STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 34318 Based on staff interview, record review and review of facility policy titled Resident Grievance Process, the facility failed to make prompt efforts to resolve dental service grievances for Resident (R) #8; and failed to maintain records of completed and/or pending grievances for R#7. The sample size was 40 residents. Findings include: Review of the facility policy titled Resident Grievance Process dated 03/2016. Overview: A grievance is a concern or complaint that is unable to be immediately resolved and requires further investigation and action by facility leadership to achieve resolution. Residents/Patients have a right to voice grievances and assure the facility is actively seeking a resolution. The facility Grievance Program monitors resident grievances and complaints, facility actions and resolution. It may be initiated by any staff member upon identification of the grievance or complaint. The Facility Administrator is responsible for the direction of the Grievance Process. The follow up is conducted by the Director of Social Services or designee and/or Facility Administrator. The Facility Administrator is responsible for verifying teammates are trained in identifying and managing grievances. Process 2. Encourage resident and/or family/responsible party to communicate needs and/or concerns immediately. 5 Address grievances and/or complaints as they arise and follow through until resolved. Document resolution on the Grievance/Complaint Report. 1. Review of the QAPI Grievance Log dated January 2022 through May 2022 revealed that a grievance was filed on 3/21/22 that Resident #8 needed dental cleaning, dental work, and dental hygiene. The Resident Grievance/Concern. Complaint Report dated 3/21/22 revealed no evidence of a resolution for the dental concerns. However, the QAPI Grievance Log annotated under the Date Resolved section as being resolved on 3/25/22. During an interview on 6/8/22 at 2:50 p.m. the Regional [NAME] President, Georgia, CC revealed that she had delegated the Regional Nursing Consultant BBBB to follow-up with the grievances for R#8. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/9/22 at 3:21 p.m. GGGG Revenue Cycle Manager revealed that the resident was not enrolled in the dental program because he receives an SSI check, and he does not have money to cover dental. During an interview on 6/14/22 at 12:19 p.m. with a family member for R#8, revealed that she has been complaining about the resident's teeth since 2015 and early 2016. She stated that she has spoken with some on the nurses on the floor and that some of the nurse would do better. Every time she has complained there would be a different Director of Nursing. His teeth look nothing like when he was first admitted to the facility. During a post survey telephone interview conducted on 9/2/22 at 9:58 a.m., Administrator BBB revealed there were initially problems going to the dentist due to COVID. However, once COVID restrictions were lifted the facility reported issues with being able to schedule an appointment because R#8 required sedation and the dental providers did not want to provide the service to the resident. It was reported that the resident could not be serviced by the dental facility due to the level of services that were needed. Administrator BBB further revealed R#8 has an appointment scheduled for this month at a provider in Tifton. 2. Review of the QAPI Grievance Log dated January 2022 through May 2022 revealed that on 3/22/22, R#7 filed a complaint related to having cold coffee and not being allowed to warm the coffee in the resident's pantry microwave. On 3/26/22, the facility obtained two written statements. There was no evidence of a resolution. The facility was unable to provide the second page of the complaint.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213 Based on observations, interviews, record reviews, and review of policy titled, Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts, the facility failed to maintain an environment free from verbal abuse for five residents (R#6, R#12, B, G, and H), mental abuse for two residents (R#9 and R#11), and physical abuse for one resident (R#1), all perpetuated by facility staff. The facility also failed to maintain an environment free from physical abuse for six residents (R#2, R#3, R#4, R#5, R#6, and R#11) and sexual abuse of one resident (R#22), all perpetuated by other residents. The sample size was 40. On 6/23/22 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. Facility Administrator BBB and Assistant Director of Nursing (ADON) DDD were informed of the Immediate Jeopardy (IJ) on 6/23/22 at 12:19 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/26/22. At the time of exit on June 29, 2022, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: The facility had a Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts Standard, with revision date of January 2021. The purpose of the Standard included that it was to outline the preventive and action steps taken to reduce the potential for abuse, mistreatment and neglect of residents and the misappropriation of resident property and to review practices and omissions which if allowed to go unchecked, could lead to abuse. The purpose statement also documented that the standard demonstrated a zero tolerance of abuse of any type or manner. The Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts Standard included Staff to Resident abuse and Resident to Resident Abuse. In regard to staff to resident abuse, the policy documented that the facility was responsible for the actions of its employees, including intentional acts by employees who are aware they are doing something wrong and are in conflict with the facility's policies and procedures. Contractors and volunteers are held to the same standard as employees. In addition, the policy notes that staff members are expected to be in control of their own behavior and understand how to work with the nursing home population. However, the facility failed to implement this Standard regarding staff to resident abuse effectively, resulting in abuse of eight residents (R#1, R#6, R#9, R#11, R#12, B, G, and H), by facility staff. In regard to Resident-to-Resident abuse, the policy documented that the facility would take all steps reasonable and necessary to protect the residents from harm at all times, including protection from any type of abuse from other residents. However, the facility failed to protect six residents (R#2, R#3, R#4, R#5, R#6, and R#11) from being physically abused by R#1 and failed to protect R#22 from being abused by R#11. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In addition to the Freedom of Abuse, Neglect and Exploitation: Abuse Prevention: Fast Alerts Standard, the facility had a Social Media Policy with a revision date of August 2021. The policy included that employees would not post images of the company/facility or residents or staff or families on any social media site. However, videos of two residents, R#9 and R#11 were posted by an agency nurse on social media. 1.Review of the Admission Record revealed Resident #5 was admitted on [DATE] with the following diagnoses that include but not limited to schizoaffective disorder, bipolar type, diabetes mellitus type 2, major depressive disorder, epilepsy, and hypertension. Review of the Minimum Date Set (MDS) Quarterly assessment dated [DATE] revealed Section G Functional Status revealed resident was independent to limited assist with one person. She did not have any impairment to upper extremities and her lower extremities. She uses a wheelchair for mobility. BIMS score of 14 indicating cognitively intact. During an interview on 4/21/22 at 11:26 a.m. R#5 stated that R#1 got in her face and said some words. She would not hit R#1 because she didn't want to go to jail for hitting a retard person. R#5 reported that she tried to tell the people, but they would not listen and told her that she was crazy and would not be getting out of the facility. R#5 continued to state that she feels unsafe at night because she thought someone would come in her room at night. She reported that she was not happy living in this facility. Review of the medical record for R #1, the nurses notes revealed an entry dated 3/5/22 that R #1 came across the hall from her room and was seen in the room of R#5 with her hands and arm around R#5's neck. R#5 was yelling for help. Review of the medical records and nurse's notes for R#5 dated 1/19/22 through 3/21/22 revealed no documented evidence of the incident where R#5 was being attacked by R#1. 2. Review of the Admission Record revealed R#3 was admitted to the facility on [DATE] with the following diagnoses that include but not limited to schizoaffective disorder, insomnia, anxiety, diabetes mellitus, seizure, and hypertension. Review of the Minimum Date Set (MDS) Annual assessment dated [DATE] revealed Section G Functional Status revealed resident required independent to supervision. She did not have any upper extremities or lower extremities impairment. Her BIMS score was 15 indicating intact cognition. Review of R#3s medical records showed no documented evidence of the incident on 3/8/22, where R#1 threw a cup at her face or that R#3 sustained a left eye laceration. Further review revealed there was no evidence that the left eye laceration was addressed. Review of R#1's medical records summarized the attack on R#3. A nurse's notes dated 3/8/22 at 4:00 p.m. revealed that R#1 was standing at the medication cart when another resident (R#3) came up the hall from the restroom. R#1 threw the cup in her hand at the other resident (R#3) and immediately attacked her, hitting, kicking and swinging at R#3. Both CNAs and the writer separated the two residents and walked the attacker (R#1) to her room. R#1 ran down the hall to attack R#3 again. The SBAR dated 3/8/22 noted that R#1 had total aggressive behaviors. She had out of control behaviors that could most likely lead to the death of another resident or staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 4/21/22 at 11:36 a.m. R#3 revealed she does not feel safe here, but it was alright. Resident had some confusion during this interview and the interview was stopped. The LPN that entered the note on 3/8/22 in R#1 medical record was not available for an interview. 3. Review of the Admission Record revealed Resident #4 was admitted to the facility on [DATE] with a readmitted [DATE] with the following diagnoses that included but was not limited to ataxia following cerebral infarction, major depressive disorder, psychotic disorder, anxiety disorder and transient ischemic deafness bilateral. Review of the Minimum Date Set (MDS) Quarterly assessment dated [DATE] revealed Section G Functional Status revealed resident required limited to extensive assistance with one or two persons assist. He did not have impairment to his upper extremities or lower extremities on either side. His BIMS score was 8 indicating moderate cognitive impairment. Review of an Incident/Accident Report dated 3/21/22 revealed that R #4 was sitting in the hallway by the nurse's station when another resident walked up to him and slapped this resident in the face. No apparent injuries noted Review of the nurse's note revealed an entry dated 3/29/22 that R #4 was sitting in his wheelchair at the nursing station requesting coffee and was returning to his room. On return to his room, a female resident (R#1) was noted to dart away from a 1:1 sitter, and slapped R #4 open handed, in the back of his head. R #4 voiced being upset because this was the second time the female resident (R#1) had slapped him in his head. There was no evidence that the 3/21/22 incident was documented in the medical record for R#4. During an interview on 4/21/22 at 11:54 a.m. R #4 revealed that he was sitting in his wheelchair and the lady (R #1) walked up to him and slapped him in the face. He thought it was a love tap initially, but he became mad when she came to his room and hit him in the back of the head the second time. 4. Review of the Admission Record revealed Resident #2 was admitted to the facility on [DATE] with a readmitted [DATE] with the following diagnoses that include but not limited to schizophrenia, chronic atrial fibrillation, contracture right ankle, contracture right foot, stiffness of right elbow, stiffness of right wrist, Alzheimer's disease, abnormal posture, hypertension, dysphagia, and pyoderma. Review of the Minimum Date Set (MDS) Quarterly assessment dated [DATE] revealed Section G Functional Status revealed resident required extensive assistance to total dependent on one or two persons. She was noted to have impairment to upper extremities and her lower extremities on both sides. Her Brief Interview for Mental Status (BIMS) was 04 indicating severe cognitive impairment. Review of the Situation Background Assessment and Recommendation (SBAR) Communication Form dated 2/26/22 revealed R#2 was bitten by another resident (R#1). The Skin evaluation section revealed multiple teeth marks on forehead, and the skin was broken. The family was notified. The Nurse Practitioner (NP) HHHH give orders for Keflex 500 milligram (mg) by mouth four times a day for seven days. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the nurse's note revealed entry dated 2/26/22 that the nurse was summoned to the room by the CNA who was reporting a physical altercation. When entering the room Resident #1 was on the floor and Resident #2 was in her chair with the CNA standing between them. Resident #2 had bite marks on the forehead with blood noted and Resident #1 had red marks on her hands. During an interview on 5/2/22 at 3:09 p.m. Licensed Practical Nurse (LPN) GGG revealed that Certified Nurse Aide (CNA) WWW and CNA VVV were the first two people that went in the room when R#1 bit R#2 on the forehead. R#2 was sitting in her Broda chair and had bite marks on her forehead. R#2 had R#1 by the hair with her left hand (non-dominant) and R#1 was sitting on the floor. The residents were separated, and R#1 was placed on 1:1 observation. During an interview on 5/9/22 at 12:24 p.m. CNA VVVV revealed that he heard a loud scream, and when he got to the room, he saw that it was R#1. R#2 had pinned R#1 down on the floor with her good arm. R#1 was trying to bite R#2 again. He reported that he separated the two residents. R#2 was bleeding from the forehead and had teeth marks that were visible. CNA WWW removed R#1 from the room. R#2 has a scar from the bite mark. During an interview on 5/10/22 at 11:00 a.m. CNA WWW revealed that she heard R #2 hollering and ran into her room. She saw R #1 lying on the floor and R#2 had R#1 by the hair. R#1 was screaming, and the bite mark area on R#2's forehead was swollen that evening. It was reported that on the following day you could see the teeth print on R #2's forehead. 5. R#1 resided at the facility from 2/21/22 through 3/29/22, on the [NAME] Hall secured unit, and had diagnoses that included bipolar disorder, violent behavior, schizophrenia, seizures, and developmental disorder. A review of the 3/5/22 Admission Minimum Data Set (MDS) assessment revealed that R#1 was independently ambulatory without an assistive device. A review of facility reported incidents revealed a Facility Incident Report Form, dated 3/11/22, that documented an allegation of staff to resident abuse. The form included that the allegation involved R#1 and LPN GG and had occurred on the morning of 3/10/22. A further review of the form revealed that R#1 had an abrasion to the left inner bottom lip and that the police, responsible party and physician were notified. LPN GG was also suspended pending the final investigation. A review of the accompanying investigation that included a staff witness statement, police reports, and a follow up summary conclusion revealed evidence that the allegation was substantiated, and LPN GG was terminated on 3/15/22. The investigation revealed that while CNA II was assisting LPN GG and LPN HH to administer an injection to R#1 for combative behavior, LPN GG punched R#1 in the mouth, causing injury to R#1's lip. Corporate Senior [NAME] President (VP) FF and corporate Regional [NAME] President (RVP) CC, the staff who completed the initial reporting and investigation of the allegation of LPN GG physically abusing R#1, were interviewed on 5/2/22 at 11:15 a.m. During the interview, VP FF stated they became aware of the allegation when they conducted staff interviews (on a different incident) on 3/11/22. CNA II reported to VP FF, on 3/11/22, that she had witnessed LPN GG hit R#1 on 3/10/22. RVP CC stated that LPN GG was the night shift nurse going off shift and LPN HH was the day shift nurse coming on shift when the incident occurred (on the morning of 3/10/22). RVP CC stated that LPN GG and LPN HH were related to each other. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During the interview with VP FF and RVP CC on 5/2/22 at 11:15 a.m., they stated that they had attempted to make contact with LPN GG or LPN HH via phone calls and letters sent via certified mail but had not heard from either one of them; both nurses had been terminated. During a subsequent interview on 5/2/22 at 1:35 p. m., RVP CC confirmed that warrants had been made for LPN GG and LPN HH. A review of the 3/10/22 police department incident report revealed that an officer responded to the facility at 8:01 a.m. for an altercation that occurred between R#1 and LPN GG. LPN GG alleged in the police report that R#1 physically attacked her, then R#1 punched herself in the mouth and said she was going to blame it on LPN GG. Further review of the police report revealed that R#1 alleged that a nurse had hit her in the mouth, and the officer observed bleeding from her mouth. R#1 was transported to the emergency room following the incident. A review of the 3/10/22 emergency room Physician Report revealed R#1 was noted with an injury to the lower lip and scratches on the face. R#1 returned to the facility on [DATE]. LPN HH documented in a 3/10/22 7:05 a.m. nurses note that R#1 exited her room to charge at LPN GG and attempted to hit the nurse. Her attempts were blocked with her hands held and R#1 dropped herself to the floor then began kicking LPN GG. LPN GG stepped back and R#1 asked for help to get up and as LPN GG assisted R#1 to get up, R#1 slapped LPN GG in the chest and bit her finger. The nurse's note further documents that R#1 then hit herself in the face and stated that she was going to say LPN GG did it so she would lose her job. Review of CNA II's written statement, dated 3/11/22, revealed that on 3/10/22 she witnessed physical abuse. The statement included that R#1 was acting out and LPN HH was going to give her an injection. LPN GG held R#1 down so LPN HH would give the injection and that CNA II held R#1's hands. Further review of the statement from CNA II revealed that LPN GG hit R#1 in the mouth with her fist, twice. During an interview on 5/11/22 at 11:25 a.m., CNA II confirmed the written statement that had been obtained from her on 3/11/22. She stated that on 3/10/22 R#1 was off the chain early that morning; LPN GG was still there from night shift and LPN HH had come in for the day shift. They were going to give R#1 an injection. The nurses were holding R#1 down, but R#1 was still swinging at the nurses, so CNA II held her hands. Then, LPN GG punched R#1 in the mouth twice and busted R#1's lip. CNA II stated the incident occurred in R#1's room. When CNA II was asked what LPN HH's reaction was to LPN GG hitting R#1, CNA II stated that LPN HH commented to CNA II that R#1 had hit LPN GG earlier in the chest and bit her finger. CNA II stated that she did notice redness to LPN GG's chest. When CNA II was asked during the interview if she had ever seen R#1 hit herself and say she was going to blame it on someone else, CNA II stated no, but that is what the nurses told the police had happened. CNA II stated that R#1 liked to hit everyone else, not herself. 3/10/22 Following CNA II's statement on 3/11/22, the police were notified. A review of the 3/11/22 police department incident report revealed that RVP CC reported that on 3/10/22 LPN GG and LPN HH held R#1 down to give her an injection. While holding R#1 down, LPN GG hit the resident two times in the mouth, busting her lip. The report included that CNA II was also present when the incident occurred and had reported it to RVP CC (on 3/11/22). The police report documented warrants would be taken out on LPN GG and LPN HH. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	6. Review of facility reported incidents revealed a Facility Incident Report Form, dated 3/10/22, that documented an allegation of staff to resident verbal abuse. The form included that the allegation involved LPN AA and the residents on the [NAME] Hall secured unit, with an unknown date and time of occurrence. Further review of the form revealed that LPN AA was suspended pending the final investigation. A review of the accompanying investigation that included staff statements, resident interviews, police report, letter sent out to responsible parties, and a follow up summary conclusion revealed evidence that the allegations of verbal abuse were substantiated. LPN AA was terminated on 3/15/22. A review of the Separation Notice and timecard information for LPN AA revealed that 3/10/22 was the last date she worked at the facility. During an interview on 5/2/22 at 11:15 a.m. with corporate VP FF and corporate RVP of Operations CC, they stated that they received an email and a call on the evening of 3/9/22 from Regional Director of Business Development FFFF. Regional Director FFFF had visited the facility and in speaking with Admissions staff, had concerns of possible abuse at the facility. One of the specific allegations she reported to them was of verbal abuse of the residents on the [NAME] Hall secured unit by LPN AA. They confirmed initially suspending LPN AA and speaking to her at that time and again when they terminated her (via phone) and stated that she denied the allegations and said it was all lies. Continued interview with VP FF and RVP CC confirmed that they terminated LPN AA based on the information they obtained in the documented staff interviews for threatening to take away resident assistive devices and smoking privileges. During a subsequent interview with corporate VP FF on 5/5/22 at 2:00 p.m. she confirmed that she and RVP CC, following the allegations they received on the evening of 3/9/22, were at the facility on 3/10/22 and 3/11/22 and through that weekend conducting an investigation. A review of the staff statements, obtained by corporate staff on 3/10/22 and 3/11/22, revealed two specific residents named in the allegations of verbal abuse; R#6 and R#12, who both resided on the [NAME] Hall secured unit. A review of the 3/11/22 written statement for Activity Director LL revealed that LPN AA was very firm and had stated to residents that their smoking privileges were taken away. During an interview on 5/23/22 at 2:10 p.m. , Activity Director LL stated that LPN AA would take R#12's walker and smoke breaks away from him and would say it was for behavior modification. Activity Director LL stated that R#12 would come out in the hall anyway and hold onto the railing to walk and they would tell him to go back to his room. A review of the of the 3/11/22 written statement from Admissions staff KK revealed that LPN AA would tell residents to get back in their rooms. One resident (unnamed) told LPN AA no and LPN AA responded that she would take their walker away. A review of the 3/11/22 written statement from LPN JJ revealed that she witnessed verbal abuse of more than one resident by LPN AA. LPN JJ's statement included that R#12 asked LPN AA for pain medicine and LPN AA kept telling him to get to his room; that she did not want to hear his complaints. The statement also included that LPN AA took R#6's wheelchair away from her because the resident kept coming out of her room, and that LPN AA threatened to take residents smoking breaks away if they did not stay in their rooms. LPN JJ's statement documented that she reported the verbal abuse to Administrator BB. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 5/24/22 at 1:57 p.m., LPN JJ confirmed her documented statement from 3/11/22. She stated that the abusive behavior she witnessed from LPN AA on the [NAME] Hall secured unit occurred in December 2021 and January 2022 and that she reported it to the Administrator each time because she did not think it was right. LPN JJ stated that after LPN AA took R#6's wheelchair away, she (LPN JJ) took the wheelchair back to the resident and reported it to the Administrator. LPN JJ included that what she witnessed occurred during a COVID-19 outbreak at the facility (in December 2021 and January 2022) and residents on other halls were encouraged to stay in their rooms, but if they came out, they were allowed to. Review of State Agency Facility Reportable Incidents revealed no evidence that these incidents were reported by the facility in December 2021 and January 2022. 7. Review of the Admission Record revealed Resident #6 was admitted on [DATE] with the following diagnoses that include but not limited to major depressive disorder, malignant neoplasm of left ovary, bilateral primary open-angle glaucoma, anxiety disorder, ascites, hypertension, and gastro-esophageal reflux disease. Review of the Minimum Date Set (MDS) Quarterly assessment dated [DATE] revealed Section G Functional Status revealed R #6 was independent to limited assist. She did not have any impairment to her upper extremities or her lower extremities on either side. Her BIMS score was a 11 indicating moderate cognitive impairment. On 3/26/22, R#6 was slapped by another resident (R#11). The medical records noted that R#6 was mocking the sound of R#11 and that R#11 slapped R#6 on the left cheek. There were no injuries. Review of the nurse's note dated 12/15/21 through 4/12/22 revealed that there was no evidence of the incident that occurred on 3/11/22, when R#6 had a bruised upper right lip because of R#1. A written statement obtained on 3/11/22 revealed that R#6 was noted to have a bruise on her right upper lip. The corporate RVP CC and corporate VP FF wrote that R#6 stated that the girl (referring to R#1) did that to her the other day. There was no evidence that the two corporate staff investigated R#6's statement. During an interview on 5/2/22 at 11:18 a.m. the corporate RVP CC and corporate VP FF revealed that all the interviews in the investigation package was done on 3/11/22 by them. During an interview on 5/26/22 at 3:28 p.m. Licensed Practical Nurse (LPN) DDDD unit manager revealed that she witnessed on 3/26/22 R#6 was standing near the nursing station. The medication cart was separating the two residents (R#6 and R#11). R#6 had come up to her to ask her for something. R#11 started making that noise and R#6 started making the same sound with body gestures. R#11 slapped R#6 on the cheek. LPN DDDD reported that to her knowledge, this was the first time R#11 had slapped another resident. 8. Record review revealed that Resident (R) #9 was admitted to the facility on [DATE] and had diagnoses that included schizoaffective disorder, antisocial personality disorder, dysphagia, seizures, dementia with behavior disturbance, impulse disorder, history of traumatic brain injury, exhibitionism, and ataxic gait. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of R#11's clinical record revealed that she was admitted to the facility on [DATE] and had diagnoses that included traumatic brain injury, dysphagia, cognitive communication deficit, anxiety disorder, seizures, aphasia, expressive language disorder, schizoaffective disorder and depressive disorder. Both R#9 and R#11 resided on the [NAME] Hall secured unit. A review of facility reported incidents revealed a Facility Incident Report Form, dated 4/21/22, that documented an allegation of staff to resident abuse. The form included that the allegation involved agency LPN VV and resident information being posted on social media. Further review of the form indicated that the incident occurred on 4/15/22. The police were notified, and LPN VV was suspended and placed on a do not use list while an investigation continued. A review of the accompanying investigation documentation that included a police report and summary conclusion of the investigation revealed evidence that LPN VV mentally abused R#9 and R#11 by posting videos of the residents on social media. A review of the 4/21/22 police department incident report documented that an officer was initially dispatched to the facility on [DATE] at 12:53 p.m. in reference to a report of videos of R#9 and another resident being posted on social media. The report included that RVP CC reported to the officer that the videos included LPN VV making sexual comments to R#9 and of R#11 screaming as they went to hunt Easter eggs outside. The report documented that the officer made a second trip to the facility that same day, on 4/21/22, after RVP CC was able to obtain the videos. The report detailed that the officer recorded the videos on his body camera. The officer's documented observations of the videos included LPN VV recording R#9. LPN VV repeated sexual comments R#9 was saying. R#9's back was visible in the video. The report also included that a female resident's face was visible. The videos LPN VV posted to social media were viewed on 5/3/22 at 2:50 p.m. There was a total of five short videos. The first video included LPN VV looking at and speaking directly into the camera with R#9 visible behind her. The back of R#9's head and back are in the frame and his voice was audible. LPN VV prompted R#9 to repeat sexual comments that he had previously made to her. LPN VV then repeated what R#9 said to her, which was that he wanted to make love to her. The name and location of the facility are also printed across the screen. The second video included LPN VV looking at and speaking directly into the camera. No residents are visible in the frame, but R#9's voice is audible as LPN VV prompted him to again repeat sexual comments, he had previously made to her. LPN VV then also repeated the sexual comments which included that R#9 wanted to put his penis in LPN VV's vagina. The third video was of a small, cracked window within a door. LPN VV was not visible, but her voice was audible. R#11's face was visible on the other side of the cracked window. The fourth video included R#11 and LPN VV. An electronic/phone generated cartoon emoji smiley face was partially covering R#11's face. In the video, LPN VV talked to R#11. R#11 responded to LPN VV with repeated loud distinctive sounds as a form of communication. The words all day were printed across the screen. The fifth video included LPN VV looking at and speaking directly into the camera while walking outside. R#11 was visible behind her. R#11 made repeated loud distinctive sounds as LPN VV spoke to her. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 5/5/22 at 2:36 p.m. with corporate VP FF and corporate RVP CC, RVP CC stated that the videos that were posted on a social media platform (by LPN VV) occurred on 4/15/22. She stated that a staff person from a home health agency phoned the facility on 4/21/22 to report the videos to the Administrator, and RVP CC took the call. RVP CC stated that she reported LPN VV to the staffing agency she worked for and worked with their information technology department to obtain a copy of the videos. She stated that she reviewed the videos, and they were disturbing. RVP CC confirmed that the police were also notified. Continued interview with RVP CC, she stated that she interviewed staff and residents, and no one else saw LPN VV make the videos. RVP CC stated that LPN VV only worked at the facility on 4/14/22 and 4/15/22 and there was no indication that videos were made on 4/14/22. 34318 9. Record review revealed that Resident (R)B was admitted to the facility on [DATE] and had diagnoses that included hypertension, epilepsy, dementia, atrial fibrillation, anemia, a history of cerebrovascular accident, hemiplegia, major depressive disorder, mild intellectual disorder, hallucinations, and diabetes. RB resided on the South Hall. A review of facility reported incidents revealed a Facility Incident Report, dated 3/18/22, that documented an allegation of staff to resident abuse. The form included that the allegation involved RB and CNA UU. Further review of the form revealed that RB had no injuries noted, and the physician and responsible party were notified. CNA UU was also suspended with an investigation in progress. A review of the accompanying investigation that included a grievance report, witness statement, resident interviews, and conclusion summary of the investigation revealed that there was evidence that CNA UU verbally abused RB. Social Service Director EEEE documented on a 3/18/22 Resident Grievance/Concern/Complaint Report form that RB reported that the day shift CNAs were mean to him when assisting him with changing soiled briefs or clothing and fussed at him for needing help. The grievance form specifically named CNA UU and included that she threatened to move RB to the [NAME] Hall secured unit of the facility if he complained. Social Service Director EEEE included on the grievance report that RB was tearful throughout the interview. Social Service Director EEEE documented an interview with RB's roommate (RC) on a 3/24/22 Written Statement-Detailed Account of Events form. The form included that RC stated that CNA UU did not know how to treat people. CNA UU fussed, did not encourage, and always threatened him with moving to the [NAME] Hall secured unit. The form also documented that CNA UU talked roughly to RB. During an interview on 5/23/22 at 10:10 a.m. with RB and RC, RB was immediately tearful. He stated that he had reported CNA UU and that she had been mean to him. RC confirmed RB's statement of CNA UU being mean. Following the facility's investigation, CNA UU was terminated. A review of the Separation Notice, dated 3/31/22, revealed that CNA UU's period of employment ended on 3/28/22. The reason for separation was listed as violation of company policy. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	10. Review of the Admission Record revealed that R#11 was admitted to the facility on [DATE] with the following diagnoses that include but not limited to schizoaffective disorder, bipolar type, aphasia, unsteadiness on feet, cognition communication deficit, anxiety disorder, personal history of traumatic brain injury and seizures. Review of the Minimum Date Set (MDS) Quarterly assessment dated [DATE] revealed Section G Functional Status revealed R#11 was independent to limited assist. She did not have any impairment to her upper extremities or her lower extremities on either side. Her BIMS score was a 00 which indicated severe cognitive impairment. R#11 care plan dated 3/1/22 revealed that the Resident is at risk for sexual behaviors with other residents. Per Physician, the resident cannot consent to sexual activities due to BIMS score. An entry dated 5/9/22 revealed that R#11 was in bed with another resident, fully dressed, on top of cover. Another entry dated 5/22/22 revealed that R#11was noted in inappropriate sexual activity with another resident. R#11 entered his room. The Interventions/Tasks for 5/9/22 revealed that the crisis nurse was to come to exam resident, but (did not show). She was to be redirected when she attempts to go into another residents room; a police report was filed; reported to state, and to the administrator. On 5/16/22, there was an intervention for medication to be added to manage sexual impulses. On 5/2[TRUNCATED]

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213 Based on interviews, record review, and review of policy titled Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts, the facility failed to ensure that one resident (R#1) was free from involuntary seclusion when locks were placed on her room and bathroom door and used intermittently by facility staff. Total resident sample was 40. On 6/23/22 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. Facility Administrator BBB and Assistant Director of Nursing (ADON) DDD were informed of the Immediate Jeopardy (IJ) on 6/23/22 at 12:19 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/26/22. At the time of exit on June 29, 2022, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: The facility had a Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts Standard with a revision date of January 2021. The standard defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. The purpose statement of the abuse standard indicated a zero tolerance of abuse of any type or manner. However, R#1 was subjected to unreasonable confinement in her room, intermittently between 2/26/22 and 3/10/22 at the instruction of Administrator BB. R#1 resided at the facility from 2/21/22 through 3/29/22, on the [NAME] Hall secured unit, and had diagnoses that included bipolar disorder, violent behavior, schizophrenia, seizures, and developmental disorder. A review of the 3/5/22 Admission Minimum Data Set (MDS) assessment revealed that R#1 was independently ambulatory without an assistive device and was continent of bowel and bladder. Review of a written statement, that was obtained by corporate staff on 3/11/22, revealed that Business Office Manager (BOM) GGGG documented that a CNA on the 3:00 p.m. to 11:00 p.m. shift had complained to her about urine and feces being in R#1's room and that the bathroom door was locked. The written statement also documented that BOM GGGG reported this complaint to Administrator BB. Review of a written statement, dated 3/11/22, revealed that Admissions staff person LL documented that Restorative CNA SS expressed to her the previous Tuesday (3/1/22) about being uncomfortable with a situation on [NAME] Hall; that R#1 was being treated poorly, and CNA SS was not comfortable about a lock being put on R#1's door. The written statement documented that Admissions staff LL reported the concern to Administrator BB, and Administrator BB responded that he was aware and was the person who had maintenance staff install the lock (on R#1's door) and that he was protecting other residents. (continued on next page)

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/26/22 at 2:17 p.m. Housekeeper TT, who provided housekeeping services on the [NAME] Hall secured unit, revealed that R#1 was urinating on the floor (in her room) and that she would have to mop the floor two to three times per day. She stated that the lock was on R#1's door for a week, then it was removed. She stated that she only saw two nurses that would let R#1 out of her room, but when R#1 began acting up, they would put her back in her room and slide the bar to lock her back in her room. Review of a 5/2/22 email from Maintenance Director QQ to RVP CC revealed that Administrator BB phoned Maintenance Director QQ on 2/26/22 and asked him to install two draw bolt locks on R#1's room door and bathroom door and did not give any details as to why the locks needed to be installed. The email further documented that Maintenance Director QQ arrived at the facility and met with LPN AA, who directed him where to install the locks. LPN AA indicated to the maintenance director that R#1 had tried to attack a couple of residents during the late night and early morning hours. Maintenance Director QQ documented in the email that he installed the locks on both doors (W5 room door and bathroom door) and left the facility. Further review of the email revealed that when the Maintenance Director returned to the facility on [DATE], he was instructed by Administrator BB to remove the draw bolt lock from R#1's bathroom door and reinstall it on the other bathroom door of the adjoining resident room (W3) that shared that bathroom. He documented in the email that he did as he was asked to do. The email then detailed that Maintenance Director QQ was on vacation from 3/6/22 through 3/14/22. During an interview on 5/2/22 at 11:15 a.m. with corporate Senior [NAME] President (VP) FF and corporate Regional [NAME] President (RVP) of Operations CC, they stated that they received an email and a call on the evening of 3/9/22 from Regional Director of Business Development FFFF. Regional Director FFFF had visited the facility and in speaking with Admissions staff, had concerns of possible abuse at the facility. One of the specific allegations she reported to them was of Administrator BB putting a lock on R#1's door. They determined through staff interviews that Administrator BB had a lock installed on R#1's room door and bathroom door and the locks were used at times to confine R#1 to her room. RVP CC and VP FF indicated during the interview that they questioned Administrator BB as to why he had the locks installed on R#1's doors and he said it was to protect other residents because he did not know what else to do with R#1. During an interview on 5/5/22 at 11:17 a.m., Maintenance Director QQ confirmed what he documented in the 5/2/22 email and that he had installed the locks on the room and bathroom of W5 (R#1's room) on 2/26/22. He stated they were slide bolt type locks. He installed one on the outside of the room door and one on the bathroom side of the bathroom door, confirming that R#1 would not have had access to her bathroom from her room, if the bathroom lock was in use. He confirmed that two days later, on 2/28/22, he removed the bathroom lock from the inside of R#1's door to the bathroom and put it on the outside of the adjoining room's bathroom door (W3), thus giving R#1 access to the bathroom. The Maintenance Director stated that he returned from vacation on 3/14/22 and the locks were not on the doors anymore, but he did not know when they were removed. He stated that he did not see the locks in use. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

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F 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately following the 5/5/22 11:17 a.m. interview, an observation was made with Maintenance Director QQ of room W5 on the secured unit. The Maintenance Director confirmed that the set of holes on the side of W5's bathroom door that was facing the bathroom was from where he installed the slide bolt lock on 2/26/22. He confirmed that a set of holes on the door jamb and exterior part of W5's room door was from where he installed the slide bolt lock. When Maintenance Director QQ was questioned if a person on the other side of the locked slide bolt would be able to get out and he confirmed that they would not be able to get out. During a subsequent interview with corporate VP FF on 5/5/22 at 2:00 p.m. she confirmed that she and RVP CC, following the allegations they received on the evening of 3/9/22, were at the facility on 3/10/22 and 3/11/22 and through that weekend conducted an investigation. She stated that Administrator BB was at the facility on 3/10/22 and they suspended him and sent him home that day. Corporate VP FF stated she went and looked at the [NAME] Hall secured unit and the locks were no longer on R#1's doors. During an interview on 5/24/22 at 1:50 p.m., Restorative CNA SS confirmed that she had been uncomfortable with the way R#1 was being treated. She stated that she saw the lock on R#1's door but never saw her locked inside the room. She further stated that she saw the lock one time and that is why she went and told Admissions staff LL. She did not recall the day she saw the lock on R#1's door but stated it was not on there the next day, it had been removed. 34318

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	115654	A. Building B. Wing	06/29/2022

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213 Based on interview, record review, and policy review titled Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts, the facility failed to implement multiple abuse policy interventions (reporting, investigation, and protection) for two staff to resident physical altercations that occurred on 3/8/22 and 3/9/22 and involved R#1. The sample size was 40. On 6/23/22 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. Facility Administrator BBB and Assistant Director of Nursing (ADON) DDD were informed of the Immediate Jeopardy (IJ) on 6/23/22 at 12:19 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/26/22. At the time of exit on June 29, 2022, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: The facility had a Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts Standard, with a revision date of January 2021. The abuse standard included the required components of screening, training, prevention, identification, investigation, protection, and reporting. However, the components of investigation, protection and reporting were not implemented for two altercations that occurred involving R#1 and CNA YY. Record review revealed that R#1 resided at the facility from 2/21/22 through 3/29/22 and had diagnoses that included seizures, bipolar disorder, violent behavior, schizophrenia, and developmental disorder and intellectual disability. She resided on the [NAME] Hall secured unit. A review of R#1's clinical record revealed nurses notes entries from 3/8/22. A 3/8/22 4:00 p.m. nurse's note entry documented that R#1 threw a cup at another resident then attacked the resident. Staff responded and separated the residents. R#1 then ran down the hall to attack the resident again. Once again staff separated the residents, and R#1 calmed down. At 5:10 p.m., a nurse's note entry documented that R#1 was standing at the medication cart and instantly walked over to a staff person and started choking her without provocation. Other staff separated R#1 from the attacked staff person. R#1 is documented as attacking the staff member again. When R#1 was held to stop her, she got loose and attacked again. Additional staff attempted to redirect R#1 to her room, but R#1 fell on the floor instead, and refused to get up. At that time four police officers were on the unit after R#1 called 911. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the 3/8/22 police report revealed that an officer was dispatched to the facility at 5:31 p.m. because a resident complained that a nurse hit her in the face. Emergency Medical Services (EMS) also responded. The officer included that he observed R#1 sitting on the floor and that she would only moan and attempt to put a shirt on that she had in her hands. EMS personnel was also present and assisted R#1 to her room, while the officer spoke with the staff member involved. The police report referenced staff member YY as a nurse, however, staff member YY was a CNA. CNA YY reported that R#1 attacked her. The report included that R#1 approached CNA YY like she was going to hug her, but then attacked instead. The report documented that CNA YY stated she defended herself, striking R#1 in the face. Following the altercation on 3/8/22, R#1 was sent to the emergency room . A review of the hospital emergency room documentation revealed documentation of a reddened area around R#1's neck. The documentation included that R#1 was evaluated by a mobile crisis team and was noted to be stable and not meeting criteria for a 1013 and would be discharged back to the nursing home. The following day, a 3/9/22 nurse's note entry in R#1's clinical record documented that she returned to the facility at 12:00 p.m. Further review of the clinical record revealed that after returning to the facility on [DATE] at 12:00 p.m., a 3/9/22 12:10 p.m. nurse's note entry revealed that licensed nursing staff administered an injection of Ativan, Benadryl and Haldol due to increased aggression and R#1 attempting to fight staff. There were no further nurses' notes for 3/9/22 after the 12:10 p.m. entry. However, a Form 1013- Certificate Authorizing Transport to Emergency Receiving Facility and Report at Transportation form was completed by Nurse Practitioner HHHH on 3/9/22 as having examined R#1 at 2:18 p.m. The 1013 form documented that R#1 was combative and violent; that she endorsed command hallucinations, destroyed property and attempted to assault staff and residents. A One on One Documentation for Resident Supervision/24 Hours form, dated 3/9/22 documented one on one supervision with hourly comments from 3/9/22 at 11:00 a.m. through 3/10/22 at 6:00 a.m. The form included an entry on 3/9/22 at 2:45 p.m. that documented R#1 attempted to attack a CNA again. Review of a 3/9/22 police department incident report revealed that officers were again dispatched to the facility at 2:54 p.m. for a report of a resident attacking a nurse. EMS also responded. The officer documented that he made contact with Administrator BB upon arrival at the facility. The report documented that Administrator BB reported that R#1 had just attacked CNA YY. The police report noted that no aggressive activity was observed at that time. Staff reported to the officer that R#1 heard voices and that the voices told R#1 to do things. R#1 would try to give someone a hug, but then attack when she got close. EMS personnel transported R#1 to the emergency room to be evaluated. The police report documented that CNA YY stated that she had just come in for her shift and was putting things in her bag when R#1 came up behind her and pulled CNA YY's hair and began attacking her. Administrator BB witnessed the attack and pulled R#1 off CNA YY. The report included that Administrator BB commented on charging R#1 for attacking CNA YY. However, the officer declined to pursue charges due to R#1's altered mental state. Further review of the police report revealed that the officer went and spoke with R#1 at the hospital. R#1 alleged that CNA YY abused her and had attacked her. The police report documented injuries on R#1 that included scratches on the left side of her face along with bruising and swelling under the left eye. There was a scratch on the front left side of the neck and bruising and swelling on the top and bottom of the left hand. There was a scratch and small bruises on the left arm, near the elbow. Pictures of R#1's injuries accompanied the report. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Following the altercation on 3/9/22, R#1 was transported to the emergency room . A review of the hospital emergency room documentation revealed documentation of a fresh scratch to the left arm. The documentation included that R#1 did not demonstrate any aggressive behavior in the emergency department and would be discharged back to the nursing home. Despite the documented evidence of physical altercations with injuries occurring between R#1 and CNA YY on 3/8/22 and 3/9/22, there was no evidence that the altercations were reported to the State Survey Agency in a timely manner. In addition, there was no evidence that an investigation of events was conducted, and the CNA involved in the altercations suspended pending the completed investigation. Administrator BB, who was documented in the 3/9/22 police report as being present at the time of the 3/9/22 altercation and being aware of the 3/8/22 altercation, was suspended by corporate staff on 3/10/22 and subsequently terminated for a separate matter. A review of CNA YY's personnel file revealed that she continued to work at the facility without suspension until she was terminated. During an interview on 5/2/22 at 1:35 p.m., RVP CC stated that CNA YY was terminated for being a no call/no show. A review of the Worksite Employee Termination/Separation form revealed that CNA YY's separation was effective 3/30/22, with her last date worked as 3/17/22. Continued interview on 5/2/22, RVP CC also stated that she was not previously aware of the altercations that occurred on 3/8/22 and 3/9/22. Following surveyor inquiry, the facility completed and submitted a Facility Incident Report Form on 5/11/22 to the State Survey Agency for the altercation that occurred on 3/8/22. 34318

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213 Based on interviews, record reviews and review of policy titled Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts the facility failed to ensure that abuse allegations, including staff to resident and resident to resident altercations were reported in a timely manner for six residents (#1, #4, #5, #6, G, and H). On 6/23/22 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. Facility Administrator BBB and Assistant Director of Nursing (ADON) DDD were informed of the Immediate Jeopardy (IJ) on 6/23/22 at 12:19 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/26/22. At the time of exit on June 29, 2022, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: The facility had a Freedom of Abuse, Neglect And Exploitation; Abuse Prevention: Fast Alerts Standard, with revision date of January 2021. The Reporting/Investigation/Response Policy section of the standard included that any complaint, allegation, observation or suspicion of resident abuse, mistreatment or neglect is to be thoroughly reported. The policy further documented that all employees are required to immediately notify the administrative or nursing supervisory staff that is on duty of any complaint, allegation, observation or suspicion of resident abuse, mistreatment or neglect so that the resident's needs can be attended to immediately and investigation can be undertaken promptly. However, the facility failed to report the involuntary seclusion of R#1 to the State Survey Agency. In addition, the verbal abuse of RG and RH and the resident-to-resident physical altercations involving R#1 and R#4, R#5, and R#6 were not reported in a timely manner to the State Survey Agency. Furthermore, witnessed physical abuse of R#1 by LPN GG was not immediately reported to facility Administration. 1. R#1 resided at the facility from 2/21/22 through 3/29/22, on the [NAME] Hall secured unit, and had diagnoses that included bipolar disorder, violent behavior, schizophrenia, seizures, and developmental disorder. A review of the 3/5/22 Admission Minimum Data Set (MDS) assessment revealed that R#1 was independently ambulatory without an assistive device and was continent of bowel and bladder. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 5/2/22 at 11:15 a.m. with corporate Senior [NAME] President (VP) FF and corporate Regional [NAME] President (RVP) of Operations CC, they stated that they received an email and a call on the evening of 3/9/22 from Regional Director of Business Development FFFF. Regional Director FFFF had visited the facility and in speaking with Admissions staff, had concerns of possible abuse at the facility. One of the specific allegations she reported to them was of Administrator BB putting a lock on R#1's door. They determined through staff interviews that Administrator BB had a lock installed on R#1's room door and bathroom door and the locks were used at times to confine R#1 to her room. RVP CC and VP FF indicated during the interview that they questioned Administrator BB as to why he had the locks installed on R#1's doors and he said it was to protect other residents because he did not know what else to do with R#1. During a subsequent interview with corporate VP FF on 5/5/22 at 2:00 p.m. she confirmed that she and RVP CC, following the allegations they received on the evening of 3/9/22, were at the facility on 3/10/22 and 3/11/22 and through that weekend, conducted an investigation. She stated that Administrator BB was at the facility on 3/10/22 and they suspended him and sent him home that day. Following the suspension of Administrator BB on 3/10/22 and initiation of an investigation, by corporate staff, into the allegations of involuntary seclusion of R#1, Administrator BB was terminated. A review of the Separation Notice and Worksite Employee Termination/Separation forms revealed that he was terminated on 3/14/22, with his last date worked as 3/10/22. The reason for separation was listed as violation of company policy. Corporate RVP CC also reported Administrator BB to local law enforcement on 3/11/22. Facility corporate staff investigated the allegation of involuntary seclusion of R#1, notified the police, and suspended and subsequently terminated Administrator BB. However, there was no evidence that the allegation was reported to the state survey agency. The facility did submit an allegation involving Administrator BB to the State Survey Agency, but it was for a different occurrence. A review of facility reported incidents revealed a Facility Incident Report Form, dated 3/11/22, that alleged potential inappropriate management of abuse reported by Administrator BB. The form documented that abuse investigations did not follow policy and Administrator BB was suspended pending investigation. A summary of the completed investigation, dated 3/17/22, referenced Administrator BB's failure to address a separate matter; allegations of verbal abuse that were reported to him. Neither the initial Facility Incident Report Form nor the follow-up summary included any information concerning the involuntary seclusion of R#1, that was initiated by Administrator BB. During the interview on 5/2/22 at 11:15 a.m., RVP CC stated that the initial report (to the state survey agency) from 3/11/22, about Administrator BB, was meant to be all inclusive, including the involuntary seclusion allegations. They did not do a separate report. Cross refer to F603 (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. A review of facility reported incidents revealed a Facility Incident Report Form, dated 3/11/22, that documented an allegation of staff to resident abuse. The form included that the allegation involved R#1 and LPN GG and had occurred on the morning of 3/10/22. A further review of the form revealed that R#1 had an abrasion to the left inner bottom lip and that the police, responsible party and physician were notified. LPN GG was also suspended pending the final investigation. A review of the accompanying investigation that included a staff witness statement, police reports, and a follow up summary conclusion revealed evidence that the allegation was substantiated, and LPN GG was terminated on 3/15/22. The investigation revealed that while CNA II was assisting LPN GG and LPN HH to administer an injection to R#1 for combative behavior, LPN GG punched R#1 in the mouth, causing injury to R#1's lip. LPN HH documented in a 3/10/22 7:05 a.m. nurses note that R#1 exited her room to charge at LPN GG and attempted to hit the nurse. Her attempts were blocked, and her hands held, and R#1 dropped herself to the floor then began kicking LPN GG. LPN GG stepped back, and R#1 asked for help to get up and as LPN GG assisted R#1 to get up, R#1 slapped LPN GG in the chest and bit her finger. The nurse's note further documented that R#1 then hit herself in the face and stated that she was going to say LPN GG did it so she would lose her job. Review of CNA II's written statement, dated 3/11/22, revealed that on 3/10/22 she witnessed physical abuse. The statement included that R#1 was acting out and LPN HH was going to give her an injection. LPN GG held R#1 down so LPN HH would give the injection and that CNA II held R#1's hands. Further review of the statement from CNA II revealed that LPN GG hit R#1 in the mouth with her fist, twice. Corporate VP FF and corporate RVP CC, the staff who completed the initial reporting and investigation of the allegation of LPN GG physically abusing R#1, were interviewed on 5/2/22 at 11:15 a.m. During the interview, VP FF stated they became aware of the allegation when they conducted staff interviews (on a different incident) on 3/11/22. She stated that CNA II sought her out and told her the next day about the incident, VP FF stated that after CNA II spoke to her, VP FF did observe R#1 and saw her busted lip and R#1 told her at that time that the nurse had hit her. RVP CC stated that LPN GG was the night shift nurse going off shift and LPN HH was the day shift nurse coming on shift when the incident occurred (on the morning of 3/10/22). RVP CC stated that LPN GG and LPN HH were related to each other. Continued interview with VP FF and RVP CC on 5/2/22, they stated that they had attempted to make contact with LPN GG and LPN HH via phone calls and letters sent via certified mail but had not heard from either one of them, and both nurses had been terminated. During an interview on 5/11/22 at 11:25 a.m., CNA II confirmed the written statement that had been obtained from her on 3/11/22, that she reported it to VP FF the next day, on 3/11/22. She further revealed that LPN GG punched R#1 in the mouth twice and busted R#1's lip. When CNA II was questioned as to why she waited to report the physical abuse until the following day, CNA II responded that the facility did not have an Administrator, and she did not know who to talk to, and she was in shock. Following CNA II's statement on 3/11/22, the police were notified. The altercation between R#1 and LPN GG occurred on 3/10/22 and was witnessed by CNA II and LPN HH. However, it was not reported to the facility corporate administrative staff until the following day, on 3/11/22, by CNA II. There was no evidence that LPN HH reported the altercation to anyone. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Cross refer to F600 34318 3. Review of the Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts, revision January 2022. Reporting/Investigation/Response Policy. Any complaint, allegation, observation or suspicion of resident abuse, mistreatment, or neglect, whether physical, verbal, mental or sexual, involuntary or voluntary, is to be communicated to the Abuse Coordinator, thoroughly reported, investigated, and documented in a uniform manner as detailed below. The intent of the regulation is that as soon as the facility is aware of a situation that meets the reporting requirements, they must immediately notify the administrator, and other officials in accordance with State Law, including the State Survey Agency. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury. Review of the Admission Record revealed R#4 was admitted to the facility on [DATE] with a readmitted [DATE] with the following diagnoses that include but not limited to ataxia following cerebral infarction, major depressive disorder, psychotic disorder, anxiety disorder and transient ischemic deafness bilateral. Review of the Facility Incident Report Form dated 3/21/22 revealed that Resident #4 was sitting in the hallway by the nurse's station, when R#1 walked up to R#4 and slapped him in the face. There was no evidence of a final report submitted to the State Survey Agency until 5/26/22. 4. Review of Admission Records revealed R#5 was admitted on [DATE] with the following diagnoses that include but not limited to schizoaffective disorder, bipolar type, diabetes mellitus type 2, major depressive disorder, epilepsy, and hypertension. Review of medical records of R#5 revealed no evidence of documentation of the incident that occurred on 3/5/22. However, the medical records of R#1 revealed that on 3/5/22, R#1 was seen in R#5 room with her hands and arm around R#5's neck. R#5 was yelling for help. Review of the Facility Incident Report Form dated 4/28/22 revealed resident to resident abuse that occurred on 3/5/22. R#1 was choking R#5. There was no evidence that the facility reported the resident-to-resident abuse (between R#1 and R#5) on 3/5/22 to the State Survey Agency. 5.Review of the Admission Record revealed R#6 was admitted on [DATE] with the following diagnoses that include but not limited to major depressive disorder, malignant neoplasm of left ovary, bilateral primary open-angle glaucoma, anxiety disorder, ascites, and gastro-esophageal reflux disease. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a written statement on 3/11/22 per VP FF, that during the initial investigation of R#1, R#6 had reported that R#1 had bruised her lip. There was no evidence of an investigation until 4/28/22. Review of the Facility Incident Report Form dated 4/28/22 revealed R#6 was not investigated during the initial abuse investigation on 3/10/22 and 3/11/22 by RVP CC and VP FF. There was no evidence that the facility reported the abuse on 3/10/22 or 3/11/22 during the initial abuse investigation in March 2022 to the State Survey Agency. 6. Review of the Admission Record revealed that Resident G was admitted to the facility with the following diagnoses that include but not limited to chronic obstructive pulmonary disease, diabetes mellitus type 2, hypothyroidism, bipolar disorder, muscle weakness, osteoarthritis, and lack of coordination. Review of the Admission Record revealed that Resident H was admitted to the facility with the following diagnoses that include but not limited to chronic obstructive pulmonary disease, dementia, psychosis, hypertension, anxiety disorder, gastro-esophageal reflux disease, and Parkinson's disease. Review of the Facility Incident Report Form dated 6/8/22 revealed that the State Survey Agency did not receive the staff to resident abuse report, that occurred on 4/24/22, until 6/8/22 at 3:51 p.m. for R G and R H. On 5/31/22 at 3:54 p.m. the RVP CC was unable to provide evidence that the state reportable had been filed, or that the investigation had been conducted on the alleged verbal abuse. During this brief meeting, she stated that she had delegated the task to RNC BBBB and that she would oversee that the reportable was done and the incident investigated. There was no evidence that the state reportable was filed nor the investigation initiated until 6/8/22 for verbal abuse by LPN ZZ towards R G and R H. Cross Reference F600

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	115654	A. Building B. Wing	06/29/2022

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. 34318 Based on resident interviews, staff interviews and facility policy Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts, the facility failed to ensure that an allegation of verbal abuse of two residents R G and R H was thoroughly investigated, and corrective actions implemented (including protection of resident) in a timely manner. The facility census is 99 residents. On 6/23/22 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. Facility Administrator BBB and Assistant Director of Nursing (ADON) DDD were informed of the Immediate Jeopardy (IJ) on 6/23/22 at 12:19 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/26/22. At the time of exit on June 29, 2022, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: Review of the facility abuse policy titled Freedom of Abuse, Neglect and Exploitation; Abuse Prevention: Fast Alerts, revision January 2021. Overview Staff to Resident Abuse. The facility is responsible for the actions of its employees, including intentional acts by employees who are aware they are doing something wrong and are in conflict with the facility 's policies and procedures. Contractors and volunteers are held to the same standard as employees. If a staff is accused of abuse by a resident/family member or another staff person, that staff member is suspended pending investigation. If it is determined the allegation is unsubstantiated through investigation, then the staff member is brought back to work; educated as to preventions, identification, reporting of abuse and allowed to continue to work. Staff observation and monitoring for this staff member will occur through the licensed nurse on duty for a time determine by the Administrator to ensure alleged staff follows Freedom of Abuse policies. If through investigation the staff member is found to be guilty of abuse, then the progressive discipline process will be initiated. Review of a Grievance dated 4/24/22 revealed that on the East Hall two Residents (R G and R H) had reported to the Registered Nurse (RN) XXX that the License Practical Nurse (LPN) ZZ had cursed at them several times when he would give them their medications on the 11-7 shift. The two residents had revealed that they both had dropped their medications on the floor when LPN ZZ started cursing at them. They reported that this has happened on more than one occasion. There was no evidence that this grievance was thoroughly investigated for the alleged allegation of verbal abuse. Review of timesheet for LPN ZZ dated 4/11/22 through 6/8/22 revealed that LPN ZZ continued to work and provide services to the two residents. The timesheet revealed that he worked on 4/24 (day of occurrence), 4/25/22, 4/26/22, 4/27/22, 4/28/22, 4/29/22, 5/1/22, 5/29/22, 5/31/22, 6/1/22, 6/2/22, 6/3/22, 6/4/22, 6/5/22, 6/6/22, and 6/7/22. He also was scheduled to work on 6/8/22. There was no evidence that LPN ZZ was suspended pending the outcome of an investigation. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN ZZ was suspended pending alleged allegations of verbal abuse for the two residents. A state reportable was filed on 6/8/22 for the 4/24/22 incident involving the two residents. Both residents (R G, R H) had expressed fear of LPN ZZ finding out they had reported him. Further investigation revealed that on 4/9/21, LPN ZZ had another incident of verbal abuse with another resident on South Hall. LPN ZZ was suspended pending outcome of the investigation. He returned to work, and he was educated on Freedom form Abuse, Counterproductive Behavior. During an interview on 5/31/22 at 3:54 p.m. Regional [NAME] President (RVP) CC revealed that she did not have a state reportable on LPN ZZ for cursing and yelling at the two residents. She stated that she had delegated Interim DON/Corporate Regional Nurse Consultant (RNC) BBBB to submit the report. During an interview on 6/2/22 at 10:28 a.m. Resident H revealed LPN ZZ had yelled at her for dropping her medication cup and told her that he was going to have a hard time finding her pills that she had dropped. She stated that the pills did not fall on the floor but on her. She explained that her hands shake a lot and sometimes the shaking was hard to control. She further stated that this was not the first time he had done this. She stated that she was not afraid of being in the facility and felt safe. But, that she did not want him to know that she had said something about him yelling at her. She stated that she was afraid he would find out, she then stated she should have not told anyone. During an interview on 6/2/22 at 10:51 a.m. Resident G revealed that she had dropped her pain medication on the floor. and LPN ZZ told her Got damn it you won't get another one. The pill had dropped on the floor, and he couldn't find the pill. She continued to state that LPN ZZ will get mad at her for telling. She stated that she did not know who to talk to when she is afraid but thinks she can talk to the Business Office Manager (BOM) GGGG but was not sure. An interview on 6/8/22 at 2:50 p.m. RVP CC revealed that she spoke with the interim DON/RNC BBBB and directed her to speak with LPN ZZ. LPN ZZ never got reported to the state agency and that she will do a late state reportable today. Cross Reference F600

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	115654	A. Building B. Wing	06/29/2022

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34318 Based on record review, staff interview, the facility failed to ensure that care plans were revised to include physical altercations that occurred with another resident (R#1) and additional interventions implemented, to prevent reoccurrence for four residents (R#3, R#5, R#6, and R#11). On 6/23/22 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. Facility Administrator BBB and Assistant Director of Nursing (ADON) DDD were informed of the Immediate Jeopardy (IJ) on 6/23/22 at 12:19 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/26/22. At the time of exit on June 29, 2022, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: 1. Review of the Admission Record revealed Resident #3 was admitted to the facility on [DATE] with the following diagnoses that include but not limited to schizoaffective disorder, insomnia, anxiety, diabetes mellitus, seizure, and hypertension. Review of the care plan dated 5/28/21 revealed that there was no evidence, that on 3/8/22 the care plan was revised to reflect that R #1 had thrown a cup in R#3's face which resulted in a small laceration to the left eye of R#3. 2. Review of the Admission Record revealed R#5 was admitted on [DATE] with the following diagnoses that include but not limited to schizoaffective disorder, bipolar type, diabetes mellitus type 2, major depressive disorder, epilepsy, and hypertension. Review of the care plan dated 8/5/21 revealed that there was no evidence, that on 3/5/22, that R#5 care plan was revised to include the 3/5/22 incident when R#1 had her hand and arm around R#5's neck. Review of the nurses' notes dated 1/19/22 through 3/21/22 revealed that there was no evidence of the neck incident from 3/5/22 when R#1 had her hand and arm around R#5's neck. 3. Review of the Admission Record revealed R#6 was admitted on [DATE] with the following diagnoses that include but not limited to major depressive disorder, malignant neoplasm of left ovary, bilateral primary open-angle glaucoma, anxiety disorder, ascites, and gastro-esophageal reflux disease. Review of the care plan dated 3/5/20 revealed that there was no evidence, that R#6's care plan was updated to reflect incidents between R#1 and R#6 on 3/10/22 and 3/11/22 which resulted in R#6 receiving a bruised upper lip. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Review of the Admission Record revealed R#11 was admitted to the facility on [DATE] with the following diagnoses that include but not limited to schizoaffective disorder, bipolar type, aphasia, unsteadiness on feet, cognition communication deficit, anxiety disorder, personal history of traumatic brain injury and seizures. Review of the care plan dated 3/1/3/22 revealed that there was no evidence that the care plan had been revised to include an incident or resident to resident abuse which resulted in R#1 choking R#11 on 3/15/22. During an interview on 5/26/22 at 2:48 p.m. Licensed Practical Nurse (LPN) JJ Minimum Data Set (MDS) Coordinator revealed that she was not aware of the 3/8/22 of R#3 incident with R#1. She explained that she was not aware of the incident on 3/5/22 with R#5 and R#1; she was not aware of the 3/11/22 incident involving R#6 and R#1; she was not aware of the 3/15/22 incident of R#11 being choked by R#1. She stated that the care plans had not been revised because she was not aware of the incidents. She stated that normally she would get the incident report. When she gets the incident reports, she would update care plan at that time. She stated she always get copies of the telephone orders every morning (Monday through Friday) and would update the care plan. And had she known, she would have revised the care plan with interventions. Cross refer F600

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	115654	A. Building B. Wing	06/29/2022

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34318 Based on observations, record reviews, residents/ staff interviews and the facility policy titled Resident Hygiene the facility failed to ensure that two female residents (R#19, R#20) had facial hair removed; failure to ensure one resident (R#23) was provided proper cleanliness during perineal care. The sample size was 40 residents. Findings include: The undated facility policy titled Resident Hygiene, Standard revealed to bathe each resident daily to include a sponge and/or bed bath five times weekly (or more often, if needed) including a tub bath, whirlpool bath or shower at least twice weekly. Tub and whirlpool bath or shower are scheduled for each resident and are given at various times of the day, modified according to the resident's condition, preferences and desires, wherever possible. Bathing include cleaning and trimming fingernails, shaving facial hair, washing the entire body and shampooing resident's hair. Procedure 8. Each resident will have his or her nails cleaned and trimmed, (unless medically contraindicated), facial hair shaved or trimmed, and hair shampooed on each bath/shower day. 1. Review of the Admission Record revealed that Resident #19 (R#19) was admitted to the facility on [DATE] with a readmission of 1/2/19 with the following diagnoses that include but not limited to schizoaffective disorder, Alzheimer's disease, anxiety disorder, stiffness of right hand, hypertension, bipolar disorder, lumbago with sciatica and polyosteoarthritis. An observation on 4/28/22 at 3:18 p.m. R#19 was observed with facial hairs on her chin. She was lying in her bed. An observation on 5/17/22 at 10:30 a.m. R#19 was observed with facial hairs on her chin. She was in her room An observation on 6/16/22 at 11:17 a.m. R#19 was observed with the Assistant Director of Nursing (ADON) , that R#19 no longer had facial hairs. Review of the care plan dated 1/13/2020 revealed resident has a self-care deficit related to needs supervision as well as limited assist with bathing, grooming, dressing, and personal hygiene. The interventions/tasks revealed provide assistance with hygiene and grooming only to extent required. Review of the Resident Care Flow Record dated 4/22 and 5/22 revealed R#19 shave section was blank. An interview on 6/16/22 at 11:10 a.m. the Interim ADON revealed that any female resident with facial hairs is to have the hair removed during ADL care/bath. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the Admission Record revealed that Resident #20 was admitted to the facility on [DATE] with a readmitted [DATE] with the following diagnoses that include but not limited to complete traumatic amputation at level between knee and ankle left lower leg, bipolar disorder, diabetes mellitus type 2, major depressive disorder, chronic hepatitis C, and schizophrenia. An observation on 4/28/22 at 3:04 p.m. R#20 was observed with excessive facial hairs on her chin. An observation on 5/2/22 at 3:06 p.m. R#20 facial hair continues to remain on her chin An observation on 5/14/22 at 4:07 p.m. observed R#20 sitting in her wheelchair at the nursing station wanting coffee, she continues to have facial hair. An observation on 5/17/22 at 10:22 a.m. observed resident in her wheelchair near her room. She continued to have facial hairs. An observation on 5/25/22 at 11:16 a.m. observed R#20 in her wheelchair self-propelling and leaving the dining room. She continues to have facial hairs. An observation on 5/25/22 at 11:31 a.m. observed resident in her bathroom trying to get on the toilet. She continues to have facial hairs. During an interview on 5/25/22 at 11:31 a.m. Resident #20 revealed that she didn't like her hair on her face. She continued to state that she has had the facial hair so long, that she was getting used to having it. An observation on 5/31/22 at 12:22 p.m. observed with the Registered Nurse (RN) HHH. R#20 continues to have facial hair. An observation on 6/16/22 at 11:10 a.m observed with the ADON DDDD that R#20 no longer had facial hairs. Review of the Resident Care Flow Record dated 4/22 (2022) and 5/22 (2022) revealed R#20 shave section was blank. 3. Review of the Admission Record revealed Resident #23 was admitted on [DATE] with a readmitted [DATE], with the following diagnoses that include but not limited to peripheral vascular disease, paranoid schizophrenia, diabetes mellitus type 2, chronic venous hypertension, and mild protein-calorie malnutrition. During an observation on 6/6/22 at 10:59 a.m. observed Licensed Practical Nurse (LPN) III wound care nurse being assisted by Certified Nurse Aide (CNA) CCCC. Resident #23 gave his permission to observe care. He was soiled with feces. CNA CCCC took a large bath towel to clean the bowel movement from the resident. After she had completed the task of cleaning the resident, the resident was observed to still have feces between the lower buttock fold, and on the interior thigh near the scrotum. CNA CCCC cleaned the residual feces from those areas identified on the skin. During this observation, CNA CCCC revealed that she did not see the feces in those areas. Cross refer to F686

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34318 Based on record review, resident interview, staff interview, the facility policies Medication Administration Guidelines and the policy Vital Signs Management, the facility failed to ensure that the physician's order for two residents (A, D) to give medication within the prescribed time; and failed to obtain vital signs as ordered for resident A. The sample size was 40 residents. Findings include: 1. Review of the Medication Administration Guideline, dated August 2021. Medication Administration. Medication may be administered with 60 minutes before or after the prescribed time. h. After medication, staff will document the administration on the MAR or will document the resident refusal if indicated. Review of the Admission Record revealed Resident D was admitted to the facility with the following diagnoses that include but not limited to paraplegia, insomnia, major depressive disorder, colostomy malfunction, neuromuscular dysfunction of bladder, acquired absence of kidney, abnormal posture, gastro-esophageal reflux disease. Review of the physician's order dated 5/1/22 through 5/31/22 revealed an order for Baclofen 20 milligram (mg) tablet by mouth every 6 hours for muscle spasms. The time prescribed was 6:00 a.m., 12:00 noon, 6:00 p.m. and 12:00 midnight. The trazodone 100 mg tablet one tablet by mouth at bedtime for insomnia. The prescribed time was 9:00 p.m. Review of the Medication Administration Record (MAR) dated 5/1/22 through 5/31/22 revealed on the back of the MAR for 5/16/22 at 10:30 p.m. Resident D had refused the trazodone and Baclofen because it was too early. However, the next prescribed time for the Baclofen was due at 12:00 a.m. (midnight), the 10:30 p.m. exceeds the time before the prescribed time. The trazodone prescribe time is 9:00 p.m. the 10:30 p.m. exceeds the time after the prescribed time. The MAR revealed that on 5/16/22 the 12-midnight dose was circled and left blank. And the trazodone was circled with LPN OOOO initials. During an interview on 5/18/22 at 9:56 a.m. resident D revealed that she had asked LPN OOOO to bring her medications back at 11:00 p.m. LPN OOOO had told her that she either take the pills now or she will put down that she refused and will throw them in the trash. When LPN AAA came on 11 - 7 shift, Resident D told LPN AAA about not getting her medications and that the medications was put in the trash can. LPN AAAA took the medication from the trash can and gave it to her. Resident D further revealed that she took the medications because she needed her medication and did not want to miss taking her medication of Trazodone and baclofen. During an interview on 5/25/22 at 10:07 a.m. LPN AAAA revealed that she got the medication that LPN OOOO had prepared and gave the pudding with two crushed tablets to the resident However, there was no evidence that LPN AAAA documented the administered medications that she had given at the beginning of her shift. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cross refer to F880 2. Review of the policy Vital Signs Management dated August 2021. Standard. It is the standard of the facility that each resident will have their vital signs monitored at least weekly or per physician order. Vital signs will also be taken as indicated by the resident's condition, medication regimen, and as directed by the resident's physician. Vital signs include blood pressure, temperature, pulse, and respirations. Procedure. The CNA or licensed nurse will take the routine weekly vital signs at the beginning of each shift. Notify the charge nurse if the vital signs are above or below the resident's baseline rate, i.e., elevated temperature, low blood pressure, etc. Review of the Admission Record revealed that Resident A was admitted to the facility on [DATE] with the following diagnoses but not limited to pancytopenia, paralytic syndrome following cerebral infarction affecting non-dominant side, chronic obstructive pulmonary disease, and ulcerative colitis. Review of the physician's order dated 4/1/22 through 4/30/22, and 5/1/22 through 5/31/22 revealed an order for complete vital signs weekly on Sunday. The April orders did not indicate which shift was responsible for obtaining the vital signs. However, the May 2022 orders did specify that the vital signs were to be obtained on the 7-3 shift. Review of the Medication Administration Record (MAR) dated 1/1/22 through 1/31/22 revealed no documentation that vital signs were obtained during the month of January 2022. The MAR dated 2/1/22 through 2/28/22 revealed that vital signs were obtained only once on 2/13/22 for the month of February 2022. Further review of the MAR for March 2022 and April 2022 revealed that vital signs were recorded every Sunday as ordered. However, the MAR dated 5/1/22 through 5/31/22 revealed no documentation that vital signs were obtained during the month of May 2022. Review of the nurse's notes dated 1/20/22 through 4/13/22 revealed no documented evidence of vital signs obtained. Review of the progress notes dated 5/16/22 through 6/5/22 revealed that on 5/26/22, Resident A had an acute change in condition related to blood pressure of 180/110 and pulse rate of 110 and altered mental status. Resident A was transported to the hospital for evaluation. There was no documented evidence from 5/1/22 through 5/25/22, that vital signs were obtained prior to the acute change in condition on 5/26/22. Review of the hospital report dated 5/26/22 revealed resident A was admitted for altered mental status and hypertension secondary to chest pain. His blood pressure upon admission was noted as 188/85. And he had an abnormal electrocardiogram (ECG) with normal sinus rhythm. He was noted to have an ejection fraction at 62%. He returned to baseline during the remainder of his hospital stay and was discharged back to the facility on [DATE]. The former DON BBBB was unavailable for interview.

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	115654	A. Building B. Wing	06/29/2022

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34318 Based on observations, staff interview, the facility policy Skin Management Standard, the facility failed to obtain depth measurement for pressure wounds for two residents (R#23 and R#24), and failed to follow the current wound order for R#24, of three residents reviewed for pressure ulcers. Findings include Review of the facility policy Skin Management Standard dated August 2021. Comprehensive Assessment of Wounds. c) Focus on local wound bed, location/etiology, dimension/size (length, width, depth), tunneling/undermining; appearance of wound base, wound edges, periwound, exudate/drainage, staging/tissue involvement. Procedure for Dressing Change 10. Clean wound bed from the center of the wound in a circular motion moving outward using cleansing agent ordered by the physician. 20. Date and initial dressing. 22. Document the condition including measurements and characteristics of the resident's wound weekly. 1. Review of the Admission Record revealed Resident #23 was admitted on [DATE] with a readmission on 12/18/21 with the following diagnoses that include but not limited to peripheral vascular disease, paranoid schizophrenia, diabetes mellitus type 2, chronic venous hypertension, and mild protein-calorie malnutrition. Resident is hospice. During an observation on 6/6/22 at 10:59 a.m. observed Licensed Practical Nurse (LPN) III wound care nurse being assisted by Certified Nurse Aide (CNA) CCCC. Resident #23 gave his permission to observe care. Resident #23 was lying on an airflow mattress and the Medline box setting was at a level 9. Resident #23 was soiled with feces and there was no sacral dressing on the wound. CNA CCCC took a large bath towel to clean the bowel movement from the resident. After she had completed the task of cleaning the resident, resident was observed to still have feces between the lower buttock fold, and on the interior thigh near the scrotum. CNA had commented that she did not see the feces. LPN III was instructed to obtain the sacral wound measurements. Her measurements were Length (L) 6.0 centimeters (cm) x Width (W) 2.0 cm. She did not do a depth for the wound bed. While inquiring about the sacral wound depth, she stated that she had to get a cotton-tip from her cart. When she left the room, she left the door, and the privacy curtain partially opened, thus leaving the resident's buttock exposed to the hall. She returned and washed her hands and donned gloves. She cleansed the sacral wound bed and took the cotton-tip applicator and obtained a measurement of 5.7 cm. This measurement was not the depth but a tunneling located at 12 o'clock. She did two wipes down the center of the wound and then packed a moistened gauze with Dakin solution and covered with an adhesive dressing. The trash bag was placed on the resident's bed. R#23 left foot was wrapped in a kerlix, there was no date on the dressing. LPN III took scissors out her pocket and without cleansing and cut off the dressing from the left foot. The scissor was placed on the bedside table. The kerlix was stuck to the wound on the outer perimeter and she peeled the dressing from the foot. Resident #23 stated that this was not comfortable, and LPN III continued to remove the stuck kerlix. The left foot had moderate drainage without odor. She cleansed the left foot with normal saline and obtained measurements of 5.8 L cm x 5.4 w cm. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R#23 left ankle measurements were 13.0 x 4.0 x 0.0. (attempted to obtain a depth by placing the paper measuring tape on the wound). She took her gloved hand placed in the trash bag on the bed to throw away a paper towel, then took a moisten gauze with Dakin solution cleansed the wound, applied dry adhesive pad to heel, Silvadene to left ankle and wrapped the foot and ankle with a kerlix and secured with tape. She takes the gloves off and placed in the plastic bag and then take the scissors from the bedside table and placed it in her left mock pocket. During an interview on 6/8/22 at 2:29 p.m. LPN III revealed that she thought the tunneling was the depth and that she was trained by LPN DDDD. She continues to state that this was her first time working as a wound nurse. She stated that the depth measurement was a lack of knowledge. And that she plans to attend a wound seminar on 6/21 to 6/24/22. 2. Review of the Admission Record revealed Resident #24 was admitted to the facility on [DATE] with the following diagnoses that include but not limited to dementia with behavioral, anxiety disorder, diabetes mellitus type 2, ventricular tachycardia, anemia, psychosis, and hypertension. An observation on 6/7/22 at 9:51 a.m. observed Resident #24 (R#24) lying on an airflow mattress with a floor mat on the left side of the bed as standing at the foot of the bed. LPN III wound care nurse was being assisted by CNA CCCC. LPN III washed her hands and donned gloves. There was no dressing on the coccyx wound. CNA CCCC commented that the dressing was soiled with feces and had been removed. LPN III obtained measurements of (L) 1.5 cm x (W) 1.5 cm. She did not obtain a depth. She cleansed the wound bed with moistened gauze with normal saline twice using a downward motion, not wiping in a circular motion and not changing the gauze or folding the used gauze to a clean portion while wiping. She applied Santyl and then took her gloved hand to open the trash bag, she then placed the gauze pad on the wound bed without changing gloves. Review of the physician orders dated 4/1/22 through 4/30/22 revealed an order for skin sweeps every week, it did not indicate which day or shift per week, and there was no wound orders. The original copy of physician's orders did not have evidence of meds reviewed (reconciliation) as indicated by a blank space. The Nurse Practitioner had the signed orders. A telephone order dated 4/28/22 revealed clean wound to coccyx with NS, apply Medihoney paste/hydrogel wound dressing, cover with adhesive foam dressing. Change every day or soiling/dislodgment was noted to be discontinued. The May physician's orders dated 5/1/22 through 5/31/22 was not provide by the facility. A physician's telephone order dated 5/17/22 revealed to clean wound with normal saline to coccyx, apply Santyl ointment to a 4 x 4 gauze, saturate with normal saline and cover with an adhesive dressing, change every day. The June physician's orders dated 6/1/22 through 6/30/22 revealed the pink blurred copy of the orders that was difficult to read. Review of the Body Audit dated 5/4/22, and 5/11/22 revealed stage 2 coccyx. The facility was unable to provide body audit forms for 4/6/22, 4/13/22, 4/20/22, 4/27/22, 5/18/22, and 5/25/22. Review of the Weekly Pressure Injury report dated 5/4/22 and 5/11/22. The facility was unable to provide weekly pressure injury record forms for 4/6/22, 4/13/22, 4/20/22, 4/27/22, 5/18/22, and 5/25/22. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Treatment Record dated 5/1/22 through 5/31/22 revealed the current wound order was not being followed as ordered. The wound order that was discontinued on 4/28/22 was to clean wound to coccyx with normal saline, apply Medihoney pasted/gel or med-honey hydrogel wound dressing, cover with adhesive foam dressing, change every day, and as need soiling, or dislodgement was the documented treatment until 5/17/22. The treatments were documented as completed as indicated by initials. During an interview on 6/8/22 at 2:29 p.m. LPN III revealed that she did not obtain the depth measurement because of a lack of knowledge.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34318 Based on observations, resident interviews, staff interviews and the facility policy Incontinence Management, the facility failed to ensure that one resident (R) (#20) was assisted with toileting to promote bladder continence. The sample size was 40 residents. Findings include Review of the policy titled Incontinence Management Standard, dated August 2021. Bladder Management. Standard. It is the goal of this facility to ensure that each resident who is incontinent of bladder is identified and assessed given the opportunity to achieve continence or to resort as much normal bladder function as is possible. Appropriated treatment and services will be provided to restore as much function as possible. Review of the Admission Record revealed that Resident #20 was admitted to the facility on [DATE] with a readmitted [DATE], with the following diagnoses that include but not limited to complete traumatic amputation at level between knee and ankle left lower leg, bipolar disorder, diabetes mellitus type 2, major depressive disorder, chronic hepatitis C, and schizophrenia. An observation on 5/17/22 at 10:22 a.m. observed Resident #20 in her wheelchair near her room. She was observed going into her room and repositioning herself using the wheelchair arm rest to urinate on the floor. Review of the Minimum Date Set (MDS) Quarterly assessment dated [DATE] revealed Section G Functional Status revealed resident was total dependence on one person for toileting. She was coded as not having any impairment on the upper or lower extremities on either side. However, R#20 has bilateral below the knee amputation. Review of the care plan dated 3/29/21 reviewed resident is incontinent of bowel and bladed, and that she refuses to attempt to let staff toilet her. She was care planned for requiring assistance with ADL's related to physical disability, she had no legs. She had interventions dated 3/21/21 to check frequently for incontinence; wash, rinse, and dry perineum; change clothing as needed after incontinence episodes. There was no evidence that R#20 had a urinary continence assessment. Review of the Resident Care Flow Record dated 4/22/22 revealed that the R#20 had seven days of incontinence and 5/22/22 revealed that R#20 had six days of incontinence on 3-11 shifts. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 5/25/22 at 11:31 a.m. observed Resident #20 in her bathroom trying to get on the toilet. She was not able to transfer from her wheelchair to the toilet. And asked the surveyor to help put her on the toilet because she did not want to pee on herself. Resident peed on her clothes, wheelchair, and the floor as she tried unsuccessfully to transfer to the toilet. During an interview on 5/25/22 at 11:31 a.m. Resident #20 stated that she did not want to pee on the floor. She did not like peeing on the floor. Sometimes she stated that she can get on the toilet. Resident stated that she was trying to get to the toilet but end up peeing in wheelchair and peeing in her clothes. During an interview on 5/31/22 at 12:32 p.m. Certified Nursing Aide (CNA) WWW revealed that the resident does toilet herself sometimes and that she wears the pullups. She stated that the resident can transfer from her wheelchair to toilet and back to wheelchair. She stated that when the resident wet her bed, that she could strip down her bed. However, this resident was not able to transfer independently to the toilet and urinated on floor, bed, and herself. An observation on 6/16/22 at 11:10 a.m.with the Assistant Director of Nursing (ADON) DDD observed R#20 sitting in her wheelchair on [NAME] Hall. Her pink pants are wet. During an interview on 6/16/22 at 11:10 a. m. the ADON DDD revealed that R# 20 required assistance for toileting, and that R#20 could not safely transfer to a toilet from her wheelchair being a bilateral amputee. During a post survey telephone interview on 9/2/2022 at 10:00 am with Administrator DDD, she was unsure if R#20 ever had a sliding board to assist with wheelchair transfers She stated that she would forward any information that she found. Review of Occupational Therapy (OT) notes received from Administrator DDD on 9/2/2022 revealed that R#20 was receiving OT since 8/18/22 to assist with upper body strength. Further review revealed no evidence to support that R#20 has ever had a sliding board or any other assistive device to help with transfers.

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	115654	A. Building B. Wing	06/29/2022

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34318 Based on record review, interviews, staff interview and the facility policy Dental Services the facility failed to ensure that two residents (R#8 and R#11) received dental services timely for R#8 wisdom teeth extraction and R#11 for broken teeth/swollen gum. The sample size was 40 residents. Findings include: Review of the Dental Services policy dated 02/15 revealed private pay residents/patients or the family/responsible party will have the opportunity to determine if they wish to utilize the dental services available and pay for those services. The facility will attempt to find alternative funding sources for residents/patients unable to pay for services. Procedure. 3. Assisting nursing to identify residents/patients that need emergency dental services including but not limited to: acute pain in teeth, gums or palate; broken or otherwise damaged teeth; any problem requiring the immediate attention of a dentist. 4. Schedule an appointment and assist in arranging for transportation, as needed. 1. Review of the Admission Record revealed that Resident #8 was admitted to the facility on [DATE] with the following diagnoses that include but not limited to psychosis, abnormal posture, stiffness of left hand, benign intracranial hypertension, anemia, dementia, and mild intellectual disabilities. During observation on 4/21/22 at 11:50 a.m., Resident #8 was observed sitting in a [NAME]-chair in his room. He had heavy plaque build up on teeth with discoloration. An observation on 4/26/22 at 3:13 p.m. observed R#8 sitting in a Geri chair in his room. His teeth remained the same with heavy plaque build up on his teeth. An observation on 5/2/22 at 3:34 p.m. observed R#8 sitting in a Geri chair in his room. His teeth remains with heavy plaque build up. An observation on 5/31/22 at 10:51 a.m. observed resident sitting in a [NAME]-chair in a room with the podiatrist. He was getting his toenails trimmed. His teeth remained with heavy plaque build up. An observation on 6/7/22 at 10:14 a.m. observed Certified Nursing Aide (CNA) CCCC provide oral care to R#8. She had R#8 to say cheese and he opened his mouth for her. He was very cooperative during this observation. She was continuously telling Resident #8 that she was going to brush his teeth and saying cheese. Resident opened his mouth and allowed CNA CCCC to clean his teeth as best as possible. Interview on 6/7/22 at 10:14 a.m. with CNA CCCC stated that the resident was cooperative with allowing her to brush his teeth. And that the resident will take the toothbrush and try to chew the toothbrush. Stated she had never had any problems cleaning his teeth. And that she has him about three times a week. Review of the Resident Care Flow Record dated 4/22 and 5/22 revealed that there was no evidence that R#8 received oral care for the month of April 2022 or May 2022, as indicated by zero's documented on the Resident Care Flow Record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical records revealed a dental patient note history dated 8/27/19 with patient being referred to an oral surgeon for extraction of wisdom teeth. During an interview on 6/9/22 at 3:21 p.m. the Revenue Cycle Manager revealed that she does not know why it has taken years to get an appointment with the dentist. And that Resident #8 was not enrolled in the dental program because he receives an SSI check, and he does not have money to cover dental. During an interview on 6/14/22 at 12:19 p.m., Family member E revealed that she has been complaining about the resident's teeth since 2015 and early 2016. She has spoken with nurses, and some will do better. There is always a new Director of Nursing (DON). She continued to state that upon admission, R#8 had nice white teeth. When she asked abour the dental services, she stated the facility told her that R#8 insurance does not pay for dental services. He needs his teeth clean and wisdom teeth extracted. R#8 was to see an oral surgeon to have his wisdom teeth extracted. R#8 never showed for the appointment, the facility stated due to transportation problems. 2. Review of the Admission Record revealed that Resident #11 was admitted to the facility on [DATE] with a readmit on 9/0/21 with the following diagnoses that include but not limited to schizoaffective disorder, bipolar type, aphasia, unsteadiness on feet, cognition communication deficit, anxiety disorder, personal history of traumatic brain injury and seizures. An observation on 4/21/22 at 11:41 a.m. observed resident ambulating in the hall, noted during her smile that she had front caries, chipped tooth, and plaque on teeth. An observation on 6/16/22 at 11:18 a.m. observed resident sitting upright in her bed, there was no sitter in the room. Observed with the ADON that R#11 top left molar cavity, front teeth chipped, and gums swollen. Review of the medical records revealed a nurse's notes entry dated 4/1/22 revealed a family member had taken R#11 for a dental appointment. There was no documentation in the medical records related to this appointment. Review of the Resident Care Flow Record form dated 5/22 revealed that one form noted resident was receiving denture care and was checked daily on the 11/7 shift. The second form for 5/22 revealed that resident had her own teeth and the oral care was checked daily for the 11/7 shift. During an interview on 6/9/22 at 3:21 p.m. the Revenue Cycle Manager GGGG revealed that R#11 receives a SSI check and that a family member takes her to dental appointments. The last dental appointment was cancelled, and everything needed to be done was not done. During an interview on 6/14/22 at 3:01 p.m., family of R#11 revealed that R#11 will not allow anyone to do her teeth. She had a scheduled appointment at the [NAME] dental school. The dental school had cancelled the appointment because the doctor was out of town. She had insurance but R#11's husband let it elapse. The veteran affairs had told her that she didn't have any veteran benefits. She has not been able to find any other dental services because R#11 has to be put to sleep. R#11 gums hurt and her teeth bleeds. She has three broken teeth that has been that way since 2020 and no one can tell her how the teeth got broken. One tooth is chipped, and another tooth is broken in half and that she didn't know where else to get dental services.

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	115654	A. Building B. Wing	06/29/2022

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 21213 Based on interviews, record reviews, and review of the job summaries for Nursing Home Administrator and Director of Nursing (DON), facility Administration failed to effectively oversee an abuse prevention program to promote, foster and maintain an abuse free environment. The facility census was 99. On 6/23/22 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. Facility Administrator BBB and Assistant Director of Nursing (ADON) DDD were informed of the Immediate Jeopardy (IJ) on 6/23/22 at 12:19 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/26/22. At the time of exit on June 29, 2022, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: The facility had a Job Summary for the Licensed Nursing Home Administrator. The primary purpose of the Nursing Home Administrator was to oversee the day-to-day operation of the facility and to review organizational performance. The description included job duties and responsibilities for the categories of resident care and quality of life, human resources, finance, leadership and management, and physical environment and safety. The category of Resident Care and Quality of Life included a job duty to oversee that residents received care in a manner and in an environment that maintained and enhanced their quality of life without abridging the safety of other residents. The category of Leadership and Management included a responsibility to ensure that policies and procedures were developed, implemented, monitored, and evaluated in order to maintain compliance with federal, state, and local rules and regulations. The facility had a Job Summary for the Director of Nursing. 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 was 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, residents' rights responsibilities, and staff development functions. A review of the list of management changes at the facility revealed that the facility had seven different Administrators since June 2021, six of them since March 2022. The facility's Administrators with their dates of service were as follows: Administrator BB (6/28/21-3/18/22), Administrator OO (3/14/22-3/20/22), Administrator DD (3/21/22-5/4/22), corporate Senior [NAME] President (VP) FF (5/4/2-5/9/22), corporate Regional [NAME] President (RVP) of Operations (5/9/22-5/23/22), Administrator AAA (5/23/22-5/30/22), and Administrator BBB as of 5/31/22. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Further review of the list of management changes at the facility revealed that the facility had six different DONs since November 2021. The facility's DONs with their dates of service were as follows: DON FFF (11/19/21-1/19/22), DON PP (11/10/21-3/17/22), DON EE (3/18/22-5/12/22), Regional Nurse Consultant (RNC) BBBB (5/13/22-6/22/22), ADON DDD (6/23/22-6/26/22) and DON ZZZ as of 6/27/22. Facility Administration failed to consistently and effectively oversee areas of the facility that were included in their job descriptions. 1. Administration failed to maintain an environment free from verbal abuse for five residents (R#6, R#12, RB, RG, and RH), mental abuse for two residents (R#9 and R#11), and physical abuse for one resident (R#1), all perpetuated by facility staff. Cross refer to F600 2. Administration failed to maintain an environment free from physical abuse for six residents (R#2, R#3, R#4, R#5, R#6, and R#11) and sexual abuse for one resident (R#22). The physical abuse and the sexual abuse were caused by other residents. Cross refer to F600 3. Administration failed to ensure that one resident (R#1) was free from involuntary seclusion. Administrator BB initiated the involuntary seclusion of R#1 on 2/26/22 by directing maintenance staff to put slide bolt type locks on her room and bathroom doors. Cross refer to F603 4. Administration failed to implement multiple abuse policy components (reporting, investigation, protection) for two physical altercations that occurred on 3/8/22 and 3/9/22 between R#1 and CNA YY. Cross refer to F607 5. Administration failed to ensure that abuse allegations were reported in a timely manner for six residents (R#1, R#4, R#5, R#6, RG and RH). Cross refer to F609 6. Administration failed to ensure that an allegation of verbal abuse of two residents (RG and RH) was thoroughly investigated, and corrective actions implemented, including protection of the residents, in a timely manner. Cross refer to F610 7. Administration failed to ensure that care plans were revised to include physical altercations that occurred with another resident and additional interventions implemented, to prevent recurrence, for four residents (R#3, R#5, R#6, and R#11). Cross refer to F657 (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	8. Administration failed to ensure concerns were identified and QAPI plans implemented, in a timely manner related to the abuse prevention system, including staff to resident abuse allegations, resident to resident abuse, and implementing all components of the abuse polices. Cross refer to F867 During an interview on 5/2/22 at 11:15 a.m. with corporate Senior [NAME] President (VP) FF and corporate Regional [NAME] President (RVP) of Operations CC, they stated that they received an email and a call on the evening of 3/9/22 from Regional Director of Business Development FFFF. Regional Director FFFF had visited the facility and in speaking with Admissions staff, had concerns of possible abuse at the facility. One of the specific allegations she reported to them was of Administrator BB putting a lock on R#1's door. They determined through staff interviews that Administrator BB had a lock installed on R#1's room door and bathroom door and the locks were used at times to confine R#1 to her room. Administrator BB was suspended and subsequently terminated. Continued interview revealed that another allegation that was initially reported to VP FF and RVP CC, by Regional Director FFFF, was of verbal abuse of the [NAME] Hall secured unit residents by LPN AA. They suspended and subsequently terminated LPN AA based on the statements obtained from staff interviews. A review of the documented staff statements revealed that Administrator BB was made aware of the allegations of verbal abuse by staff but with no evidence that the allegations were addressed. During the interview, RVP CC also stated that DON PP (DON from 1/10/22-3/17/22) had been out a lot and she had been in the process of progressive discipline of her. 34318

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	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 21213 Based on record review and staff interview, the facility failed to thoroughly conduct a facility wide assessment that included and documented all required components of the resident population and facility resources. The facility census was 99. Findings include: Review of the Facility Assessment Tool revealed a 20-page document with an assessment date of 7/15/21 and an assessment review date of 7/22/21. The documented resident population information did not include the facility's resident capacity or any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility. The assessment also failed to include the following information on facility resources: all personnel, including managers, staff (both direct hire and contract), and volunteers, as well as their education and/or training and any competencies related to resident care; contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and health information technology resources. During interviews on 6/28/22 at 10:00 a.m. and 10:55 a.m., Administrator BBB confirmed that Facility Assessment Tool document was the faclity's assessment and had been provided by corporate staff. 34318

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	115654	A. Building B. Wing	06/29/2022

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34318 Based on interviews, record reviews, and review of the Health Information Management Manual, the facility failed to maintain complete and/or accurate clinical records for five residents (R#10, R#11, R#14, R#15, and R#22) from a total sample of 40 residents. Findings include: The facility had a Health Information Management Manual, dated [DATE]. The overview of section 1.1 of the manual documented that the facility maintained a separate medical record for each resident. Managing health information included, but was not limited to: processing of discharge records, managing the organization of the medical record, and safeguarding and storing medical records. 1. Closed Record Review of the Admission Record revealed Resident #14 was admitted on [DATE] with a readmit on [DATE] with the following diagnoses that include but not limited to spinal stenosis lumbar region, gastroesophageal reflux disease, hypertension, mood disorder, alcoholic cirrhosis of liver without ascites, chronic hepatitis B without Delta-agent, hepatitis C and generalized epilepsy and epileptic syndrome. Resident noted as full code. Review of the Office of the Coroner subpoena for records dated [DATE] revealed medical records were requested for the past 2 months including diagnoses and medications list. Review of the documents provided was the following records: the Admission Record with diagnosis and conditions, case management progress note dated [DATE], the nurse practitioner progress notes dated [DATE] and [DATE]; the physician progress notes dated [DATE], physician's order for [DATE] and two telephone phone order for [DATE] and [DATE] During an interview on [DATE] at 3:14 p.m. the Coroner UUUU revealed that he had requested medical records from the facility and did not receive what he had requested. Continued to state that R#14 body was at the crime lab pending an autopsy. The resident expired in the facility on [DATE]. During an [DATE] at 1:58 p.m. the Interim Agency DON EE revealed on [DATE] the coroner returned to the facility with a subpoena for medical records. She was not told the specific reason only that the medical examiner wanted to review her death. And that she provided what she could find in the facility. During an interview on [DATE] at 2:31 p.m. Coroner VVVV revealed that the autopsy was still pending. And that Coroner UUUU was handling this case. 2. Closed Record (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nurse's notes dated [DATE] through [DATE] revealed that on [DATE] that R#15 had an acute dermatitis noted as having multiple redden itchy patches on chest, arm and upper thighs. On [DATE], she was noted as having blisters bilateral upper extremities and bilateral lower extremities and across her chest. And on [DATE], the records revealed that the resident did not feel good. On the morning of [DATE] at 9:30 a. m., resident was noted to have increase agitation, resisting assistance. She was continuously moaning and yelling out. At 7:40 p.m., resident was mouth breathing and at this phase of change an order was given to send to hospital. Review of the hospital report dated [DATE] revealed Resident#15 had healing blisters wounds all over her body. During an interview on [DATE] at 4:15 p.m. LPN WW revealed that she tried to send the resident to the emergency room (ER) around the end of October. LPN AA had screamed at her telling her that she doesn't send anybody out the facility without going through her because she was the unit manager. And that the resident could be treated in house. LPN AA canceled the emergency room transportation pickup. Resident was going to be a direct admit to the hospital. She described the resident's skin as having open sores that some of the sores had started oozing. The sores would start out as a blister, then burst opened. The resident was having a decline, and that was what prompted her to get an order. She stated she had been a nurse for [AGE] years and has worked long term care for [AGE] years. And that she had written a detail nurse's note, telephone order and had call for set up for transportation for the resident pickup. LPN WW commented that she should have made a copy of her nurse's note. During an interview on [DATE] at 11:07 a.m. the Nurse Practitioner HHHH revealed that she could recall giving an order to send the resident to the ER to evaluate and treatment. And that the day shift nurse (LPN AA) had called her telling her that the night shift nurse was inexperienced and wanted to cancel the orders to send out. NP HHHH stated that the facility should have a copy of those verbal orders. And that she does not keep track of orders given. The facility was unable to provide [DATE] telephone orders and the nurse's notes for this event. The facility provided nursing notes for [DATE] and [DATE]. 3. Review of Resident #11 medical records revealed missing original nurse's notes. There were copies of the original that were missing the back side of the page. The facility was unable to provide the documents from the medical records overflow. A behavior note dated [DATE] revealed resident continues to have behaviors. She recently was noted to be in the bed of a male resident. (See nurses notes). The facility was unable to provide original nurse note for this incident. A nurse's note entry dated [DATE] - Resident went to room [ROOM NUMBER] bed and laid down. Assisted back out of resident (name). The remainder of the narrative was missing from the copy. The facility was unable to provide the original nurse's note. 4. Review of the Admission record revealed Resident #22 was admitted to the facility on [DATE] with the following diagnoses that include but not limited to diabetes mellitus type 2, schizophrenia, paralytic syndrome following cerebral infraction affecting left non-dominant side, conduct disorder, and cognition communication deficit. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical records paper charting and electronic charting revealed no evidence of nursing notes for this resident. The former DON BBBB was unavailable for an interview 21213 5. An observation on [DATE] at 10:39 a.m. observed upon entrance of the medical records room disorganized cardboard file box and plain cardboard box. The plain cardboard boxes had multiple records of residents ranging from 2018 to present. On the left side of the room were multiple blue and brown folders and a torn cardboard box of resident's documents that had not been filed. An observation on [DATE] at 10:25 a.m. observed the door to the medical records/supply room open. Upon entering observed the human resources and a Restorative CNA SS were in the building. The Restorative CNA SS commented that they were going through the piles of boxes looking for missing records that had been requested by the surveyors. However, they were unable to provide the records requested. 6. Resident (R)#10 resided at the facility from [DATE] through [DATE]. A review of R#10's medical records, which included both paper and electronic documentation, revealed that the [DATE] and February 2022 Medication Administration Records (MAR's) and the [DATE], [DATE] and February 2022 Treatment Administration Records (TAR's) were missing. During an interview on [DATE] at 9:48 a.m., interim Director of Nursing (DON) BBBB stated they had looked for but had been unable to locate the missing MAR's and TAR's. R#10 had a physician's order on [DATE] for 7.5 milligrams (mg) of Remeron to be administered daily at bedtime as an appetite stimulant. Further review of the Physician's Telephone Orders form that the Remeron order was documented on, revealed a handwritten note that the order was refaxed on [DATE]. During interviews on [DATE] at 3:43 p.m. and on [DATE] at 2:25 p.m., interim DON BBBB stated that the pharmacy initially filled the Remeron prescription on [DATE]. However, review of the [DATE] MAR revealed that the medication was inaccurately documented as being administered starting on [DATE].

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	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 21213 Based on interviews, record reviews, and policy review, the facility failed to identify concerns and effectively implement QAPI plans related to abuse. The facility census was 99 residents. On 6/23/22 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. Facility Administrator BBB and Assistant Director of Nursing (ADON) DDD were informed of the Immediate Jeopardy (IJ) on 6/23/22 at 12:19 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/26/22. At the time of exit on June 29, 2022, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: The facility had a Quality Assurance Performance Improvement Management program, with revision date of August 2021. The program overview documented 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 program policy specified that the Administrator shall be responsible for the management of the program in the administration of the facility. The policy also included that QAPI committee members should meet at least monthly and more often as needed to identify issues with respect to which QAPI activities were necessary. 1. During an interview with corporate VP FF on 5/5/22 at 2:00 p.m. she confirmed that she and RVP CC, following the allegations they received on the evening of 3/9/22, they were at the facility on 3/10/22 and 3/11/22 and through that weekend, conducting an investigation. Administrator BB was suspended and subsequently terminated. In addition, VP FF stated that they conducted and Ad Hoc QAPI meeting. Following corporate staff entering the building on 3/10/22, an Ad Hoc QAPI meeting was held on 3/11/22. Review of the meeting documentation revealed that the identified concern addressed in the meeting was: inappropriate management of abuse reporting and investigations. Allegations of abuse on the secured unit were not being identified and reported as required. Review of an Inservice Sign In Sheet revealed that the 3/11/22 Ad Hoc QAPI meeting plan was also reviewed on 3/18/22. A review of QAPI performance plans revealed that the following problems were identified and QAPI plans had been developed: 1. Staff were not following abuse policy regarding resident potential identified abuse or allegations of abuse; investigations of abuse; lack of administrative oversight by the abuse coordinator. The start date was listed as 3/9/22 with a completion date of ongoing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. Facility leadership was not producing positive resident outcomes nor regulatory compliance; policies regarding Freedom of Abuse were not followed and resident rights were violated. The start date was listed as 3/9/22 with a completed date of ongoing. 3. Violation of resident rights regarding freedom of abuse and the manner in which care and services were provided. The start date was listed as 3/15/22 with a completion date of ongoing. 4. Staff education regarding following abuse policy; investigations of abuse and timely reporting. The start date was listed as 3/15/22 with a completion date of ongoing. Further review of the facility identified problems and plans revealed that the plans shared root cause of lack of leadership/oversight, lack of competent leadership, lack of Administrator and/or DON oversight. As part of the QAPI committee, facility administration failed to identify areas of concern for resident abuse, in a timely manner, and effectively implement interventions to prevent recurrence. During an interview on 6/9/22 at 3:45 p.m., Administrator BBB stated that she could not locate any QAPI plans (from the previous Administration) on abuse prior to March 2022 (when corporate staff entered the facility to investigate abuse allegations). 2. A review of facility QAPI documentation revealed that the QAPI committee met monthly on 8/24/21, 9/21/21, 10/19/21, 11/30/21, and 12/28/21. There was no evidence of an further QAPI meetings until 3/11/22. During an interview on 6/29/22 at 2:10 p.m., Administrator BBB, who had been at the facility since 5/31/22, stated that the Administrator was in charge of QA. She stated that the facility's policy stated they (QAPI committee) would meet monthly. A review of the list of management changes at the facility revealed that the facility had seven different Administrators since June 2021. The facility's Administrators with their dates of service were as follows: Administrator BB (6/28/21-3/18/22), Administrator OO (3/14/22-3/20/22), Administrator DD (3/21/22-5/4/22), corporate Senior [NAME] President (VP) FF (5/4/2-5/9/22), corporate Regional [NAME] President (RVP) of Operations (5/9/22-5/23/22), Administrator AAA (5/23/22-5/30/22), and Administrator BBB as of 5/31/22. The facility had six different DONs since November 2021. The facility's DONs with their dates of service were as follows: DON FFF (11/19/21-1/19/22), DON PP (11/10/21-3/17/22), DON EE (3/18/22-5/12/22), Regional Nurse Consultant (RNC) BBBB (5/13/22-6/22/22), ADON DDD (6/23/22-6/26/22) and DON ZZZ as of 6/27/22. 34318

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 21213 Based on observations, interviews, and record reviews, the facility failed to ensure that nursing staff used and maintained shared resident equipment in a sanitary manner and failed to ensure that care and services were provided in an appropriate and sanitary manner, during Activities of Daily Living (ADL) care and medication administration for one resident (R#17), and wound care for one resident (R#23), from a total sample of 40 residents. Facility staff also failed to wear Personal Protective Equipment (PPE) in accordance with facility practice to decrease exposure and spread of COVID-19 on three halls (South, East, and West) of four halls. Findings include: 1. During an interview on 5/18/22 at 9:56 a.m. resident D revealed that she had asked LPN OOOO to bring her medications back at 11:00 p.m. LPN OOOO had told her that she either take the pills now or she will put down that she refused and will throw them in the trash. Resident D stated that she did not take the pills. LPN OOOO threw away the pills mixed with pudding. The pills were thrown in the roommate's trash can near the door. When LPN AAA came on 11/7 shift, Resident D told LPN AAA about not getting her medications and that the medications was put in the trash can. LPN AAAA took the medication from the trash can and gave it to her. She described the medication was placed in a plastic cup with pudding. Resident D stated that she took the medications that LPN AAAA had taken out of the trash can. She stated that she took the medications because she needed her medication and did not want to miss taking her medication of Trazodone and baclofen. During an interview on 5/23/22 at 3:15 p.m. LPN OOOO revealed that Resident D had requested her medications. She went into her room around 10:20 p.m. to 10:40 p.m. after she had prepared the medications by crushing the tablets and putting the crushed medications into a plastic medication cup with pudding. The medications were Trazodone and baclofen. When she tried to give the medication to the resident, the resident refused. She continued to state that she told the resident that if she didn't take the medication, that she would throw it away and chart that she had refused. She stated the resident told her that the medication was too early and refused to take the medication. LPN OOOO stated that she then threw the crushed medication with pudding in the trash can near the exit door. (This was the roommate trash can). During an interview on 5/25/22 at 10:07 a.m. LPN AAAA revealed that at the beginning of the shift, that LPN OOOO had told her that the resident had refused to take her medications. She told LPN OOO, that she would try to give the resident the medications. She stated that she got the medication that LPN OOOO had prepared and gave the pudding mixture with two crushed tablets to the resident. She was asked what was in the cup, LPN AAAA stated that LPN OOOO had crushed a baclofen and a trazodone and put in pudding, which was what she gave. When she was asked where (name) left the medications, she initially replied that she had gotten the medication where LPN OOOO left them. When asked where did LPN OOOO leave the medication, LPN AAAA stated on top of the medication cart. Again, she was asked where the medication cup was, she then replied on top of the medication cart. Afollow up interview on 5/31/22 at 12:08 p.m., with LPN OOOO, she clarified that she did not leave the pudding mixture on the medication cart but had thrown the medication mixture in the trash can by the door. And she did not make another pudding medication mixture for the resident. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The interview with LPN AAAA regarding where she found the medications that she gave R D conflicted with what Resident D and LPN LLLL revealed. 2. During an observation for perineal care on 5/25/22 at 2:14 p.m. observed agency CNA QQQQ assisted by agency CNA RRRR with providing perineal care to Resident D with her permission. CNA RRRR was observed going across the room to the roommate side and she brings the bedside table of the roommate to the Resident D side. She did not clean the soiled tabletop. She then puts clean towels and wash cloths on the dirty tabletop to perform perineal care for Resident D. The agency CNA was not available for an interview. 3. Review of a report dated 4/24/22 revealed that on 4/22/22 on the 11/7 shift, LPN ZZ had an accident, whereas he had an episode of diarrhea in his uniform. LPN ZZ took off his underwear and washed them in the lavatory at the nursing station. He then proceeds to dry his underwear in the microwave located in the East Hall pantry. Review of an inservice sign in sheet dated 4/27/22 revealed that LPN ZZ was educated on infection control and that at no time is personal or resident clothing to be washed in community sink. At no time is the microwave to be used for anything except food and drinks. Review of an invoice dated 4/25/22 revealed a purchase order for a new microwave to be delivered to the facility. During an interview on 6/1/22 at 3:45 p.m. RN XXX revealed that the incident involving the microwave, that she had received report from the 11/7 shift CNAs about the poop on the toilet. The CNAs had reported to her and LPN UUU that there was poop on the toilet on the East Hall staff restroom, and that LPN ZZ had used the microwave to dry his underwear after washing them. During an interview on 6/2/22 at 10:19 a.m. LPN UUU revealed that the CNAs that had worked 11/7 shift came to her and told her that there was poop in the bathroom. She stated when she came in on day shift after his shift, he would have feces everywhere behind the nursing station, and staff bathroom. She stated that she has brought in her own cleaning supplies and had to clean the bathroom multiple times (4-5 times). She has never seen him out of his uniform but have seen his uniform pants wet. When he leaves, she would sanitize the chairs, desk, phone, anything at the nursing station, medication cart. The outside of the medication record administration book, she would spray Lysol. A post survey telephone interview was conducted on 9/2/2022 at 9:58 a.m. with Administrator BBB, DON ZZZ and LPN BBBBB, revealed that Administrator BBB and DON ZZZ reported that they were not working in the facility when the incident with the LPN putting soiled underwear in the resident's microwave. Administrator BBB further reported that based on everything that she has reviewed the staff who were aware of concerns with LPN ZZ did not tell management until after the incident with the microwave occurred. (continued on next page)

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	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. The facility had a COVID-19 Protocol Phase IV. A 3/31/21 update to the protocol documented that health care personnel should always have well-fitting masks. A 7/28/21 update documented that all vaccinated and unvaccinated staff were to wear masks while indoors. A 10/11/21 update documented that all facility staff and essential healthcare workers, regardless of position, who may interact with residents were to wear a surgical mask or N95 mask. A review of in-service education records revealed that staff had been educated on infection control measures, including donning and doffing PPE on 11/25/21, 12/10/21, 1/5/22, and 1/27/22. However, staff were observed not wearing face masks appropriately while in resident accessible areas on 6/6/22, 6/8/22, and on 6/13/22. On 6/6/22 at 9:58 a.m. agency Licensed Practical Nurse (LPN) CCC was observed standing at the medication cart on the East Hall. LPN CCC was not wearing a face mask. A male resident was behind her in a wheelchair, with a face mask on. The LPN was also observed to enter R#27's room without a mask on. Immediately following the observation, LPN CCC was interviewed about the absence of a face mask and she stated that there were masks at the sign-in that morning, but no one told her they were mandatory. On 6/8/22 at 9:55 a.m. three nursing staff members were observed collected at the East Hall nursing station. Two of the three nursing staff had their surgical masks pulled down below their chins. During the observation, the two nursing staff members who had their masks pulled down, walked away from the nursing station and down the resident hallway; their masks remained partially pulled down. During an interview on 6/8/22 at 2:25 p.m., interim Director of Nursing (DON) BBBB confirmed that facility staff were supposed to wear face masks. When DON BBBB was asked how agency nursing staff would know to wear a face mask, she stated that a sign was posted on the front door (of the facility). When DON BBBB was asked where (in the facility) staff were supposed to wear face masks, she responded that staff were to wear masks in patient care areas. On 6/13/22 at 9:48 a.m. two male staff members were observed standing at the entrance to R#13's room on the South Hall. R#13 was also sitting in his wheelchair at the entrance to his room. One male staff member had his face mask pulled down below his nose and mouth, and the other male staff member had his face mask pulled down below his nose. 5. An observation on 6/7/22 at 10:19 a.m. LPN NN was on the [NAME] Hall eating Lays potato chips and drinking a sprite at the nurse's desk. An observation on 6/8/22 at 2:29 p.m. LPN III had placed her scissors in her pocket and her gloved hand to open the trash bag to drop a gauze into it and continued to put on wound dressing. She revealed that this was result of her subconscious and her being nervous. 6. During a covid outbreak in the facility, the following observations: An observation on 6/23/22 at 4:01 p.m. with LPN MMMM on South Hall revealed that there was two available face shield and one blue gown and a box of yellow gloves sitting on the nursing station for staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 6/23/22 at 4:04 p.m. LPN NNNN agent nurse on the South Hall Covid unit was wearing a yellow surgical mask. She was not wearing any other personal protective equipment (PPE). An observation on 6/23/22 at 4:05 p.m. the Occupation Therapist (OT) EEE was wearing a N95 and no other PPE on South Hall Covid unit. An observation on 6/24/22 at 11:20 a.m. observed Interim DON on the South Hall Covid unit wearing a N95 and no face shield or eye goggle. She had her regular eyeglasses sitting on top of her head. An observation on 6/24/22 at 11:30 a.m. LPN OOOO was wearing a black N95 and her personal eyeglasses. She was not wearing a face shield or eye goggle on the South Hall Covid unit. An observation on 6/24/22 at 11:46 a.m. observed R#35 sitting on a chair on the South Hall Covid unit without wearing a mask or face shield. He was in his eyeglasses. He was admitted to facility with covid. During an interview on 6/29/22 at 10:28 a.m. the [NAME] President Quality Improvement YYY revealed that on the covid unit, the staff should be wearing a N95 mask, face shield or eye goggle. And before going into the resident's room scrubs or jumpsuit, gowns, N95 mask, face shield or eye goggle, and gloves before going in the resident's room. 34318

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

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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. 34318 Based on record review and interview, the facility policy Infection Control Manual the facility failed to ensure that five of six residents (R) (R#7, R#32, R#33, R#34, R#35) were offered and/or received the influenza and/or pneumococcal vaccine. Findings include: Review of the facility policy Infection Control Manual Infection Prevention, Immunization Standing Orders, dated 06/2016: * All resident of the facility, regardless of age and medical condition, will receive the influenza vaccine annually, conditioned upon the availability of the vaccines, unless there is a documented contraindication, decline or refusal of vaccine and depending on availability of vaccine. The facility will attempt to obtain vaccine from alternative source if unavailable from primary source. * All resident of the facility, regardless of age and medical condition, will receive the pneumococcal vaccine at least once unless there is documented medical contraindication, decline or refusal of vaccine. In October of 2005, CMS began requiring as a condition of participation in the Medicare and Medicaid programs that nursing homes ensure there their resident receive influenza and pneumococcal vaccinations. 1. Review of R#7 medical records revealed that the Influenza Immunization Informed Consent and the Pneumococcal Conjugated Vaccine (PCV) Informed Consent were not completed. The forms only had R#7 name on both forms. There was no evidence that the resident was offered either vaccine or had been educated on the vaccines. The Test/Immunization Record revealed a Tuberculin Skin Test dated 7/29/21. There was no other vaccination annotated on this form. However, on 6/29/22, the facility was unable to obtains records from GRITs. 2. Review of R#31 medical records revealed that the Influenza Immunization Informed Consent revealed in the Reason for Vaccine Decline Box B (Personal Reason(s): Check all that apply was incomplete and was not dated. The Pneumococcal Conjugated Vaccine (PCV) Informed Consent was blank and was without the resident's name. The Test/Immunization Record form was blank and without a name. However, on 6/29/22, the facility was able to obtain records from GRITs that indicated that R#31 had received PCV on 10/29/2018 and PPV on 4/15/2019. There was no evidence that the facility had verified R#32 pneumococcal vaccination status prior to obtaining the GRITs record. 3. Review of R#32 medical records revealed that there was no evidence that the Influenza Immunization Informed Consent was offered to R#32 to received or decline the influenza vaccine. There was no evidence that the Pneumococcal Conjugated Vaccine (PCV) Informed Consent was offered to R#32 to receive or decline the pneumococcal vaccine. The Test/Immunization Record revealed a Tuberculin Skin Test dated 3/29/21. There was no other vaccination annotated on this form. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, on 6/29/22, the facility was able to obtain records from GRITs that indicated that R#32 had received PCV on 10/29/2018 and PPV on 4/15/2019. There was no evidence that the facility had verified R#32 pneumococcal vaccination status prior to obtaining the GRITs record. 4. Review of R#33 medical records revealed that the Influenza Immunization Informed Consent was dated and signed on 9/30/2019 to indicate that the resident had received the information about influenza and have been educated on the benefits and risks associated with the influenza vaccine. R#33 decline to receive the influenza. There was no evidence that R#33 had been offered the influenza vaccine since 9/30/2019. The Test/Immunization Record revealed a Tuberculin Skin Test was administered on 8/31/19; the pneumococcal vaccine was refused on 9/30/19; and influenza vaccine was refused on 9/2020. There was no evidence that R#33 was offered influenza vaccine after 9/2020. However, on 6/29/22, the facility was unable to obtains records from GRITs. 5. Review of R#34 medical records revealed that the Pneumococcal & Annual Influenza Vaccine Information and Request form was not dated. The form was noted as a refusal for the pneumococcal and the annual influenza. The resident signature was witnessed by a Certified Nurse Aide. There was two influenza Immunization Informed Consent forms neither were dated. One of the form decline permission to receive the influenza and that the resident refused to sign. The second form listed the resident and was incomplete. There was two Test/Immunization Record, one form had influenza vaccine refused on 11/2021 and the second form had pneumococcal vaccine refused on 9/24/18. However, on 6/29/22, the facility was unable to obtains records from GRITs. During an interview on 6/29/22 at 10:28 a.m. Regional [NAME] President Quality improvement YYY revealed that the pneumococcal and influenza vaccination not documented are not done and that this was out of compliance.

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	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Perform COVID19 testing on residents and staff. 34318 Based on record reviews and interview, and the facility policy Covid-19 Protocol Phase IV, the facility failed to ensure that an outbreak COVID-19 testing was initiated. Findings include: Review of the undated facility policy Covid-19 Protocol Phase IV revealed when prioritizing individuals to be tested , facility should prioritize individuals with signs and symptoms of COVID-19 first, then perform testing triggered by an outbreak investigation. Review of facility documents revealed that for May 2022, staff were supposed to be tested on ce per week. Review of staff testing logs dated 4/28/22 through 6/8/22 revealed that on 4/28/22, 5/3/22, 5/4/22, 5/14/22 one employee was tested ; on 5/16/22, 5/18/22, and 5/20/22 two employees were tested ; on 5/5/22, 5/6/22, 5/8/22, 5/9/22, 5/10/22, 5/11/22, 5/13/22, 5/17/22 three employees was tested . The log data review by name revealed that only two of the tested employees were vaccinated and the unvaccinated employees were sporadicly tested . Review of three covid positive staff revealed that on 5/18/22 Licensed Practical Nurse (LPN) PPP worked the 11/7 shift. She called in for work on 5/19/22 due to feeling ill. And on 5/21/22 she received a positive covid test from an outside test site. LPN PPP contacted the facility on 5/22/22 to inform them of her positive covid result. Review of the facility testing logs dated 5/22/22 revealed that the scheduled employees that worked on 5/22/22 were the only staff tested . There was no evidence that the facility initiated an outbreak testing to test all employees. The facility total staff was 90. The facility outbreak logs dated 5/23/22 through 6/12/22 indicated sporadic testing of unvaccinated employees. The facility was contacted by corporate to inform the facility that corporate staff had tested positive for covid on 6/15/22. The facility at this time did initiate an outbreaking testing and identified one positive resident 6/15/22, the facility had their first positive resident. There was no evidence to indicate that he had left the facility for any reason. On 6/20/22 two more residents tested positive and one on 6/22/22. The former Director of Nursing (DON) BBBB was unavailable for an interview. During an interview on 6/28/22 10:59 a.m. the Administrator BBB revealed that the facility received a call on 6/15/22 that the Corporate Senior [NAME] President FF was positive for covid. The facility started an outbreak testing for staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/28/22 at 1:51 p.m. the DON ZZZ revealed that on 5/22/22 the staff that was positive had called the facility on 5/21/22. The facility should have started testing twice a week testing. The residents should have been tested every seven days and that the outbreak testing would have ended on June 5 as long as there was no other positive resident. On 6/15/22, everybody (staff) should be tested twice a week until no positive. And on 6/22/22, was the last positive resident for the facility. And that she was not sure how often employee with exemption, should be tested . She stated that she will look up this information. During an interview on 6/29/22 at 10:28 a.m. the Regional [NAME] President Quality Improvement YYY revealed that staff are to be tested twice a week for 2 weeks during an outbreak. On the 5/22/22 all staff should have been tested . Testing staff that worked on 5/22/22 was not a complete testing for outbreak. As of 6/29/22, the facility currently had seven residents on the covid unit and five staff recovering from COVID-19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center	176 Lincoln Ave Fitzgerald, GA 31750

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213 Based on observation and record review, the facility failed to maintain an environment free from dried spills for two residents (R#27 and R#28) from a total sample of 40 residents. Findings include: 1. Review of Resident (R)#27's clinical record revealed that she received all nutrition and hydration via a gastrostomy tube. Review of the physician's orders revealed that she received the nutritional supplement, Jevity 1.5, at a rate of 72 millitiers (ml) per hour for 20 hours per day via a gastrostomy tube. During observations of R#27's room on 6/6/22 at 9:58 a.m. and 2:36 p.m., on 6/7/22 at 9:46 a.m. and 3:43 p.m. and again on 6/13/22 at 3:20 p.m. dried light brown liquid stains were observed caked on the base of pole that a pump, that delivered the gastromy tube nutritional supplement, was mounted on. Multiple dried light brown liquid stains were also observed on the floor surrounding the pole base, and splattered on the nearby chest of drawers and air conditioner unit cover. 2. Review of R#28's clinical record revealed that she received all nutrition and hydration via a gastrostomy tube. Review of the physician's orders revealed that she received the nutritional supplement, Jevity 1.5, at a rate of 50 ml per hour for 20 hours per day via a gastrostomy tube. During observations of R#28's room on 6/8/22 at 2:16 p.m. and again on 6/13/22 at 9:45 a.m., multiple dried light brown liquid stains were observed all over the floor around the gastrostomy tube pump pole and on the base of the pole. 34318 In addition, an observation on the initial round on 4/19/22 at 11:17 a.m. on the [NAME] Hall room [ROOM NUMBER]A bed had a bed pad with dry yellow ring with brown outer edge. The resident's floor was noted to be dirty and dried spill spots.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115654	A. Building B. Wing	06/29/2022

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 21213 Based on observations and review of pest control service records, the facility failed to maintain an environment free from flies for three residents (R#8, R#20 and R#27) on three halls (East, West, and South) from a total of four halls and sample of 40 residents. Findings include: The facility had a contract in place with a pest control company since 1/9/17. The contract included that pest control services would be performed on a monthly basis or as needed based on the nature of any recurring pest problem. A review of the pest control service records from December 2021 through May 2022 revealed that pest control services had been provided on 12/10/21, 1/7/22, 2/4/22, 3/4/22, 3/16/22, 4/11/22, and 5/5/22. 1. An observation on 5/17/22 at 10:22 a.m. observed Resident #20 sitting in her wheelchair near her room. Standing in the hall looking into her rooms were 8 flies on the resident bed. The Housekeepers TT made the comment that the Resident #20 have flies in her room because she was always peeing on the floor. An observation on 5/31/22 at 12:22 p.m. with Registered Nurse (RN) HHH, observed Resident #20 sitting in her wheelchair on [NAME] Hall. She had three flies on her back of the upper portion of her shirt and one fly on the wheelchair arm rest. 2. During an observation of the East Hall on 6/6/22 at 2:36 p.m., R#27 was lying in the bed. Three flies were observed crawling on her bed linens. During an observation on 6/7/22 at 3:43 p.m., R#27 was lying in the bed. A fly was observed flying around the room and landing and crawling on different surfaces including the mattress, bed spread, R#27's right hand, and the trashcan. 34318 3. An observation on 6/7/22 at 10:14 a.m. Resident #8 was observed with six flies on clothes while he was sitting in his Geri-chair in his room. He had a fly swatter on the 2-drawer nightstand that was next to his bed. An observation on 6/23/22 at 3:51 p.m. observed two flies on the medication cart and LPN LLLL has a fly swatter.