STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115478	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Rehab & Skilled Nursing Center	8329 Stevens Lane Columbus, GA 31909

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on observations, staff interviews, record review, and review of the facility's policy titled, Self-Administered Medications, Treatments, the facility failed to ensure one of 27 sampled residents (R) (R438) was assessed to determine if the practice of self-administration of medications would be safe, that physician's orders were obtained, and that medications were safely secured. The deficient practice had the potential to result in medication errors and to allow access to medications otherwise not prescribed by a physician to other residents. Findings included: Review of the facility's policy titled, Self-Administered Medications, Treatments dated October 2020, revealed under the policy statement, Self-administered medications and treatments must be carefully monitored and recorded in the Medication Administration Record (MAR) and Treatment Administration Record (TAR). Self-administration of medications or treatments by residents is permitted by a physician order that includes dosage, route, and any special instructions. All medications and treatments will be kept with the resident or in a locked drawer in the resident's room. 1. The RN Manager assesses resident competency to self-administer mediations and documents the resident's wishes in the nursing note with consideration of the following: a. Ability to receive information from the surrounding environment. b. Capacity to remember information received. c. Ability to make a decision and give reason for it. d. Ability to use relevant information in making decisions. e. Ability to appropriately asses relevant information. 2. A decision to permit self-administration is made by the Interdisciplinary Team Members in convert with the resident. 3. Obtain an order from the physician. Record in MAR and nursing notes. 4. Explain the procedure to the resident. 10. Update Resident Care Plan as needed. Record review revealed R438 was admitted to the facility on [DATE] with diagnoses of but not limited to spondylosis with myelopathy cervical region, type two diabetes mellitus with diabetic chronic kidney disease, and dysthymic disorder. Record review revealed a Minimum Data Set (MDS) assessment was not completed due to resident was a new admit. Review of R438's active orders dated December 3, 2024, lacked orders for medications of any kind to be self-administered. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes and documents in the electronic record lacked documented evidence that R438 was evaluated for self-administration of medications. Review of R438's care plan with a start date of 11/26/2024 lacked documented evidence of interventions for self-administration of medications. Observation and interview on 12/4/2024 at 9:27 am revealed R438 sitting on the bedside doing a word search. A medication cup was on the bedside table filled with pills. R438 revealed they were her morning medications. Observation and interview on 12/4/2024 at 10:10 am with Licensed Practical Nurse (LPN) AA revealed that she watched R438 swallow her morning medications. LPN AA then observed and acknowledged the pills sitting in the disposable medication cup and said she left the pills with R438 because R438 asked for syrup, and LPN AA got distracted. LPN AA revealed it was not normal practice to leave medications at the bedside and the risk would be R438 missing her medication. Interview on 12/4/2024 at 10:17 am with the Director of Nursing (DON) revealed that LPN AA notified her that LPN AA had left medications at the bedside. The DON stated that she felt LPN AA was distracted and that she would have normally watched R438 take the medications or would have taken the medication with her. DON revealed it was her expectation that nurses watch the resident swallow the medications or if an issue arises, the nurse should take the medications and not leave them with the resident.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on resident and staff interviews, record review, review of the facility's Admission Packet, and review of the facility's policy titled, Advance Directive Policy, the facility failed to provide residents and/or their representatives written information with options regarding the right to accept or refuse medical or surgical treatment for three of 33 residents (R) (R437, R438, and R25). This failure denied the residents and/or representatives the opportunity to have choices and preferences with their health care decisions and formulating an Advance Directive. Findings included: Review of the facility's policy titled, Advance Directive Policy dated 1/1/2017, revealed under policy statement, Each resident with decision-making capacity has the right to make their own decisions related to his/her medical care. An integral component of self-determination is the right to make choices pertaining to one's health, including the right to refuse or alter treatment plans, to accept or refuse medical or surgical treatment, refuse to participate in experimental research and to formulate advance directives. Further review revealed under section titled Informing resident and/or representative of rights/options: 4. The Advance Directive Checklist form (Appendix B) will be completed and filed on the resident's Chart. This form documents that written information was provided. Review of the facility's Admission Packet revealed it did not contain language that pertained to the facility's provision of written information about the resident/representative's right to accept or refuse medical or surgical treatment. 1. Review of the medical record revealed R437 was admitted to the facility on [DATE] with diagnoses of but not limited to chronic respiratory failure whether with hypoxia or hypercapnia, chronic diastolic (congestive) heart failure, paroxysmal atrial fibrillation, dependence on supplemental oxygen. Review of the Admission Minimum Data Set (MDS) assessment revealed it was not completed due to the resident being newly admitted on [DATE]. Interview on 12/3/2024 at 11:16 am with R437 revealed that she had an advanced directive but didn't remember the facility discussing or providing her anything in writing regarding her right to either accept or deny consent for medical or surgical treatment. 2. Record review revealed R438 was admitted to the facility on [DATE] with diagnoses of but not limited to spondylosis with myelopathy cervical region, type two diabetes mellitus with diabetic chronic kidney disease, and dysthymic disorder. Review of the Admission MDS assessment revealed it was not completed due to the resident being newly admitted on [DATE]. Interview on 12/4/2024 at 9:27 am with R438 revealed she was not provided anything in writing regarding her right to either accept or refuse medical and surgical treatment. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R25 was admitted to the facility on [DATE] with diagnoses of but not limited to dementia with behavioral disturbance, mood (affective) disorder, major depressive disorder, recurrent severe with psychotic symptoms, and anxiety. Review of the Significant Change MDS assessment dated [DATE] assessed a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. Interview on 12/4/2024 at 1:57 pm with R25 revealed she was not given anything in writing about her right to either refuse or accept medical or surgical treatment. Interview on 12/4/2024 at 10:40 am with the Social Services Director (SSD) revealed she was responsible for providing information to residents about advanced directives. The SSD revealed that she had never heard of a consent for either the acceptance or denial for medical and surgical treatment.

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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** 49675 Based on observations, staff interviews, record review, and review of the facility's policy titled, Care Plans, the facility failed to follow the care plan for oxygen therapy for two of eight residents (R) (R437 and R28). Specifically, the facility failed to follow the care plan for R437 and R28 to ensure the oxygen flow rate was set based on the physician order. The deficient practice had the potential to place the residents at risk for medical complications and a diminished quality of life. Findings included: Review of the facility policy titled, Care Plan, dated 10/20/2020, revealed 10. The care plan team will include participation by CNA's (Certified Nursing Assistant)'s, Licensed Charge Nurses, Registered Nurse Supervisors (including the Director of Nursing), Social Services Worker, Activities Staff Member, and a Dietary Representative as deemed appropriate for the conference being held that day. These staff members will be invited to assure a comprehensive review of the resident's current status and needs. 1. Review of the medical record revealed R437 was admitted to the facility on [DATE] with diagnoses of but not limited to chronic respiratory failure, chronic diastolic (congestive) heart failure, paroxysmal atrial fibrillation, dependence on supplemental oxygen. Record review revealed the Admission Minimum Data Set (MDS) assessment was not completed due to the resident being newly admitted on [DATE]. Review of active orders included an order for oxygen dated 11/26/2024, Oxygen at 2/LPM (liters per minute) via (by) nasal cannula (NC) to keep O2 sat (saturation) greater than 90% (percent) as needed. Review of the care plan initiated on 11/26/2024, revealed, [R437] has diagnosis of chronic respiratory failure. Oxygen setting O2 via NC as ordered by provider and as indicated. Observation on 12/3/2024 at 9:43 am revealed R437 with oxygen being administered at a rate of 3/LPM via N/C. Observations on 12/4/2024 at 10:05 am and 1:45 pm revealed R437 with oxygen being administered at a rate of 2.5/LPM via N/C. Interview and observation on 12/4/2024 at 2:17 pm with the Director of Nursing (DON) confirmed photos of oxygen captured during observations not set at prescribed rate. The DON revealed that when nurses came on duty, they should check residents on oxygen and check the rate to ensure it was set at rate the physician ordered. 50877 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the electronic record revealed R28 was admitted with diagnoses and a history of chronic respiratory failure and congestive heart failure. Review of the Admission Minimum Data Set (MDS) assessment dated on 11/26/2024 assessed a Brief Interview for Mental Status (BIMS) score of 15 indicating little to no cognitive impairment. Record review of R28's electronic records revealed there were no Physician orders for oxygen to be administered. Observation on 12/3/2024 at 9:47 am revealed R28 with oxygen being administered at a rate of 2/LPM via N/C. Interview on 12/5/2024 at 9:48 am with the MDS Coordinator revealed that she was contracted to complete care plans for the facility. She revealed that each department was responsible for completing their section. She revealed that she was responsible for the nursing section and was working on making the care plans more individualized. She revealed that a resident's care plan would not include specific oxygen rates (LPM), rather it would be generic stating oxygen as ordered because she doesn't have time to update the care plan every time the order was changed. She revealed all nurses were responsible for looking at the care plan and assuring all interventions were implemented. Interview on 12/5/2024 at 11:35 am the DON confirmed that orders, care plan, and MDS did not sync for the care of R28. She also confirmed that the care plan was not specific to R28.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50877 Based on observations, staff interviews, record review, and review of the facility's policy titled, Oxygen Therapy Guidelines, the facility failed to ensure oxygen (O2) was administered according to the physician order for two of eight residents (R) (R28 and R437) receiving oxygen. The deficit practice had the potential to place R28 and R437 at risk for medical complications and a diminished quality of life. Findings included: Review of the facility's policy Oxygen Therapy Guidelines with review/revision date of 6/21/2023, under Clinical Responsibilities revealed, Changes in O2 therapy may be adjusted by RRT (Registered Respiratory Therapist) or nurse, while maintaining SPO2 >88 (oxygen saturation above 88 percent) (oxygen saturation is a measurement of how much oxygen your blood is carrying as a percentage) or as ordered by physician . Pulse oximetry will be checked every shift. MAR (Medication Administration Record) documentation must include whether or not oxygen is in use (on/off), liter flow, delivery device, (i.e. 2 liters nasal cannula), and the patient's SpO2 reading. 1. Review of the electronic record revealed R28 was admitted on [DATE] with diagnoses of but not limited to chronic respiratory failure and congestive heart failure. Review of R28's active orders revealed there were no physician order documented for oxygen (O2) to be administered. Review of the Admission Minimum Data Set (MDS) assessment dated on 11/26/2024 for R28 assessed a Brief Interview for Mental Status (BIMS) score of 15 indicating little to no cognitive impairment. Observation on 12/3/2024 at 9:47 am revealed R28 with oxygen being administered at 2 LPM (liters per minute) via (by) nasal cannula (N/C). Interview on 12/5/2024 at 11:35 am the Director of Nursing (DON) revealed that all standing orders for oxygen was 2/LPM. If it was continuous, it required a provider order and check vital signs every shift. The DON confirmed there were no specified orders for oxygen. 49675 2. Review of the medical record revealed R437 was admitted to the facility on [DATE] with diagnoses of but not limited to chronic respiratory failure, chronic diastolic (congestive) heart failure, paroxysmal atrial fibrillation, and dependence on supplemental oxygen. Record review revealed there was not a completed MDS assessment due to the resident being newly admitted . Review of the active orders included an order for oxygen dated 11/26/2024, oxygen at 2 LPM via NC to keep O2 sat (saturation) greater than 90% as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan initiated on 11/26/2024, revealed, [R437] has diagnosis of chronic respiratory failure. Oxygen setting O2 via NC as ordered by provider and as indicated. Observation on 12/3/2024 at 9:43 am revealed R437 with oxygen running at a rate of 3/LPM via N/C. Observations on 12/4/2024 at 10:05 am and 1:45 pm revealed R437 with oxygen running at a rate of 2. 5/LPM via N/C. Interview on 12/4/2024 at 2:17 pm with the DON, she observed photos of R437's oxygen being administered at flow rates of 2.5 and 3/LPM, and confirmed the flow rates were incorrect. The DON revealed that when nurses come on duty, they should check residents on oxygen and check the rate to ensure it was set at the rate the physician ordered. The DON confirmed the oxygen order was not increased. The DON revealed she was unsure why the rate would be set on the incorrect rate. Interview on 12/4/2024 at 2:38 pm with Licensed Practical Nurse (LPN) AA revealed she had not called the doctor or anyone else regarding R437's oxygen. Interview on 12/4/2024 at 2:46 pm with the DON revealed that she spoke with LPN AA and she had contacted the physician this morning about R437's oxygen and he advised to increase it. The DON revealed that LPN AA had not had time to document. Interview on 12/5/2024 at 12:10 pm with the Respiratory Therapist revealed he expected all oxygen orders, PRN (as needed) and continuous, to be followed to ensure oxygen saturation levels were within defined limits. Providers/nurses input orders to be followed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on staff interviews, record review, and review of the facility's policy titled, Use of Psychotropic Medication, the facility failed to ensure that psychotropic medications were not ordered as needed (PRN) beyond 14 days, and/or failed to indicate a stop date for the extension for psychotropic medication for one of 27 sampled residents (R) (R25). Findings included: Review of the policy titled Psychotropic Medications with a reviewed/revised date of October 2017 under Procedural Guideline revealed, D. PRN (as needed) orders for psychotropic drugs are limited to 14 days. 1. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the patient's medical record and indicate the duration for the PRN order. Review of the clinical record revealed R25 was admitted to the facility with diagnoses of but not limited to dementia with behavioral disturbance mood (affective) disorder, major depressive disorder, recurrent, severe with psychotic symptoms, and anxiety. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE] assessed a Brief Interview for Mental Status (BIMS) score of 11 indicating moderately impaired cognition. Section N (medications) reported the resident was receiving antipsychotics, antidepressants, and antianxiety medications. Review of the electronic medical record (EMR) revealed physician's orders for R25 included but was not limited to lorazepam oral tablet, a medication used to relieve anxiety. The dosage ordered was 0.5 milligram (mg) give one tablet by mouth every two hours as needed for anxiety; agitation or restlessness. The last ordered date was 10/10/2024, and end date was indefinite. Interview on 12/4/2024 at 3:52 pm with Licensed Practical Nurse (LPN) AA revealed since R25 was on hospice she did not require a stop date for the antianxiety medication. Interview on 12/4/2024 at 3:53 pm with the Director of Nursing (DON) revealed that all residents whether they are on hospice or not, required a stop or end date for PRN psychotropic medications including antianxiety medications. The DON confirmed there was no stop or end date for the lorazepam order. Interview on 12/4/2024 at 3:55 pm with Registered Nurse (RN) BB revealed that hospice entered orders, but the facility went in and approved the hospice orders. She revealed that the order for the antianxiety medication should have had an end or stop date and confirmed R25 did not have a stop or end date for the prescribed lorazepam.