STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115564	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER HEALTH OF CENTRAL GEORGIA	**712 PATTERSON STREET BYROMVILLE, GA 31007**

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** Based on observation, interview, and record review, the facility failed to ensure a dignified dining experience for one resident (A), from a total sample of 15 residents. Findings include: During an observation of the lunch meal on 7/23/2020 at 1:29 p.m. the first lunch cart for West Unit was observed on the hall. At 1:36 p.m., Resident (R) A was observed in his room, sitting up in bed, awake, and looking around. His two roommates were also in the room and had their lunch trays set up in front of them and were eating. RA was observed to have a meal tray on his overbed table next to him. However, it was a breakfast tray containing a plate of untouched, cold food with insects flying around it. At 1:40 p.m. all of the lunch trays on the cart had been passed out without RA receiving a tray. At 1:45 p.m. a staff person removed the cold breakfast tray from RA's room. RA was observed to remain awake and sitting up without a lunch tray, while his roommates continued to eat. At 1:53 p.m., a second cart of lunch trays arrived on the unit and RA was served at 1:55 p.m. During an interview on 7/27/2020 at 10:15 a.m., the Dietary Manager stated that for meal service, two carts are sent to the East Unit first, and a third cart goes to the West Unit. Once one of the two carts returns to the kitchen from the East Unit, they load it up with the remaining trays for the West Unit and then send it out. For the West Unit, they make sure the trays for the residents who smoke go on the first cart, so that they can eat and get to the smoke break. However, a review of a list of residents who smoked revealed that RA was included on the list. RA confirmed during an interview on 7/29/2020 at 2:15pm that he was a smoker.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide an environment free from debris and trash build-up in one resident room (West Unit) and one designated outside smoking area (East Unit). Findings include: 1. During an interview on 7/27/2020 at 9:55am the Housekeeping Supervisor stated that the housekeeping staff have a job routine posted in the laundry and a guide that tells them what they should be doing and when. She stated that all resident rooms are cleaned once a day but staff go in them twice a day to check on supplies like tissue, soap, sanitizer, trash can liners, etc. Also, some rooms have to be cleaned more than once. Housekeeping staff complete a morning tour to start with, then they go back around and start their cleaning, and then complete an afternoon tour to make sure supplies have not run out and the can liners are in the trashcans. A review of the daily cleaning guide revealed that it included a cleaning schedule for West Unit which included making morning rounds, cleaning, and making afternoon rounds of assigned areas. A 5 Step Procedure was included for cleaning. The 5 step procedure guide listed pulling trash, cleaning horizontal surfaces, cleaning vertical surfaces, dust mopping and damp mopping as daily tasks to complete. However during an observation on 7/22/2020 at 1:30 p.m. of room [ROOM NUMBER], there were three clumps of a black/brown substance stuck to the wall near bed A with liquid-like stains running down the wall below the substances. The substances remained on the wall during subsequent observations on 7/23/2020 at 1:05 p.m. and 1:41 p.m. 2. During an observation on 7/28/2020 at 3:26 p.m. with the Director of Nursing (DON), the ground in and around the designated smoking area outside of the East Unit exit was observed to be littered with debris including a glove, a mask and cigarette butts too numerous to count. A trash can and two cigarette disposal containers were available in the area. After re-entering the building, the DON stated that she had called for someone to come clean up the area. A follow up observation on 7/28/2020 at 3:55 p.m. revealed that the mask, glove, and most of the cigarette butts had been removed. During an interview on 7/29/2020 at 9:40 a.m., the Administrator stated that it was housekeeping and maintenance staff's responsibility to keep the area clean.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medications were administered as care planned for one resident (#7) from a total sample of 15 residents. Findings include: Resident (R) #7 had a [DIAGNOSES REDACTED]. The resident's care plan included that R#7 used anti-anxiety medications and antipsychotic medication. The care plan included an intervention for nursing staff to administer medication as ordered by the physician. A review of the clinical record revealed a 6/19/2020 readmission order for a 50 milligram (mg) intramuscular injection of [MEDICATION NAME] (an antipsychotic medication) to be administered every 14 days. The physician's orders [REDACTED]. During an interview on 7/29/2020 at 3:25 p.m., Pharmacy Manager BB stated that the medication was shipped from the pharmacy on 6/22/2020 and was signed for at the facility by nurse CC on 6/23/2020 at 12:14 a.m. However, a review of the clinical record revealed no evidence that R#7 received the injection of [MEDICATION NAME] on 6/24/2020, as ordered, as care planned. Further review of the clinical record revealed that the medication was noT administered until 7/4/2020. Cross refer to F760
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to ensure that one resident (#7) was free from significant medication errors, from a total sample of 15 residents. Findings include: Resident (R) #7 had a [DIAGNOSES REDACTED]. The resident's care plan included the use of antipsychotic medication with an intervention for nursing staff to administer medication as ordered by the physician. R#7 was hospitalized from [DATE] through 6/19/2020. A review of the clinical record revealed a 6/19/20 readmission order for a 50 milligram (mg) intramuscular injection of [MEDICATION NAME] (an antipsychotic medication) to be administered every 14 days. The physician's orders [REDACTED]. The pharmacy Work With Order Fills form documented that the [MEDICATION NAME] was ordered on [DATE] and shipped on 6/22/2020. During an interview on 7/29/2020 at 3:25 p.m., Pharmacy Manager BB stated that the medication was shipped from the pharmacy on 6/22/2020 and was signed for at the facility by nurse CC on 6/23/2020 at 12:14 a.m. Further review of the pharmacy Work With Order Fills' form revealed that the medication was ordered and shipped again on 7/1/2020. However, despite evidence that the facility received two doses of the medication, a review of the clinical record revealed no evidence that R#7 received the injection of [MEDICATION NAME] on 6/24/2020, as ordered until 7/4/2020. Further review of R#7's clinical record revealed conflicting information regarding the availability of the [MEDICATION NAME] injection on 6/24/20. A 6/24/2020 nurse's note documented

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) that the resident was due for a [MEDICATION NAME] injection but it was unavailable; the pharmacy was notified and they stated it was on order and they would send when (the medication) was available. The nurse's note also documented that the physician was notified and a new order was obtained to place the [MEDICATION NAME] on hold until it was available. A review of physician's orders [REDACTED]. During the interview on 7/20/2020 at 3:25 p.m. with Pharmacy Manager BB, she stated that when nursing staff called on 6/24/2020 to check on the [MEDICATION NAME] medication, the information that it had been shipped on 6/22/2020 and received at the facility on 6/23/2020 would have been available to communicate to nursing staff. The 6/19/2020 readmission orders [REDACTED]. A review of the July 2020 electronic Medication Administration Record [REDACTED]. The [MEDICATION NAME] would have been due again on 7/10/2020. However, a review of the clinical record revealed no evidence that the patch was administered on 7/10/2020, as scheduled, as ordered. On 7/11/2020 nursing staff documented in a 7/11/2020 nurse's note that the resident was noted with elevated blood pressure twice; that she was awake, alert, verbally responsive, with no change in level of consciousness or mental status. The physician was notified and new orders were obtained to increase the [MEDICATION NAME] blood pressure medication and to apply a [MEDICATION NAME]. However, the nurse's note included that the resident refused the medications on 7/11/2020. A reviow of blood pressure documentation in the electronic clinical record revealed a blood pressure reading of 239/114 on 7/11/2020. On 7/12/2020 R#7's blood pressure was documented as 182/79. During an interviews on 7/23/2020 at 11:15 a.m. and on 7/20/2020 at 9:40 a.m., the Administrator stated that since the facility switched over to an electronic clinical record on 7/1/2020, it had been a learning process for the nuses on inputting orders. When R#7's [MEDICATION NAME] order was first put into the electronic record, it was not alerting the nurses correctly to administer it weekly. Licensed Practical Nurse (LPN) AA identified the error and the Administrator stated she has also developed a Quality Assurance (QA) plan to address it. The Administrator stated that they were still in the process of auditing the physicians orders as part of the QA plan. During an interview on 7/23/2020 at 12:00 p.m., the Director of Nursing (DON) stated that she contacted LPN AA and she confirmed that she applied the [MEDICATION NAME] on 7/13/2020.