resident's room and extra tracheostomy supplies in the nursing supply room, in-servicing nursing staff on location of tracheostomy supplies and tracheostomy care, care plan revision, and re-education of administration staff. Through interviews with facility staff, observation of tracheostomy supplies, clinical record review of revised care plans, and review of staff in-services, the survey team verified all elements of the facility's IJ Removal Plan, and the immediacy of the deficient practice was removed on 2/10/2022. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the provision of care for residents with tracheostomies. Findings include: Review of the facility's policy titled, NSG Trach Care, revised 01/02/19, indicated, A replacement tracheostomy tube must be available at the bedside at all times. The policy further stated, A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times. Review of facility's undated policy titled, Tracheostomy Emergency Bedside Supplies, revealed, .Each tracheostomy patient will have the following supplies at the bedside: Spare tracheostomy tube with obturator of the same make and size currently used, or one size smaller if the same size is not available .syringe . manual resuscitation bag, any necessary connectors to fit patient's tracheostomy tube. 1. Review of R5's undated Face Sheet provided by the facility revealed R5 was admitted to the facility on [DATE] with a tracheostomy. Review of R5's Physician Orders, located in the resident's electronic medical record (EMR) under the Orders tab revealed an order dated 10/19/21 of Shiley (brand of tracheostomy) #6. Upon entering R5's room during the initial tour on 02/07/22 at 11:44 AM, emergency tracheostomy supplies were not visible. An additional observation by a second surveyor was completed on 02/07/22 at 12:15 PM. During this observation, there were no emergency supplies visible at bedside or in R5's room. An interview was conducted on 02/07/22 at 4:14 PM with LPN2 regarding R5. LPN2 confirmed there were no emergency supplies available in R5's room. LPN2 stated she did not know how to use the emergency tracheostomy kit. An interview and observation were conducted by two surveyors on 02/08/22 at 9:21 AM with the Assistant Director of Nursing (ADON) regarding R5. The ADON stated the tracheostomy emergency supplies should be readily visible in the resident's room. The ADON looked through R5's bedside table drawers and found the emergency kit with the following items: three foam tracheostomy ties, tracheostomy cleaning kit, Shiley size 7.6 mm (millimeter), Shiley size 6.4 mm, and tracheostomy mask. The ADON confirmed there were no sterile gloves, lubricating jelly, or obturator in R5's room. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a Respiratory Therapy note, provided to the survey team by the facility's Respiratory Therapist (RT), dated 01/06/22 revealed the following for R5: Pt needs #8 trach @ [at] bs [bed side] for emergency purposes, a red airway emergency bag . 2. Review of 23's undated Face Sheet provided by the facility revealed R23 was admitted to the facility on [DATE]. R23 was admitted with a tracheostomy. Review of R23's Physician Orders located in the resident's EMR under the Orders tab, revealed an order dated 10/24/21 of Shiley #6. Upon entering R23's room during the initial tour on 02/07/22 at 2:15 PM, there was an ambu (self-inflating bag resuscitator) bag hanging on the resident's closet door and a red cloth bag hanging on the closet door. At the time of observation, the contents of the red cloth bag were unknown. An additional observation by a second surveyor was completed on 02/07/22 at 2:42 PM. During this observation, R23's had an ambu bag and red cloth bag remained hanging on the closet door. An interview was conducted on 02/07/22 at 4:46 PM with LPN3 regarding R23. LPN3 stated she did not know the location of tracheostomy emergency supplies for R23. An interview and observation were conducted by two surveyors on 02/08/22 at 9:16 AM with the ADON regarding R23. The ADON confirmed R23 had an ambu bag and emergency kit containing the following supplies: Shiley size 5.0 mm, two Shiley size 6.4, suctioning kit, tracheostomy cleaning kit, two foam tracheostomy ties, tracheostomy mask. The ADON confirmed there were no sterile gloves, lubricating jelly, or obturator in R23's room. 3. Review of R27's undated Face Sheet provided by the facility revealed R27 was admitted to the facility on [DATE]. R27 was admitted with a tracheostomy. Review of R27's Physician Orders located in the EMR under the Orders revealed an order dated 12/02/21 for Shiley #6. Review of R27's significant change Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 12/20/21 indicated R27 had a Brief Interview for Mental Status (BIMS) of 13 out of 15, which indicated the resident was cognitively intact. Upon entering R27's room during the initial tour on 02/07/22 at 2:12 PM, emergency tracheostomy supplies were not visible. An additional observation by a second surveyor was completed on 02/07/22 at 3:22 PM for R27. During this observation, the ambu bag was covered by other items and there was no emergency tracheostomy supplies available. An interview was conducted on 02/07/22 at 4:44 PM with LPN3 regarding R27. LPN3 confirmed there were no emergency supplies available in R27's room. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted by two surveyors, with the ADON present, on 02/08/22 at 9:14 AM with R27. The resident stated that she has an ambu bag in her room but does not have the emergency kit. R27 further stated, I have heard other people receiving the red emergency kit, but I didn't get one. Review of a Respiratory Therapy note, provided to the survey team by the facility's RT, dated 01/06/22 revealed the following for R27: Pt needs placed @ bs: red emergency airway bag, #6 trach and #4 trach for emergency bs equip. An additional RT note, dated 12/17/21 revealed the following for R27: Pt needs emergency bs equipment noted as well as a red emergency airway bag. An additional RT note dated 12/08/21 revealed the following for R27: Pt needs emerg bs equipment - Ambu bag/mask, #6 trach, #4 trach (red airway bag). These items should remain visible and easily accessible. An interview and observation were conducted by two surveyors on 02/08/22 at 9:10 AM with the ADON regarding R27. The ADON stated the tracheostomy emergency supplies should be readily visible in the resident's room. The ADON searched through R27's drawers, closets, and bathroom. The ADON confirmed the emergency supply kit was not in R27's room nor an obturator but did find the ambu bag behind R27's curtain. 4. Review of R31's electronic medical record (EMR), labeled R31, under the tab Clinical revealed R31 was admitted to the facility on [DATE] with a re-admitted [DATE]. R31 was readmitted with a tracheostomy. Review of R31's Physician Orders, located in the resident's EMR under the Orders tab revealed, R31 had no information regarding his trach including, physician orders for tracheostomy size, no physician orders for tracheostomy care management or emergency management and no physician order for oxygen administration. Review of R31's Medication Administration Record (MAR) for the month of February 2022, contained no information regarding trach management, suctioning, cleaning, or changing inner cannula, trach cannula size, trach emergency management or oxygen administration through trach mask. Attempted to review, the Treatment Administration Record (TAR), the results obtained were No Order data found for TREATMENT ADMINISTRATION RECORD. The Med Review of R31's Med Diag [diagnosis] tab located in the resident's EMR revealed multiple diagnoses including tracheostomy (03/21/21), malignant neoplasm of glottis and absence of larynx, acute and chronic respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD). An observation was conducted on 02/07/22 at 12:38 PM, entered R31's room (during the initial tour) there were no emergency tracheostomy supplies visible in R31's room. An interview was conducted on 02/07/22 at 3:46 PM with LPN1 regarding R31. LPN1 confirmed and verified there were no emergency supplies available in R31's room. LPN1 further stated she had not received tracheostomy care or emergency tracheostomy training from the facility. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview and observation were conducted by two surveyors on 02/08/22 at 8:47 AM with LPN4 regarding R31. LPN4 stated there should be a replacement tracheostomy at R31's bedside. LPN4 confirmed with two surveyors that there was no replacement tracheostomy in R31's room. LPN4 stated she received training last year on suctioning and cleaning the tracheostomy but not on emergency tracheostomy (in the event R31's tracheostomy became dislodged). LPN4 further stated she would obtain a replacement tracheostomy from the nursing supply room. An interview and observation were conducted by two surveyors on 02/08/22 at 8:56 AM with the ADON regarding R31. The ADON stated the tracheostomy emergency supplies should be readily available and visible in the resident's room. The ADON confirmed the emergency supplies were not available or visible. The ADON searched R31's room and found the emergency supply kit in the resident's closet. The ADON confirmed the emergency supply kit contained the following: tracheostomy cleaning kit, inner cannula size 6. 4 mm, and an opened suction catheter. The ADON stated the emergency supply kit should have also contained the following: extra tracheostomy, lubricating jelly, sterile gloves, suction cannula, and obturator. The ADON further stated she would check the nursing supply room for tracheostomy supplies if the supplies were not available in the resident's room. An interview and observation were conducted by two surveyors on 02/08/22 at 9:04 AM in the supply room with the ADON regarding the nursing supply room on the Gardenia Unit. The ADON stated the supply room did not have the following items: emergency tracheostomy kits, inner cannulas, sterile gloves, or suctioning catheter kits. An interview was conducted on 02/08/22 at 10:07 AM, with the ADON, Director of Nursing (DON) and Administrator. The DON and Administrator confirmed and verified emergency tracheostomy equipment was not at bedside for R5, R23, R27, and R31. The DON and Administrator verified emergency tracheostomy equipment should be visible and available for residents residing at the facility with tracheostomies. An interview was conducted on 02/10/22 at 3:25 PM with the facility's RT regarding R5, R23, R27, and R31. She stated the following emergency equipment should be at bedside, readily visible and accessible: suction machine, ambu bag with mask, same size tracheostomy and a size smaller, and obturator.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37245 Based on interviews, record review and review of facility's policies, the facility failed to ensure tracheostomy (trach) care management for an artificial airway (cuff inflation, airway cleaning, tube changes, assessments and ongoing monitoring of respiratory functioning) was provided by competent, trained and skilled licensed staff, who were allowed to provide tracheostomy care for four of five sampled residents (Resident (R) 5, R24 R37 and R31). On 2/8/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on 2/8/2022 at 6:46 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/7/2022. The IJ is outlined as follows: The facility failed to ensure four of five residents with a tracheostomy had the necessary supplies in the event of a life-threatening emergency and failed to train facility nursing staff on the need and use of emergency tracheostomy kits at the bedside. The facility had five residents with tracheostomies. Upon observations on 2/7/2022 and 2/8/2022, four of the five residents, R5, R23, R27, and R31 did not have necessary emergency tracheostomy supplies at bedside and additional supplies were not located in the facility. In addition, interviews on 2/7/2022 and 2/8/2022 with nursing staff caring for the residents with tracheostomies (Licensed Practical Nurse (LPN)1, LPN2, and LPN3) revealed a lack of knowledge and training regarding emergency tracheostomy supplies. The IJ was related to the facility's noncompliance with the program requirements as follows: 42 CFR 483.21(b)(1) -- Develop/Implement Comprehensive Care Plan (F656 Scope/Severity (S/S): K), 42 CFR 483.25(i) -- Respiratory/Tracheostomy Care and Suctioning (F695 S/S: K), 42 CFR 483.35(a)(3)(4)(c) -- Competent Nursing Staff (F726 S/S: K), and 42 CFR 483.70 - Administration (F835 S/S: K). Additionally, Substandard Quality of Care was identified with the requirements at 42 CFR 483.25(i) -- Respiratory/Tracheostomy Care and Suctioning (F695 S/S: K). (continued on next page)

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	115537	A. Building B. Wing	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spalding Post Acute LLC	415 Airport Road Griffin, GA 30224

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Acceptable Removal Plan was received on 2/10/2022. The removal plan included placing tracheostomy supplies at the bedside in the resident's room and extra tracheostomy supplies in the nursing supply room, in-servicing nursing staff on location of tracheostomy supplies and tracheostomy care, care plan revision, and re-education of administration staff. Through interviews with facility staff, observation of tracheostomy supplies, clinical record review of revised care plans, and review of staff in-services, the survey team verified all elements of the facility's IJ Removal Plan, and the immediacy of the deficient practice was removed on 2/10/2022. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the provision of care for residents with tracheostomies. Findings include: Review of facility-provided paper document titled, Facility Assessment Tool, dated 04/22/21 under the heading Staff training, education and competencies ., revealed .Training and competencies are maintained in the associates personnel file and updated periodically & annually as determined by center and recertification needs. Review of facility-provided paper document titled, Assistant Director or Nursing [ADON] job description revealed .Ensures that staff participates in training programs .relevant policies and procedures Review of facility-provided paper document titled, Licensed Practical Nurse [LPN] job description revealed . Attends continuing education programs to maintain competency . Requested from the facility a policy for tracheostomy management and tracheostomy emergency management. The facility did not provide policy for review. Review of the facility-provided policy titled, Tracheostomy Care-Suctioning dated 09/19/20 date revealed, . The facility will ensure that residents who need respiratory care, including tracheal suctioning, are provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. 1. Review of R5's undated Face Sheet provided by the facility revealed R5 was admitted to the facility on [DATE]. R5 was admitted with a tracheostomy. Review of R5's Physician Orders, located in the resident's electronic medical record (EMR) under the Orders tab revealed an order dated 10/19/21 of Shiley (brand of tracheostomy) #6. Observations on 02/07/22 at 11:44 AM and 12:15 PM revealed no emergency supplies visible at bedside or in R5's room. An interview was conducted on 02/07/22 at 4:14 PM with Licensed Practical Nurse (LPN) 2 regarding R5. LPN2 stated she did not know how to use an emergency tracheostomy kit. LPN2 further stated she had not received tracheostomy care or emergency tracheostomy training at this facility. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Review of 23's undated Face Sheet provided by the facility revealed R23 was admitted to the facility on [DATE]. R23 was admitted with a tracheostomy. Review of R23's Physician Orders located in the resident's EMR under the Orders tab, revealed an order dated 10/24/21 of Shiley #6. Observations on 02/07/22 at 2:15 PM and 2:42 PM revealed an ambu (self-inflating bag resuscitator) bag hanging on R23's closet door and a red cloth bag hanging on the closet door. The emergency kit (red cloth bag) was missing sterile gloves, lubricating jelly, and obturator. An interview was conducted on 02/07/22 at 4:46 PM with LPN3 regarding R23. LPN3 stated she did not know the location of tracheostomy emergency supplies for R23. 3. Review of R27's undated Face Sheet provided by the facility revealed R27 was admitted to the facility on [DATE]. R27 was admitted with a tracheostomy. Review of R27's Physician Orders located in the EMR under the Orders revealed an order dated 12/02/21 for Shiley #6. Observations on 02/07/22 at 2:12 PM and 3:22 PM, and 4:44 PM (with LPN3) revealed no emergency supplies available in R27's room. An interview was conducted on 02/07/22 at 4:44 PM with LPN3 regarding R27. LPN3 stated she did not know what emergency equipment would be used if R27's tracheostomy became dislodged. LPN3 further stated she received approximately two minutes of training regarding suctioning of tracheostomy but did not receive training on emergency care. 4. Review of R31's electronic medical record (EMR), labeled R31, under the Clinical tab, revealed R31 was readmitted to the facility on [DATE] with a tracheostomy. An observation was conducted on 02/07/22 at 12:38 PM and there were no emergency tracheostomy supplies visible in R31's room. An interview was conducted on 02/07/22 at 3:46 PM with LPN1 regarding R31. LPN1 further stated she had not received tracheostomy care or emergency tracheostomy training from the facility. An interview and observation were conducted by two surveyors on 02/08/22 at 8:47 AM with LPN4 regarding R31. LPN4 stated there should be a replacement tracheostomy at R31's bedside. LPN4 stated she received training last year on suctioning and cleaning the tracheostomy but not on emergency tracheostomy (in the event R31's tracheostomy became dislodged). Review of the Daily Assignment Sheet, provided to the survey team by the facility, revealed that the LPNs interviewed were the primary caregivers for R5, R23, R27, and R31. Review facility-provided paper document titled Trach Training by RT [Respiratory Therapist] dated 10/07/21 (2 hours) revealed six licensed staff members signatures. The content of the material taught was not provided by the facility. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An informal interview was conducted on 02/08/22 at 10:30 AM with the Administrator who verified and confirmed the facility's staff had no access to facility's policies and procedures. The Administrator also verified and confirmed facility's policy and procedures were for guidance for staff members including licensed staff. The Administrator confirmed and verified, DON was not able to access facility's policies or procedures. The Administrator further stated the DON was a new employee at the facility and did not have authorization to access the information in the computer. An interview conducted on 02/10/22 at 3:09 PM revealed, Respiratory Therapy (RT), confirmed she provided trach education to LPN staff regarding trach care on 10/07/21. The RT confirmed only six staff attended the trach education class at the facility on 10/07/21. The RT stated, the content of the material covered in the class included: trach suctioning, trach care, 30-day replacement, manual resuscitation (ambu) for trach residents. The RT confirmed emergency trach equipment should be kept at resident's bedside and visible, including an ambu bag for manual ventilation. The RT also confirmed and verified she taught LPN staff to reinsert trachs for residents with dislodged or displaced trachs. The RT stated the staff could cover the trach stoma with their finger and perform rescue breathing using an ambu bag mask, sealed over resident's nose and mouth to aid with oxygen replacement, for respiratory distress (in the event of an emergency (for displacement or dislodged trach).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36190 Based on observation, interview, record review, and policy review, the facility failed to ensure ovens, cold storage units, walls, ceiling, light fixtures, furniture, and floors throughout the kitchen and other food areas were kept clean and/or in good repair. This deficient practice had the potential to affect 112 of 114 residents who receive meals prepared in the facility's only kitchen. Findings include: During the kitchen tours with the Dietary Manager (DM) on 02/07/22 at 9:42 AM and with the DM and District Manager on 02/09/22 at 10:00 AM the following observations were made: The wall columns were gouged with broken edges. The walls throughout kitchen were scraped and the blue paint was peeling and worn, especially around the hand sink and three-compartment sink. The double door reach-in refrigerator was noted to have standing water throughout the bottom shelf. The DM stated the unit had a leak that needed to be addressed. The walk-in freezer contained a large accumulation of ice on 02/07/22. The DM stated at this time the unit had a leak. On 02/09/22, the district manager confirmed there was still a leak that needed to be addressed. The floor in front of the three-compartment sink had five ceramic tiles missing. The DM stated repairs to the floor had just been completed and the tiles had come lose since the repairs. A section of the ceiling contained large water stains. The DM stated the stains were from two months ago. Another ceiling section adjacent the air duct contained a torn piece of gypsum (fire resistant dry wall) board. The DM stated at this time the air conditioning was recently repaired. The oven on the left side of the range and the left convection oven contained an accumulation of baked-on residue. At least three pans were noted to have a build-up of cooked-on black residue on the exterior bottoms. The bottom shelf on the beverage station contained rust stains and torn shelf liner paper. The area in and around the dish machine was noted to have low level lighting. A ceiling light fixture above the dish machine had exposed wires hanging down and no light bulbs. Two other light fixtures above the dish machine area were noted to have burnt out bulbs. The window seal in the dish machine area was badly gouged and worn paint. The DM confirmed the observations and stated new pans had been ordered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The double doors leading into the utility hall contained worn, scraped paint. The vinyl tile flooring in the space across the kitchen housing the ice machine and a cold storage unit was noted to be worn, stained and gapping tiles. During the tours of the nourishment rooms called pantries on 02/10/22 at 8:53 AM for the north station and at 3:40 PM for the south station, the following observations were made: The north station pantry was noted to contain rodent-like droppings and old condiment packet trash debris in the drawer against the wall. The lower cabinet was noted to have more rodent-like droppings, a broken shelf, trash debris, and dried spillage. The Housekeeping Supervisor observed these conditions at 9:30 AM and he stated it was housekeeping's responsibility to clean these rooms. The south station pantry was noted to contain a bed spread in the cabinet below sink soaking up water. The right-side cabinet contained dead bug debris. Review of the kitchen's policy for the environment, revised 9/2017, reflected All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. Review of the kitchen's policy for equipment, revised 9/2017, reflected All food service equipment will be clean, sanitary, and in proper working order.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37245 Based on observation, record review, interview, and facility policy review, the facility failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to maintain the highest practicable level of well-being four of five residents (Resident (R) 5, R23, R27, and R31) sampled for tracheostomy care. Specifically failing to ensure that competent nursing staff were available and trained to care for residents admitted with special care needs such as care for a tracheostomy. The facility also failed to ensure staff had adequate supplies in the event of an emergency for residents with tracheostomies. On 2/8/2022, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on 2/8/2022 at 6:46 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/7/2022. The IJ is outlined as follows: The facility failed to ensure four of five residents with a tracheostomy had the necessary supplies in the event of a life-threatening emergency and failed to train facility nursing staff on the need and use of emergency tracheostomy kits at the bedside. The facility had five residents with tracheostomies. Upon observations on 2/7/2022 and 2/8/2022, four of the five residents, R5, R23, R27, and R31 did not have necessary emergency tracheostomy supplies at bedside and additional supplies were not located in the facility. In addition, interviews on 2/7/2022 and 2/8/2022 with nursing staff caring for the residents with tracheostomies (Licensed Practical Nurse (LPN)1, LPN2, and LPN3) revealed a lack of knowledge and training regarding emergency tracheostomy supplies. The IJ was related to the facility's noncompliance with the program requirements as follows: 42 CFR 483.21(b)(1) -- Develop/Implement Comprehensive Care Plan (F656 Scope/Severity (S/S): K), 42 CFR 483.25(i) -- Respiratory/Tracheostomy Care and Suctioning (F695 S/S: K), 42 CFR 483.35(a)(3)(4)(c) -- Competent Nursing Staff (F726 S/S: K), and 42 CFR 483.70 - Administration (F835 S/S: K). Additionally, Substandard Quality of Care was identified with the requirements at 42 CFR 483.25(i) -- Respiratory/Tracheostomy Care and Suctioning (F695 S/S: K). (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Acceptable Removal Plan was received on 2/10/2022. The removal plan included placing tracheostomy supplies at the bedside in the resident's room and extra tracheostomy supplies in the nursing supply room, in-servicing nursing staff on location of tracheostomy supplies and tracheostomy care, care plan revision, and re-education of administration staff. Through interviews with facility staff, observation of tracheostomy supplies, clinical record review of revised care plans, and review of staff in-services, the survey team verified all elements of the facility's IJ Removal Plan, and the immediacy of the deficient practice was removed on 2/10/2022. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing the provision of care for residents with tracheostomies. Findings include: Review of the facility administrator's job description revealed under the Administrative Functions Plan, develop, organize, implement, evaluate, and direct facility's programs and activities, and Assist in development of written policies and procedures that govern operation of facility . Staff Development Participates in in-service training prior to performing tasks that are new or that employee does not feel competent performing . Competency section Maintains competency & is tested to be competent in: subject to change based on educational needs of staff . Equipment & Supply Functions Ensure that all personnel have proper equipment needed to do their job. Review of the facility-provided paper document titled, Director of Nursing . [DON's] job description revealed the position was, .plan, organize, develop, and direct the overall operations of the Nursing Service Department .to ensure that the highest degree of quality of care is maintained at all times . Facility Administration, including the Administrator and DON, failed to consistently and effectively oversee areas of the facility that were included in their job descriptions. 1. Administration failed to ensure care plan interventions regarding emergency tracheostomy care were developed for R5; and failed to ensure care plan interventions regarding emergency tracheostomy care were implemented for R23, R27, and R31. Cross refer to F656. 2. Administration failed to ensure emergency tracheostomy supplies were readily available at the bedside for R5, R23, R27, and R31. Cross refer to F695. 3 Administration failed to ensure residents with tracheostomies (R5, R24 R37 and R31) were provided nursing care by competent, trained and skilled licensed staff. Cross refer to F726. R5, R23, R27, and R31 were observed on 02/07/22 with lack of emergency tracheostomies supplies at bedside. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview and observation were conducted by two surveyors on 02/08/22 at 9:04 AM in the supply room with the ADON regarding the nursing supply room on the Gardenia Unit. The ADON stated the supply room did not have the following items: emergency tracheostomy kits, inner cannulas, sterile gloves, or suctioning catheter kits. An interview was conducted on 02/08/22 at 10:07 AM with the ADON, Director of Nursing (DON) and Administrator. The DON and Administrator confirmed and verified emergency tracheostomy equipment was not at bedside for R5, R23, R27, and R31. The DON and Administrator verified emergency tracheostomy equipment should be visible and available for these residents. The Administrator stated, the trach supplies were delivered to the facility on Friday and currently are sitting outside on the dock in boxes. The Administrator stated the staff would not know to look for tracheostomy supplies on the dock outside. An interview was conducted on 02/08/22 at 10:30 AM with the Administrator, DON, and the Regional Director of Operations. The Administrator verified and confirmed the facility's staff had no access to facility's policies and procedures. The Administrator verified and confirmed facility's policy and procedures were for guidance for staff members including licensed staff. The Administrator confirmed and verified, DON was not able to access facility's policies or procedures. The Administrator stated the DON was a new employee at the facility and did not have authorization to access the information in the computer. The Regional Director of Operations stated the staff at the facility did not have access to the policies and procedures due to the company recently purchasing the building and the policies and procedures had not transitioned from the corporate level to the facility level. An interview was conducted on 02/10/22 at 10:06 PM with the Administrator. The Administrator stated he was not aware tracheostomy supplies were not at R5, R23, R27, and R31's bedside, and was unaware of the lack of tracheostomy supplies in the nursing supply closet. The Administrator also stated tracheostomy care was not included in any of the facility quality assurance plans.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262 Based on record review, interview, and review of policy, the facility failed to document which pneumococcal vaccine residents received. In addition, the facility failed to provide the pneumococcal vaccines to residents who were eligible for the vaccine and had not received the vaccine. This deficient practice affected five residents (Resident (R) 14, R32, R65, R85 and R97) reviewed for pneumococcal vaccination in the sample of 34. Findings include: Review of the Resident Listing Report dated 02/07/22 provided by the facility revealed that R14 was [AGE] years old, R32 was [AGE] years old and R97 was [AGE] years old. Review of R14, R32 and R97's Electronic Medical Record (EMR) revealed the Immunization Report under the Misc. tab documented R14, R32 and R97 received the pneumovax vaccine on 01/14/21. There was no documentation on the form to indicate which pneumovax vaccine, Prevenar 13 (PCV13) or Pneumovax (PPSV23), these residents received. Interview with the Assistant Director of Nursing (ADON) on 02/10/22 at 2:42 PM, the ADON provided R14's, R32's, and R97's immunization document and confirmed that there was no documentation on the forms to indicate which pneumovax the residents received. The ADON indicated that she obtained the pneumovax immunization information from the GRIT [Georgia Registry of Immunization Tracking]. The ADON stated that she has not been able to contact these residents' physicians or the residents' families to obtain further information regarding what type of pneumovax the residents received. Review of the Resident Listing Report, dated 02/07/22 provided by the facility revealed R65 was [AGE] years old and R85 was [AGE] years old. Review of R65 and R85's EMR revealed the Immunization Report under the Misc. tab documented that R65 and R85 had not received the pneumovax vaccine. During the interview with the ADON on 02/10/22 at 2:42 PM, revealed that there was no documentation in these residents' EMRs that the pneumovax was offered and education was provided, so that the residents could make an informed decision whether to receive the pneumovax vaccine. Review of the undated facility's policy titled, Pneumococcal Vaccination: Prevenar 13 (PC13) or Pneumovax (PPSC23) revealed, The Center will provide the opportunity to receive the pneumococcal vaccine to all patients. A licensed nurse will provide pneumococcal vaccinations to patients .Process. 1. Upon admission, obtain the pneumococcal vaccination history of all patients .2.1 provide the patient/resident representative education .regarding the benefits and potential side effects of vaccination .2.3 For patients [AGE] years of age or older .document discussion between healthcare provider and patient/resident representative .4. Document the patient either receive the pneumococcal vaccination in patient's MAR [Medication Administration Record] and in the [EMR], did not receive the pneumococcal vaccination due to contraindications, refusal or already received in [EMR] .

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report COVID19 data to residents and families. 09262 Based on interview, record review, and review of Centers for Medicare & Medicaid Services (CMS) Quality, Safety & Oversight (QSO) memo 20-29, the facility failed to notify the residents, families and their representatives by 5:00 PM the next calendar day following the occurrence of a resident or staff that tested positive for COVID-19 four times in December 2021. Findings include: Interview with the Administrator on 02/10/22 at 9:00 AM, the Administrator described her process for the notification of residents, families, and their resident representatives of residents and/or staff that test positive for COVID. The Administrator stated that she creates a message which identifies how many staff and/or residents were positive for COVID-19 and then sends out the information per email or text messages to the resident, families, and residents' representatives. Review of the facility's line list which indicated COVID-19 positive residents and/or staff revealed that on 12/18/21, a staff person tested positive for COVID-19. Review of the Administrator's notification revealed that there was no documentation to indicate that the residents, families, and representatives were notified by 12/19/21 at 5:00 PM. Review of the facility's line list which indicated on 12/20/21 a staff person tested positive for COVID-19. However, review of the Administrator's message that was sent to residents, families and representatives revealed that they were notified on 12/22/21 at 5:00 PM. Review of the facility's line list which indicated on 12/24/21, that a staff person tested positive for COVID-19. However, there was no documentation that residents, families, and representatives were notified by 12/25/21 at 5:00 PM. Review of the facility's line list which indicated on 12/25/21, that a staff person tested positive for COVID-19. However, review of the Administrator's notification revealed that the message that was sent to residents, families, and representatives on 12/27/21 at 5:00 PM. During the interview on 02/10/22 at 9:00 AM, the Administrator confirmed that based on the line list and her emails, two instances, 12/20/21 and 12/25/21, residents, families and representatives were not notified by the next day at 5:00 PM. She also verified that on 12/18/21 and 12/24/21, she did not send out a message per email or text to notify residents, families, and representatives that staff had tested positive for COVID-19. Review of the undated facility's policy titled, Coronavirus (COVID19) (SARS-CoV-2) revealed, .Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19 . Review of the CMS QSO memo 20-29 which indicates, .Include any cumulative updates for residents, their representatives, and families . by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified .