STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan, consistent with resident rights, which included measurable objectives and timeframes to meet a resident's medical needs for four of 33 sampled residents (R) (R11, 72, 125, and 162) Related to (1) antidepressant medication usage for R11; (2) observing for side effects and behaviors for the resident's antidepressant medication usage for R72; (3) observing for side effects and behaviors for R125's antidepressant medication usage; (4) for risk of falls for R162. Findings included: A review of the facility policy, Use of Psychotropic Medication, dated 6/1/2023, revealed: residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). The record also revealed: 12. The effects of psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: a. Upon physician evaluation (routine and as needed), b. During the pharmacist's monthly medication regiment review, c. During MDS review (quarterly, annually, significant change), and d. In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice. 1. A review of the clinical record for R11's revealed the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis that included major depressive disorder. A review of the Annual Minimum Data Sheet (MDS) assessment, dated 9/22/2023, revealed R11 had a Brief Mental Interview Score (BIMS) of 14, which indicated the resident was cognitively intact and received antidepressant medications for seven of seven days during the look back date. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	10/13/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R11's care plans, dated 10/9/2023, revealed the following care areas were addressed: (R11) receives antidepressant medication related to depression with interventions to: Administer Antidepressant medications as ordered by physician. Observe /document/report PRN (as needed) adverse reactions to Antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL (activity of daily living) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt (weight) loss, n/v (nausea/vomit), dry mouth, dry eyes. Observe/document side effects and effectiveness Q-SHIFT (every-shift). A review of R11's medical record revealed the following active orders: Citalopram Hydrobromide Oral Tablet 20 MG (milligram) Give one tablet by mouth one time a day related to Major depressive disorder, with a Start Date of 3/1/2023, and no end date. Mirtazapine Oral Tablet 15 MG Give one tablet by mouth at bedtime related to Major depressive disorder, with a start date of 2/28/2023, and no end date. Trazodone HCl Oral Tablet 150 MG Give one tablet by mouth at bedtime for insomnia related to Major depressive disorder, with a start date of 5/24/2023, and no end date. Observation: Antidepressant Medication - Observe for behavior (specify resident's behavior). Observe for side effects: GI (Gastrointestinal) upset, insomnia, fatigue, dizziness, dry mouth, headache. Document 'Y' if resident is free of side effects. Document 'N' if the resident is NOT free from side effects. If 'N' document SE (Side effects) in the PNs (Progress Notes) every day and night shift, with a start date of 8/9/2023, and no end date. A review of R11's October 2023 Medication Administration Record (MAR), dated 10/12/2023, revealed the resident was administered the prescribed Trazadone, Mirtazapine, and Citalopram Hydrobromide as ordered. The record revealed for the order to observe for the antidepressant medication usage for side effects and an unspecified behavior; there were documented checkmarks instead of a yes (y) or no (n) as ordered. A review of R11's Progress Notes, from 9/12/2023, to 10/13/2023, did not reveal any progress notes indicating the resident exhibited any behaviors or side effects. A review of R11's Documentation Survey Report, dated 10/12/2023, revealed the Certified Nursing Assistant (CNA) provided documentation if the resident did, or did not, have behavior symptoms on 10/4/2023, 10/5/2023, 10/6/2023, 10/8/2023, 10/11/2023, and 10/12/2023. However, they were not documented on all three shifts. 2. A review of R72's face sheet, dated 10/12/2023, revealed the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis that included major depressive disorder. A review of R72's Quarterly MDS assessment, dated 7/23/2023, revealed the resident had a BIMS of 15, which indicated the resident was cognitively intact. The record also revealed the resident received antidepressant medication for three of seven days during the look back today. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R72's care plans, dated 8/8/2023, revealed the following focus: (R72) receives antidepressant medication related to Depression, Poor adjustment to admission, Poor nutrition, and pain, with interventions to: Administer Antidepressant medications as ordered by physician. Observe/document side effects and effectiveness Q-SHIFT .Observe/document/report PRN adverse reactions to Antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes. A review of R72's medical record revealed the following active orders: Sertraline HCl Oral Tablet 50 MG Give three tablets by mouth one time a day related to Major depressive disorder, with a start date of 1/24/2023, and no end date. Duloxetine HCl Oral Capsule Delayed Release Particles 60 MG Give one capsule by mouth one time a day related to Major depressive disorder, with a start date of 1/24/2023, and no end date. The record did not reveal any orders to observe the resident for side effects and/or behaviors from antidepressant medication usage. A review of R72's October 2023 MAR, dated 10/12/2023, revealed the resident was administered the prescribed Sertraline and Duloxetine as ordered. However, R72 refused the Sertraline on 10/8/2023, and 10/10/2023 through 10/12/2023. The record revealed no order of documentation of observations for the antidepressant medication usage for side effects and/or behaviors. A review of R72's Progress Notes, from 9/12/2023, to 10/13/2023, did not reveal any progress notes indicating the resident exhibited any behaviors or side effects. 3. A review of R125's face sheet, dated 10/12/2023, revealed the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included major depressive disorder. A review of R125's Annual MDS assessment, dated 7/25/2023, revealed the resident had a BIMS of 15, which indicated the resident was cognitively intact. The record also revealed the resident received antidepressant medication for seven of seven days during the look back today. A review of R125's care plans, dated 9/20/2023, revealed the focus of: (R125) receives antidepressant medication related to depression, with interventions to: Administer Antidepressant medications as ordered by physician. Observe/document side effects and effectiveness Q-SHIFT . Observe/document/report PRN adverse reactions to Antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes. A review of R125's medical record revealed the following active orders: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Duloxetine HCl Oral Capsule Delayed Release Particles 20 MG Give one capsule enterally one time a day related to major depressive disorder, with a start date of 7/20/2023, and no end date. Observation: Antidepressant Medication - Observe for behavior (specify resident's behavior). Observe for side effects: GI upset, insomnia, fatigue, dizziness, dry mouth, headache. Document 'Y' if resident is free of side effects. Document 'N' if the resident is NOT free from side effects. If 'N' document SE in the PNs every day and night shift, with start date of 8/22/2023, and no end date. A review of R125's October 2023 MAR dated 10/12/2023, revealed R125 was administered the prescribed Duloxetine as ordered. The record revealed for the order to observe for the antidepressant medication usage for side effects and an unspecified behavior; there were documented checkmarks instead of a yes or no as ordered. A review of R125's Progress Notes, from 9/12/2023, to 10/13/2023, did not reveal any progress notes indicating the resident exhibited any behaviors or side effects. A review of R125's Documentation Survey Report, dated 10/12/2023, revealed the CNA provided documentation if the resident did, or did not, have behavior symptoms on 10/1/2023, 10/2/2023, 10/6/2023 through 10/9/2023. However, they were not documented on all three shifts. During an interview, on 10/12/2023, at 10:07 am, Licensed Practical Nurse (LPN) OO reported she worked with R11 and was one of the nurses that documented the checkmarks on the resident's MAR for observing for behaviors and/or side effects from antidepressant medication usage. She reported the checkmarks meant R11 wasn't having a behavior. LPN OO also reported that if the resident was having a behavior such as crying, isolating herself, or depressed, they would write a progress note. LPN OO also noted the order did indicate that to document with a Y or N, and that she had not being doing that because the system was not set up to document as such. LPN OO also confirmed the order asked for two different observations, and that the MAR did not allow them to indicate if the resident was having a behavior or side effects or both. LPN OO reported she wasn't the normal nurse for R72 and R125. During an interview, on 10/12/2023, at 10:42 am, with Unit Manager (UM) MM, they confirmed residents taking psychotropic medications were to be monitored to make sure the medication was effective for the behavior it was treating, and if there were any side effects from the medication. UM MM confirmed R11 was taking anti-psychotropic and antidepressant medications. UM MM also confirmed R11's order to observe behaviors and/or side effects from antidepressant medication usage was not documented as per the physician's order for documenting with a Y or N. UM MM reported that, even though it was not documented as per the order, if the nurse identified the resident was having a behavior or side effect, then they would document it on a progress note. UM MM confirmed the order asked for two different observations, and that the MAR did not allow them to indicate if the resident was having a behavior or side effects or both, which was confusing to her. During an interview, on 10/12/2023, at 10:52 am, UM MM confirmed R72 was receiving antidepressant medication. UM MM also confirmed the resident's order and that the MAR did not have documentation of resident behavior or side effects being monitored after the antidepressant medication usage; but she confirmed there should be documentation. (continued on next page)

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	115270	A. Building B. Wing	10/13/2023

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 10/12/2023, at 10:55 am, UM MM confirmed R125 was receiving antidepressant medication. UM confirmed R125's order to observe behaviors and/or side effects from antidepressant medication usage was not documented as per the physician's order for document with a Y or N. UM MM reported that even though it was not documented as per the order, if the nurse identified the resident was having a behavior or side effect then they would document it on a progress note. UM MM confirmed the order asked for two different observations, and that the MAR did not allow them to indicate if the resident was having a behavior or side effects or both. UM MM reported they may need to adjust how the order was input into the electronic system so that they could document with Y or N. During an interview, on 10/12/2023, at 12:01 pm, Regional Nurse GG confirmed R11, R72, and R125 were taking psychotropic medications. Regional Nurse GG confirmed Residents R11 and R125 both had orders to observe them for behaviors and side effects from antidepressant medication usage that were not documented as per the order on the MAR. Regional Nurse GG confirmed R72 did not have an order that she could find to document on the MAR for observations of side effects and/or behaviors from antidepressant medication usage. Regional Nurse GG reported the residents, as per CNA documentation, were documented on behavioral symptoms per shift; and that was a source of documentation of the behaviors the residents may have exhibited during their usage of antidepressant medication. A review of R11's Documentation Survey Report, dated 10/12/2023, revealed the CNA documented if the resident did, or did not, have behavior symptoms on 10/4/2023 through 10/6/2023, 10/8/2023, 10/11/2023, 10/12/2023. However, they were not documented on all three shifts. A review of R72's Documentation Survey Report, dated 10/12/2023, revealed the CNA documented if the resident did, or did not, have behavior symptoms on 10/6/2023 and 10/7/2023. However, the behaviors were not documented on one of three shifts. A review of R125's Documentation Survey Report, dated 10/12/2023, revealed the CNA documented if the resident did, or did not, have behavior symptoms on 10/1/2023, 10/2/2023, 10/6/2023 through 10/9/2023. However, they were not documented on all three shifts. During an interview, on 10/12/2023 at 2:35 pm, Regional Nurse GG reported the facility's [NAME] President of Clinical Services reported they could not find an order for side effect and behavior monitoring for R72 but said that they don't have to have an order to monitor, but that they were to document the side effects and behaviors. 4. The facility's policy for fall prevention titled, Fall Prevention Program, was reviewed. The policy was reviewed/revised by the facility on 3/1/2023. Step six of the policy indicated that each resident's risk factors, and environmental hazards would be evaluated when the comprehensive care plan was being developed, and that interventions would be monitored for effectiveness. A review of the medical record for R162 revealed an admitted [DATE]. R162's medical diagnoses included Parkinson's Disease and a history of falls with fracture. A quarterly MDS assessment, dated 9/6/2023, revealed a BIMS score of 99, indicating impaired cognition. The assessment identified R162 as requiring extensive to total dependence on staff for ADL care. The assessment also identified R162 as having sustained two falls since admission/entry into the facility. (continued on next page)

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	115270	A. Building B. Wing	10/13/2023

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R162's nursing progress notes revealed an entry date of 6/18/2023, at 11:22 am, which indicated that R162 was observed on the floor during rounds at 8:15 am. The note added that R162 communicated that she was trying to get comfortable in bed and slipped too far on one side. A subsequent Post Fall Review, dated 6/18/2023, indicated that R162's bed would be kept in low position. Continued review of R162's nursing progress notes revealed an entry, dated 8/18/2023, at 6:35 am, which indicated R162 was found on the floor at 5:30 am. The nursing note indicated that R162 stated at that time that she rolled out of the bed. A review of R162's comprehensive care plan revealed a focus area for falls. The care plan indicated that R162 sustained a fall on 6/18/2023, and a second fall on 8/18/2023, with a goal to be free from further falls. The care plan also indicated that the falls on 6/18/2023, and 8/18/2023, were consistent with R162 rolling off the bed. Further review of the care plan revealed an intervention, dated 6/18/2023, which directed nursing staff to place a wedge to the left side of R162's bed to establish parameters. A second intervention, dated 8/18/2023, revealed an intervention which directed staff to apply an air mattress with bolsters to again establish parameters. On 10/11/2023 at 11:35 am, LPN VV was observed to be exiting R162's room. Upon entering the room, the bed was noted to be elevated to an unsafe working height. There was no positioning wedge to R162's left side, and the mattress did not have perimeter bolsters. On 10/11/2023 at 11:47 am, an interview was conducted with LPN VV regarding R162. During the interview, LPN VV was asked to review R162's care plan for falls. LPN VV reviewed the medical record and confirmed that R162's care plan interventions included the placement of a positioning wedge to the resident's left side as well as perimeter bolsters to the resident's mattress. LPN VV further acknowledged that neither the positioning wedge nor the perimeter mattress bolsters were in place at the time of the interview. On 10/12/2023, at 10:33 am, a subsequent observation of R162's room was conducted. The bed was again found to be elevated to a working height. There was no positioning wedge in place, and no perimeter bolsters were on the mattress.

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	115270	A. Building B. Wing	10/13/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on observations, interviews, and record review, the facility failed to provide an environment that was free from accident hazards for one of 45 sampled residents (R) (R162). Findings included: The facility's policy for fall prevention titled, Fall Prevention Program, was reviewed. The policy was reviewed/revised by the facility on 3/1/2023. Step three of the policy described interventions for residents with a low to moderate risk for falls. One of those interventions read, Bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed. Step six of the policy indicated that each resident's risk factors, and environmental hazards would be evaluated when the comprehensive care plan was being developed, and that interventions would be monitored for effectiveness. A review of the medical record for R162 revealed an admitted [DATE] with diagnoses including Parkinson's Disease and a history of falls with fracture. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R162 presented with a Brief Interview for Mental Status (BIMS) score of 99, indicating impaired cognition; R162 required extensive to total dependence on staff for activities of daily living (ADL) care; and R162sustained two falls since admission/entry into the facility. A review of R162's nursing progress notes revealed an entry, dated 6/18/2023, at 11:22 am, which indicated that R162 was observed on the floor during rounds at 8:15 am. The note added that R162 communicated that she was trying to get comfortable in bed and slipped too far on one side. A subsequent Post Fall Review, dated 6/18/2023, indicated that R162's bed would be kept in low position. Continued review of R162's nursing progress notes revealed an entry, dated 8/18/2023, at 6:35 am, which indicated R162 was found on the floor at 5:30 am. The nursing note indicated that R162 stated at that time that she rolled out of the bed. A review of R162's comprehensive care plan revealed a focus area for falls. The care plan indicated that R162 sustained a fall on 6/18/2023, and a second fall on 8/18/2023, with a goal to be free from further falls. The care plan also indicated that the falls on 6/18/2023, and 8/18/2023, were consistent with R162 rolling off the bed. Further review of the care plan revealed an intervention, dated 6/18/2023, which directed nursing staff to place a wedge to the left side of R162's bed to establish parameters. A second intervention, dated 8/18/2023, revealed an intervention which directed staff to apply an air mattress with bolsters to again establish parameters. (continued on next page)

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	115270	A. Building B. Wing	10/13/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/2023, at 11:35 am, an observation and interview was conducted of R162. Licensed Practical Nurse (LPN) VV was observed to be exiting the room at that time. Upon entering the room, the bed was noted to be elevated to a working height. There was no positioning wedge to R162's left side, and the mattress did not have perimeter bolsters. R162 explained that the nurse had just finished changing the resident's wound dressing. During the interview, R162 was able to recall that she had fallen in the facility but was not able to recall the characteristics of either fall. R162 did state, I know I rolled onto the floor. When asked whether she recalled facility staff speaking with her about preventing future falls, R162 stated, I don't think so. Resident #162 described her mattress as uncomfortable, and added that she had requested an alternative one from staff on more than one occasion with no response. On 10/11/2023, at 11:47 am, an interview was conducted with LPN VV regarding R162's fall history and risks. LPN VV confirmed that they did not lower R162's back to a low position prior to leaving the room. During the interview with LPN VV, on 10/11/2023, at 11:47 am, LPN VV explained that they were familiar with R162 and were able to recall that the resident had fallen in the facility. LPN VV was not able to recall whether the resident had suffered any injuries from the falls. During the interview, LPN VV was asked to review R162's care plan for falls. LPN VV reviewed the medical record and confirmed that R162's care plan interventions included the placement of a positioning wedge to the resident's left side as well as perimeter bolsters to the resident's mattress. LPN VV further acknowledged that neither the positioning wedge nor the perimeter mattress bolsters were in place at the time of the interview. On 10/12/2023, at 10:33 am, a subsequent observation of R162's room was conducted. The bed was again found to be elevated to a working height. There was no positioning wedge in place and no perimeter bolsters were on the mattress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	10/13/2023

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36233 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs, to include adequate monitoring for three of seven residents (R11, R72 and R125) reviewed for unnecessary medications. Findings included: A review of the facility policy, Use of Psychotropic Medication, dated 6/1/2023, revealed: residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). The record also revealed: 12. The effects of psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: a. Upon physician evaluation (routine and as needed), b. During the pharmacist's monthly medication regiment review, c. During MDS review (quarterly, annually, significant change), and d. In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice. 1. A review of R11's face sheet dated 10/12/2023 revealed the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included spinal stenosis, Schizoaffecive disorder, major depressive disorder, and anxiety disorder. A review of R11's Annual Minimum Data Sheet (MDS) assessment dated [DATE], revealed the resident had a Brief Mental Interview Score (BIMS) of 14, which indicated the resident was cognitively intact and received antipsychotic and antidepressant medications for seven of seven days during the look back today. A review of R11's medical record revealed active orders for Aripiprazole Oral Tablet related to Schizoaffecive disorder; Citalopram Hydrobromide Oral Tablet related to Major depressive disorder; Mirtazapine Oral Tablet related to Major depressive disorder; and Trazodone HCl Oral Tablet for insomnia related to Major depressive disorder. Further review of the medical record revealed active orders for: Observation: Antidepressant Medication - Observe for behavior (specify resident's behavior). Observe for side effects: GI (Gastrointestinal) upset, insomnia, fatigue, dizziness, dry mouth, headache. Document 'Y' if resident is free of side effects. Document 'N' if the resident is NOT free from side effects. If 'N' document SE (Side effects) in the PNs (Progress Notes) every day and night shift .Psychotropic Med Use: Observe Resident closely for significant side effects: Sedation, Drowsiness, confusion, agitation, H/A, dry mouth, ataxia, dizziness, extra pyramidal reaction, muscle tremor, N/V, constipation, blurred vision, edema, postural hypotension, sweating, weight gain/excessive gain, loss of appetite, urinary retention, skin rash, photosensitivity every day and night shift If significant side effects noted, notify MD (Physician), with a start date of 2/28/2023, and no end date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R11's October 2023 Medication Administration Record (MAR), dated 10/12/2023, revealed the resident was administered the prescribed Trazadone, Mirtazapine, Aripiprazole and Citalopram Hydrobromide as ordered. The record revealed for the order to observe for the antidepressant medication usage for side effects and an unspecified behavior there were documented checkmarks instead of a yes (y) or no (n) as ordered. A review of R11's Progress Notes, from 9/12/2023, to 10/13/2023, did not reveal any progress notes indicating the resident exhibited any behaviors or side effects. A review of R11's Documentation Survey Report, dated 10/12/2023, revealed the Certified Nursing Assistant (CNA) documented if the resident did, or did not, have behavior symptoms on 10/4/2023 through 10/6/2023, 10/8/2023, 10/11/2023, and 10/12/2023. However, they were not documented on all three shifts. 2. A review of R72's face sheet dated 10/12/23 revealed the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included quadriplegia, spastic hemiplegia affecting unspecified side, and major depressive disorder. A review of R72's Quarterly MDS assessment dated [DATE], revealed the resident had a BIMS of 15, which indicated the resident was cognitively intact. The record also revealed the resident received antidepressant medication for three of seven days during the look back today. A review of R72's medical record revealed the following active orders: Sertraline HCl Oral Tablet 50 MG, related to Major depressive disorder and Duloxetine HCl Oral Capsule Delayed Release Particles 60 MG related to Major depressive disorder. The record did not reveal any orders to observe the resident for side effects and/or behaviors from antidepressant medication usage. A review of R72's October 2023 MAR dated 10/12/2023, revealed the resident was administered the prescribed Sertraline and Duloxetine as ordered. However, R72 refused the Sertraline on 10/8/2023 and 10/10/2023 through 10/12/2023. The record revealed no order of documentation of observations for the antidepressant medication usage for side effects and/or behaviors. A review of R72's Progress Notes, from 9/12/2023, to 10/13/2023, did not reveal any progress notes indicating the resident exhibited any behaviors or side effects. 3. A review of R125's face sheet, dated 10/12/2023, revealed the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included psychosis not due to a substance or known physiological condition, major depressive disorder, and acute on chronic diastolic (cognitive heart failure). A of R125's Annual MDS assessment, dated 7/25/2023, revealed the resident had a BIMS Score of 15, which indicated the resident was cognitively intact and revealed the resident received antidepressant medication for seven of seven days during the look back today. A review of R125's medical record revealed the following active orders: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Duloxetine HCl Oral Capsule Delayed Release Particles 20 MG (Duloxetine HCl) Give 1 capsule enterally one time a day related to major depressive disorder, with a start date of 7/20/23 and no end date. *Observation: Antidepressant Medication - Observe for behavior (specify resident's behavior). Observe for side effects: GI upset, insomnia, fatigue, dizziness, dry mouth, headache. Document 'Y' if resident is free of side effects. Document 'N' if the resident is NOT free from side effects. If 'N' document SE {side effects} in the PNs {Progress Notes}. every day and night shift, with start date of 8/22/23, and no end date. A review of R125's October 2023 MAR dated 10/12/2023, revealed the resident was administered the prescribed Duloxetine as ordered. The record revealed the order to observe for the antidepressant medication usage for side effects and an unspecified behavior; there were documented checkmarks instead of a yes (y) or no (n) as ordered. A review of R125's Progress Notes, from 9/12/2023, to 10/13/2023, did not reveal any progress notes indicating the resident exhibited any behaviors or side effects. A review of R125's Documentation Survey Report, dated 10/12/2023, revealed the CNA documented if the resident did, or did not, have behavior symptoms on 10/1/2023, 10/2/2023, and 10/6/2023 through 10/9/2023. However, they were not documented on all three shifts. During an interview on 10/12/2023 at 10:07 am, Licensed Practical Nurse (LPN) OO reported she worked with R11 and was one of the nurses that documented the checkmarks on the resident's MAR for observing for behaviors and/or side effects from antidepressant medication usage. She reported the checkmarks meant R11 wasn't having a behavior. LPN OO also reported if the resident was having a behavior such as crying, isolating herself, or was depressed, they would write a progress note. LPN OO also noted the order did indicate to document with a Y or N, and that she had not being doing that because the system was not set up to document as such. LPN OO also confirmed the order asked for two different observations, and that the MAR did not allow them to indicate if the resident was having a behavior or side effects or both. LPN OO reported she wasn't the normal nurse for R72 and #125. During an interview on 10/12/2023 at 10:42 am, with Unit Manager (UM) MM, they confirmed residents taking psychotropic medications were to be monitored to make sure the medication was effective for the behavior it was treating, and if there were any side effects from the medication. UM MM confirmed R11 was taking anti-psychotropic and antidepressant medications. UM MM also confirmed R11's order to observe behaviors and/or side effects from antidepressant medication usage was not documented as per the physician's order to document with a Y or N. UM MM reported that even though it was not documented as per the order, if the nurse identified the resident was having a behavior or side effect, then they would document it on a progress note. UM MM confirmed the order asked for two different observations, and that the MAR did not allow them to indicate if the resident was having a behavior or side effects or both, which was confusing to her. During an interview on 10/12/2023 at 10:52 am, UM MM confirmed R72 was receiving antidepressant medication. UM MM also confirmed the resident's order and that the MAR did not have documentation of the resident's behavior or side effects being monitored after the antidepressant medication usage; but she confirmed there should be documentation. (continued on next page)

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	115270	A. Building B. Wing	10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/12/2023 at 10:55 am, UM MM confirmed R125 was receiving antidepressant medication. UM MM confirmed R125's order to observe behaviors and/or side effects from antidepressant medication usage was not documented as per the physician's order for document with a Y or N. UM MM reported that even though it was not documented as per the order, if the nurse identified the resident was having a behavior or side effect, then they would document it on a progress note. UM MM confirmed the order asked for two different observations, and that the MAR did not allow them to indicate if the resident was having a behavior or side effects or both. UM MM reported they may need to adjust how the order was input into the electronic system so that they could document with Y or N. During an interview on 10/12/2023 at 12:01 pm, Regional Nurse GG confirmed R11, R72, and R125 were taking psychotropic medications. Regional Nurse GG confirmed R11 and R125 both had orders to observe them for behaviors and side effects from antidepressant medication usage that were not documented as per the order on the MAR. Regional Nurse GG confirmed R72 did not have an order that she could find to document on the MAR for observations of side effects and/or behaviors from antidepressant medication usage. Regional Nurse GG reported the residents, as per CNA documentation, were documented on behavioral symptoms per shift, and that was a source of documentation of the behaviors the residents may have exhibited during their usage of antidepressant medication. A review of R11's Documentation Survey Report dated 10/12/2023 revealed the CNA documented if the resident did, or did not, have behavior symptoms on 10/4/2023 through 10/6/2023, 10/8/2023, 10/11/2023, and 10/12/2023. However, they were not documented on all three shifts. A review of R72's Documentation Survey Report dated 10/12/2023 revealed the CNA documented if the resident did, or did not, have behavior symptoms on 10/6/2023 and 10/7/2023. However, the behaviors were not documented on one of three shifts. A review of R125's Documentation Survey Report dated 10/12/2023 revealed the CNA documented if the resident did, or did not, have behavior symptoms on 10/1/2023, 10/2/2023, and 10/6/2023 through 10/9/2023. However, they were not documented on all three shifts. During an interview on 10/12/2023 at 2:35 pm, Regional Nurse GG reported the facility's [NAME] President of Clinical Services reported they could not find an order for side effect and behavior monitoring for R72 but said that they didn't have to have an order to monitor, but that they were to document the side effects and behaviors.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on observation and staff interview, the facility failed to ensure medications were secured in locked compartments when not within direct line of sight of the staff observed during medication administration on two of three floors (Fourth Floor and Third Floor). Findings included: On 10/10/2023, at 10:33 am during facility tour, an observation outside the door of room [ROOM NUMBER] on the fourth floor revealed that the medication cart was left unlocked and unattended. Certified Medication Aide (CMA) LL was in resident's room [ROOM NUMBER] administering medication and did not have a visual view of the unlocked medication cart which was not secured by the locking mechanism. There were noted to be visitors, staff, and residents who passed in the vicinity of her medication cart. During an interview on 10/10/2023 at 10:35 am, with CMA LL, she was asked if she was aware that she had left the medication cart unlocked and unsecure. She stated, Yes I am, but I don't have keys to the medication cart, the nurse has the keys. On 10/11/2023 at 8:15 am, during the facility tour, an observation outside the door of room [ROOM NUMBER] on the third floor revealed that the medication cart was left unlocked and unattended. Also, keys to the medication cart were left unsecure on the top of the medication cart. Registered Nurse (RN) KK failed to lock the medication cart on 10/11/2023 at 8:15 am, when he left the cart and entered resident's room [ROOM NUMBER], leaving the cart unattended and unlocked with the keys unsecured on the top of the cart. He did not have a visual view of the unlocked medication cart which was not secured by the locking mechanism. There were noted to be visitors, staff, and residents who passed in the vicinity of his medication cart. During an interview on 10/11/2023 at 8:22 am with RN KK, he was asked if he was aware that he had left the medication cart unlocked and unsecure, and the keys to the medication cart on top of the cart. He stated, Yes, I am now, and I should have locked the medication cart and not left the keys to the medication cart on top of the cart before going into the residents room.

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	115270	A. Building B. Wing	10/13/2023

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32880 Based on observation, record review, and interview, the facility failed to date and label resident food items in the refrigerator, failed to keep the refrigerator clean, and failed to keep the microwave clean in between uses. This failure had the potential to affect all residents that resided on the third-floor unit, 65 residents out of 220 residents in the building. Findings included: A review of facility policy and procedure titled, Date Marking for Food Safety, dated 4/1/2023, states the following: Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety .Policy Explanation and Compliance Guidelines for Staffing: Refrigerated, ready-to eat, time/temperature control for safety food (i.e. perishable food) shall be held at a temperature of 41 [degrees] F [Fahrenheit] or less for a maximum of seven days. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening or preparing a food shall be responsible for the date marking the food at the time the food is opened or prepared. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded. The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as day one. (For example, food prepared on Tuesday shall be discarded on or by Friday). The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard adoringly. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly. Corrective action shall be taken as needed. Note: prepared foods that are delivered to the nursing units shall be discarded within two hours, if not consumed. These items shall not be refrigerated as the time/temperature controls cannot be verified. On 10/10/2023 at 11:00 am, an observation was conducted in the refrigerator that was in the resident's dining room on the third-floor unit. The following was identified: 1) A baked potato was inside a plastic container with no name and no date; 2) the refrigerator had red liquid stains on the shelves and the bottom of the refrigerator has food stains in multiple areas; 3) pineapple inside a plastic container did not have a name or date on the container; 4) a biscuit with a sausage patty inside the biscuit was wrapped up in a paper towel with no name and no date; 5) the microwave had food pieces of corn and liquid inside and was not clean; and 6) the refrigerator did not have temperatures taken from 10/6/2023 - 10/10/2023, per the temperature log taped to the front of the refrigerator. An interview was conducted with Resident Care Assistant (RCA) AA on 10/10/2023 at 12:10 pm. RCA AA stated the refrigerator in the resident's dining room was used to store residents' food items. RCA AA stated the above noted food items were not labeled and dated and should have a label and date when the food was first placed in the refrigerator. (continued on next page)

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	115270	A. Building B. Wing	10/13/2023

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Certified Nursing Assistant (CNA) BB, on 10/10/2023, at 12:11 pm, CNA BB stated the above noted food items were not labeled and dated and should have a date and label on them. CNA BB stated the above noted food items belonged to the residents on the third floor. CNA BB stated the nursing staff were responsible for ensuring that the temperature log was completed daily. An interview was conducted with Registered Nurse Manager (RNM) CC on 10/10/2023, at 12:14 pm. RNM CC stated all food items within the resident's refrigerator should be labeled and dated and the refrigerator should be kept clean and confirmed that the refrigerator was not clean. RNM CC stated the microwave and kitchen area should always be kept clean, as it is used for the residents who reside at the facility. RNM CC stated the overnight nursing shift was responsible for taking the temperatures for both the refrigerator and the freezer, and stated the nursing staff did not take temperatures from 10/6/2023 - 10/10/2023 per policy. An interview was conducted with the Director of Nursing (DON) on 10/10/2023, at 12:23 pm. The DON stated the food that was stored in the resident's refrigerator should be labeled and dated, and the fridge should also be kept clean. The DON noted food items were not labeled and dated per policy, and the refrigerator and microwave needed to be cleaned. On 10/10/2023, at 3:10 pm an interview was conducted with the Certified Dietary Manager (CDM) FF. CDM FF stated his expectations were to store food belonging to residents in a manner that was sanitary and maintained at the appropriate storage temperature.

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	115270	A. Building B. Wing	10/13/2023

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36233 Based on interviews and record reviews, the facility failed to maintain clinical records that are complete, accurate, readily accessible, and systematically organized for one of 33 sampled residents (R) (R125) reviewed for medical records accuracy. Findings included: A review of the Admission Packet revealed for Personal Belongings that: all personal items brought from home and/or hospital should be documented on [an] inventory sheet. Record review of the policy Resident Personal Belongings, dated 3/1/2022, revealed: Residents and families are encouraged to inventory belongings with the Resident Care Assistants on admission. As new items are brought into the facility during the resident's stay, residents and family are encouraged to notify the social worker or designee so that the items may be inventoried. The residents and families are encouraged to refrain from keeping cash and are encouraged to bring cash to the business office to be kept in the safe. A review of R125's face sheet dated 10/12/2023 revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. During an observation and interview with R125 on 10/9/2023 at 12:43 pm, revealed the resident lying in his bed with a Samsung cellphone, 3-prong cellphone stand, a personal fan, electronic back massager, and other items of value. R125 said he had items of value that he believed were taken during his hospital stay. He reported that he told the previous Administrator of the missing items. R125 could not remember if an inventory sheet had been completed for his items, but he had receipts for the items. Observation, on 10/10/2023, at 11:06 am, revealed R125 lying in his bed with the same items of value still in his possession as the day prior. A review of R125's medical record, paper and electronic, did not reveal a completed inventory sheet for the resident's items. In the paper record binder, there was a blank inventory sheet. A review of the Grievances from October 2022 to October 2023 did not reveal a grievance for R125 on missing items. During an interview on 10/11/2023 at 11:57 am, Unit Manager (UM) MM confirmed R125's inventory sheet was blank. During an interview on 10/11/2023 at 12:04 pm, the Health Information Coordinator confirmed there was no inventory in the medical records file cabinet. The Health Information Coordinator reported R125 was a resident before the facility recently went through a change of ownership, and with that process some of the resident records may have been kept by the previous owner. The Health Information Coordinator reported that because there was not a completed inventory sheet for R125, she would go and visit with the resident to complete one. (continued on next page)

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	115270	A. Building B. Wing	10/13/2023

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/2023 at 1:49 pm, the Health Information Coordinator reported she spoke with R125 and completed the inventory sheet. She reported R125 also told her he was missing items, and she told the Administrator, and she was told to complete a grievance form. She completed the grievance form and wrote the items that he was able to provide a receipt for on the inventory sheet.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 17500 Based on observations and interview, the facility failed to ensure staff administered medications in a manner to prevent the spread of infections for two of four residents (R) (R201 and R216) observed during medication administration. Findings included: During medication administration observation on 10/11/2023 at 8:25 am, Registered Nurse (RN) KK was observed preparing medications to be administered to R201. RN KK opened the drawer to the medication cart, took out medications in packaged unit dose envelopes, and began to punch each medication in a plastic medication cup. When RN KK popped three tablets of escitalopram (Lexapro) 5 mg from a bubble pack, the tablets dropped into his ungloved right hand and with his bare ungloved fingers. He then placed the tablets into the plastic medication cup and administered these medications to R201. During medication administration observation on 10/11/2023 at 8:36 am, RN KK was observed preparing medications to be administered to R216. RN KK opened the drawer to the medication cart, took out medications in a packaged bubble pack, and began to punch each medication in a plastic medication cup. Each tablet dropped into his ungloved right hand and with his bare ungloved fingers, he placed them into the plastic medication cup. He then administered the following medications to R216 after touching them with ungloved hands: Eliquis 5 mg (milligrams) twice a day, Folic acid 1 mg daily, Glipizide 5 mg daily, Metformin 1000 mg twice a day, and Jardiance 10 mg daily. During an interview with RN KK on 10/11/2023 at 9:10 am, RN KK confirmed the above observations and stated that he should have discarded the medication and replaced it.