STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115697	A. Building B. Wing	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountainview Ctr for Alzheimer	2631 North Druid Hills Road N E Atlanta, GA 30329

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on record review, staff interview, review of Medicare Advanced Beneficiary Notice (ABN) instructions, and policy review, the facility failed to ensure each resident receiving skilled services under Medicare Part A whose services were being terminated received the appropriate form, Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) Medicare Form 10055, indicating termination date and appeal options for two of three residents (R) R86 and R20, reviewed for Beneficiary Notices. Findings include: Review of the facility's policy titled, Advance Beneficiary Notices, dated 2/1/2018, revealed it is the policy of the [name] center to provide timely notices regarding Medicare eligibility and coverage. Policy Explanation and Compliance Guidelines: Number 4. The facility shall inform Medicare beneficiaries of his or her potential liability for payment. A liability notice shall be issued to Medicare beneficiaries upon admission or during a resident's stay, before the facility provides: Number 5. The current CMS (Centers for Medicare and Medicaid Services) - approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form. a. For Part A items and services. the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). Form CMS-10055. b. For Part B items and services, the facility shall use the Advance Beneficiary Notice of Noncoverage (ABN) Form CMSR-131. c. A Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending. no matter resident is leaving the facility or remaining in the facility. This informs the resident on how to request an appeal or expedited determination from their Quality Improvement Organization (QIO). i. This notice is used when all covered services end for coverage reasons. ii. An exhaustion of benefits is not considered a termination for coverage reasons . (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. To ensure that the resident, or representative. has enough time to make a decision whether or not to receive the services in question and assume financial responsibility. the notice shall be provided at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. Review of the Form Instructions: Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566 documented Medicare inpatient hospitals and skilled nursing facilities (SNFs) use other approved notices for Part A items and services when notice is required in order to shift potential financial liability to the beneficiary. However, these facilities must use the ABN for Part B items and services. 1. Review of the undated Admission Record located in the electronic medical record (EMR) under the profile tab for R86 revealed admission to the facility on [DATE]. R86 had Medicare Part A benefits and was discontinued from skilled therapy services on 11/6/2023 per the information provided by the facility. R86 had not exhausted his Medicare benefit days. Review of the SNF Beneficiary Protection Notification Review, the facility documented the form CMS-10055 was issued. The facility failed to issue the correct form regarding the ending of Medicare payment coverage for Part A services. The facility issued form CMS-R-131 which was to be use for Part B services. The resident remained in the facility. Further review of the EMR revealed no documentation that form CMS-10055 was issued to R86 and/or R86's representative. 2. Review of the undated Admission Record located in the EMR under the profile tab for R20 revealed admission to the facility on [DATE]. R20 had Medicare Part A benefits and when she was discontinued from skilled therapy services on 8/30/2023 per the document provided by the facility, R20 had not exhausted her Medicare benefit days. Review of the SNF Beneficiary Protection Notification Review, the facility documented the form CMS-10055 was issued. They failed to issue the correct form regarding the ending of Medicare payment coverage for Part A services. The facility issued form CMS-R-131 which is to be used for Part B services. The resident remained in the facility. Further review of the EMR revealed no documentation of the form CMS-10055 being issued to R20 and/or R20's representative. During an interview on 1/16/2024 at 1:35 pm, the Social Services Director (SSD) stated, I used the form CMS-R-131 to notify them of the end of their benefits. I should have used form CMS 10055. I've been using the wrong form.

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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 - 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** 06401 Based on observations, interviews, record review, and review of the policy titled Comprehensive Care Plans, the facility failed to implement the comprehensive person-centered plan of care for one two residents (R) (R53) reviewed for restorative rehabilitation services. The facility's failure to apply a hand splint to R53's contracted left hand as directed in the resident's plan of care placed the resident at risk of development of worsening contractures. Findings include: Review of the policy titled Comprehensive Care Plans, dated 9/1/2023, documented the policy of [name of facility] is to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental, and psychological needs that are identified in the resident's comprehensive assessment. Review of the clinical record revealed R53 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, and contracture of muscle of left hand. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R53 had functional limitation in range of motion impairment on one side of his upper extremities. Review of the Clinical Physician Orders dated January 2024, revealed the following physician order: Wear comfort splint on left hand for four hours and off for for{sic} hours every day. This physician's order had a start date of 10/7/2023 and a revised date of 10/9/2023. Review of the care plan reviewed on 12/14/2023 revealed resident may have resting hand splint to left hand up to four hours daily as tolerated. Skin and circulation checks while in use. The care plan indicated the staff responsible for implementing the resident's left-hand splint included, Licensed Practical Nurse (LPN), Registered Nurse (RN), Certified Nursing Assistant (CNA), and Restorative Nursing Assistant (RNA). Interview on 1/18/2024 at 9:07 am, LPN 2, who cared for R53, stated she had not seen R53's left hand splint for a while and did not know where the resident's left-hand splint could be located. Interview on 1/18/2024 at 3:00 pm, the MDS Coordinator (MDSC) stated the physician's order for R53's left hand splint was originally written on 10/7/2023. The MDSC explained on 10/9/2023 the intervention for the daily use of the left-hand splint was placed on R53's plan of care and had remained as an on-going intervention on his care plan. The MDSC verified the resident's care plan listed the CNA, RNA, LPN, and RN staff as being responsible for applying the resident's left-hand splint each day. Cross Refer F688

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F 0686 Level of Harm - 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** 15189 28604 Based on observations, interviews, record review, and review of the policy titled Pressure Injury Prevention and Management, the facility failed to implement pressure injury interventions to prevent the development of unstageable pressure ulcers for two of five sampled residents (R) (R37 and R98) reviewed for pressure ulcers; failed to conduct weekly skin assessments of R98's left hip DTI (deep tissue injury) and document treatments to R98's left hip for 10 days. Harm was identified to occur on 9/6/2023 for R37 when an unstageable DTI developed on the right heel, and then increased to a Stage 3 pressure ulcer. In addition, harm was identified to occur on 1/1/2024 when the facility failed to transcribe wound care orders for R98, resulting in the development of a DTI to the left hip, which after debridement developed into a Stage 4 pressure ulcer. Findings include: Review of the policy titled Pressure Injury Prevention and Management, dated 4/4/2022, revealed the policy indicates the facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. Policy Explanation and Compliance Guidelines: Number 3. Assessment of Pressure Injury Risk. c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record . Number 4. Interventions for Prevention and to Promote Healing a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, and wound characteristics). c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing. Support surfaces; iv. Maintain or improve nutrition and hydration status, where feasible. d. Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present . 5. Monitoring a. The RN Unit Manager, or designee will review all relevant documentation regarding skin assessments. pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record 1. Review of R37's undated Admission Record revealed R37 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, senile degeneration of the brain, congestive heart failure (CHF), and contracture of left and right ankle. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R37's annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated she was severely cognitively impaired. The MDS indicated R37 required supervision or touching assistance with rolling from left to right, and partial/moderate assistance with sit to lying, lying to sitting on side of the bed, and sit to stand as well as used a wheelchair. The MDS revealed she did not have any pressure ulcers, was at risk for developing pressure ulcers, had a pressure reducing device for the bed and the chair, and was on a turning and repositioning program. Review of R37's Braden Observation, dated 7/10/2023 revealed a score of 15 which indicated at risk for pressure ulcers. Review of R37's care plan dated 7/24/2023 indicated that the resident is at risk for skin breakdown related to impaired mobility, incontinence, and fragile skin with interventions to provide assistance to turn and reposition at regular intervals, check for incontinence at regular intervals, and pressure relieving-mattress to bed. However, there were no interventions developed to address relieving pressure to the heels when in the wheelchair and to float heels when in the bed. Review of R37's significant change MDS dated [DATE], revealed a BIMS score of one out of 15 which indicated she was severely cognitively impaired. The MDS indicated R37 was dependent on staff for rolling in bed, sit to lying, lying to sitting on the side of the bed and used a Broda chair. The MDS also indicated she did not have any pressure ulcers, was at risk for developing pressure ulcers, had a pressure reducing device for the bed and the chair, and was on a turning and repositioning program. Review of R37's Medication Administration Record (MAR) dated August 2023 revealed there was no documented evidence that R37 was turned and repositioned, and a pressure relieving mattress was on the bed. Review of R37's Physician's Orders, dated 9/6/2023 revealed an order for Heel protectors when in bed as tolerated. Review of R37's Rapid Skin Inspection, dated 9/6/2023 revealed skin was not intact. New skin issue. There was no documented evidence in the resident's EMR Progress Notes or MAR that R37's heels were offloaded while in the chair and in the bed. Review of R37's care plan dated 9/7/2023 revealed R37 is at risk for skin breakdown related to impaired mobility, incontinence, and fragile skin and has a DTI to her right heel. Interventions to care include pressure-relieving mattress to bed, float heels as tolerated .provide assistance to turn and reposition at regular intervals, pressure-relieving mattress to bed, encourage/assist to weight shift while sitting up in chair, float heels as tolerated, and heel boots as tolerated. Review of R37's Physician's Order dated 9/7/2023 revealed an order to cleanse right heel with wound cleanser. Pat dry. Wipe right heel with skin prep and leave open to air twice daily every day and evening shift for wound to right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R37's Wound Weekly Observation Tool, dated 9/27/2023 revealed A. Communication 3. Special Equipment/Preventative measures: Blank B. Observations/Data 1. Location: Right Heel 2b. Date acquired: 8/6/2023. [sic] (date acquired was 9/6/2023) 3a. Type: Pressure 4. Pressure Ulcer Stage: SDTI [suspected deep tissue injury]. 5. Visible Tissue: 5a. Overall impression: b. improving. 5e. Necrotic tissue present. Wound Measurements: 8a. Length (cm) [centimeters] 3 8b. Width (cm) 3.5 C. Treatment 2. Current treatment plan: continue with skin prep daily. Review of R37's Wound Weekly Observation Tool, dated 10/4/2023 revealed A. Communication 3. Special Equipment/Preventative measures: Air loss mattress, heels up cushion, multipodus boots B. Observations/Data 1. Location: Right Heel 2b. Date acquired: 9/8/2023. [sic] (date acquired was 9/6/2023) 3a. Type: Pressure 4. Pressure Ulcer Stage: SDTI. 5. Visible Tissue: 5a. Overall impression: b. improving. 5e. Necrotic tissue present. Wound Measurements: 8a. Length (cm), 2.6 8b. Width (cm) 2.4 C. Treatment 2. Current treatment plan: Skin-prep. Review of R37's Initial Wound Evaluation & Management Summary dated 11/6/2023 revealed Focused Wound Exam (Site 1) Stage 3 Pressure Wound on the right heel full thickness Etiology (quality) Pressure MDS 3.0 Stage 3 Wound Size (L x W x D): 0.5 x 0.6 x 0.2 cm Surface Area: 0.30 cm Exudate: Light Serous Thick adherent devitalized necrotic tissue: 60% Granulation tissue: 40%. Plan of care reviewed and addressed. Recommendations - float heels in bed; off-load wound; reposition per facility protocol. Review of R37's Physician's Order dated 11/7/2023 revealed an order for Medihoney [is wound and burn gel made from 100% Leptospermum (Manuka) honey. Manuka honey is unique in that it has antibacterial and bacterial resistant properties, meaning it prevents bacteria from building a tolerance to its beneficial effects] wound and burn dressing apply to right heel topically every day shift for wound cleanse right heel with wound cleanser. Pat dry. Apply Medihoney and dry dressing daily. Review of R37's Initial Wound Evaluation & Management Summary, dated 11/13/2023 revealed Focused Wound Exam (Site 1) Stage 3 Pressure Wound on the right heel full thickness Etiology (quality) Pressure MDS 3.0 Stage 3 Wound Size (L x W x D): 0.3 x 0.5 x 0.2 cm Surface Area: 0.15 cm Exudate: Light Serous Thick adherent devitalized necrotic tissue: 30% Granulation tissue: 70%. Wound progress: Improved evidenced by decreased surface area. Plan of care reviewed and addressed. Recommendations - float heels in bed; off-load wound; reposition per facility protocol. Review of R37's Initial Wound Evaluation & Management Summary, dated 11/20/2023, revealed Focused Wound Exam (Site 1) Stage 3 Pressure Wound on the right heel full thickness Etiology (quality) Pressure MDS 3.0 Stage 3 Wound Size (L x W x D): 0.2 x 0.3 x 0.2 cm Surface Area: 0.06 cm Exudate: Light Serous Granulation tissue: 100%. Wound progress: Improved evidenced by decreased surface area. Plan of care reviewed and addressed Recommendations - Float heels in bed; off-load wound; reposition per facility protocol. Review of R37's Initial Wound Evaluation & Management Summary, dated 11/27/2023 revealed Focused Wound Exam (Site 1) Stage 3 Pressure Wound on the right heel full thickness Etiology (quality) Pressure MDS 3.0 Stage 3 Wound progress: Resolved. Review of R37's Braden Observation, dated 12/2/2023 revealed a score of 12 which indicated high risk for pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 1/15/2024 at 10:15 am, 4:29 pm, and 1/16/2024 at 3:30 pm revealed R37 was lying in bed in a supine position (lying horizontally with the face and torso facing up) with heel protectors on, and a pillow under her lower legs and ankles which floated the heels. Observation on 1/17/2024 9:34 am and 1/17/2024 at 9:52 am, revealed R37 was seated in a [name of chair] (specialized chair providing pressure redistribution and air flow for increased sitting comfort and support) with socks on and a pillow under her lower legs and ankles which floated the heels. During an interview on 1/17/2024 at 9:55 am, the Director of Nursing (DON) stated R37 was moved to the [NAME] Unit in August 2023 due to the progression of her dementia and was in a wheelchair prior to moving to this unit. The DON stated R37 began using a [name of chair] in August 2023, so her legs could be elevated in the chair. The DON acknowledged R37 developed a pressure ulcer because her health condition deteriorated, and she had contractures to her feet, so her heels were digging into the mattress when she was in bed. During an interview on 1/18/2024 at 2:45 pm, Certified Nursing Assistant (CNA) 4 stated R37 was in a wheelchair, was more mobile, and required less assistance with ADLs prior to moving to this unit. CNA 4 confirmed she turned R37 from side to side in bed but did not place a pillow under her lower legs to keep them off the lower part of the [name of chair], did not apply heel protectors, and did not place a pillow under her legs and ankles in the bed prior to the development of the DTI to the right heel. During an interview on 1/18/2024 at 3:24 pm, the Medical Director stated R37 had an overall health decline, was not ambulatory, and was placed on hospice in August 2023. The Medical Director stated R37 was high risk for skin breakdown due to her decline, heel protectors were not added until after the pressure ulcer developed, and the wound was due to pressure on her heel. During an interview on 1/18/2024 at 3:33 pm, Licensed Practical Nurse (LPN) 1 stated R37's health declined in August 2023, and she was in bed more and placed in a specialized chair. LPN 1 verified when R37 developed a pressure ulcer to her right heel, heel protectors were applied when in bed, pillow was placed under her legs when in bed and in the specialized chair, and a pressure relieving device was applied to the bed; however, these interventions were not in place prior to the development of the wound in September 2023. 2. Review of R98's Admission Record revealed the resident was admitted to the facility on [DATE] and readmitted to the facility on [DATE] after an acute hospital stay with diagnoses that included dementia, chronic kidney disease (stage three), hypernatremia, and heart failure. Review of R98's care plan dated 9/28/2023 indicated resident was at risk for skin breakdown related to impaired mobility, incontinence, and fragile skin with interventions to assist with turning and repositioning at regular intervals, pressure relieving mattress to bed, pressure relieving cushion to chair, and observation of skin during routine daily care for redness, rashes or open areas. Review of the Progress Note dated 1/1/2024 documented the following written by LPN 1: Noted DTI Lt. [left] Hip, surrounding skin intact . skin - prep BID [two times per day] daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 1/17/2024 at 11:04 am, LPN 1 revealed that the physician gave a verbal order for treatment to R98's left hip DTI with 'Skin Prep' two times per day. However, she confirmed that she failed to transcribe the physician's verbal order for treatment to R98's left hip pressure ulcer to the Treatment Administration Record (TAR). Review of the January 2024 TAR revealed that the treatment ordered on 1/1/2024 to apply 'Skin Prep' two times a day to R98's left hip pressure ulcer was not transcribed to the TAR, and there was no documentation on the TAR that the treatment was administered to the resident's left hip pressure ulcer as ordered 1/1/2024 through 1/9/2024. Review of the Rapid Skin Inspection dated 1/2/2024 revealed skin not intact, existing skin issue. Review of the Physician's Progress Notes dated 1/2/2024 revealed that the Medical Director, who was R98's attending physician, documented the following, Wound/DTI, Lt. hip, Air mattress, add Prostat & [name of wound consultant company] . Review of the paper chart revealed that the Medical Director wrote the following Physician Orders dated 1/2/2024, . Prostat 30 cc [cubic centimeters] po [by mouth] bid, Vit [vitamin] C 500 mg [milligrams] po bid, [Name of wound consultant company] consult, Air mattress . Review of the Rapid Skin Inspection dated 1/9/2024 revealed skin not intact, existing skin issue. Review of the January 2024 TAR revealed that on 1/10/2024 a treatment was ordered to cleanse R98's left hip wound with wound cleanser, pat dry, apply Medi Honey directly on wound only, cover with non-stick dressing and border dressing every day until healed. Review of R98's EMR revealed that there was no documentation a Skin & Wound Evaluation of the resident's left hip pressure ulcer after 1/2/2024 through 1/15/2024. Review of the Wound consult dated 1/15/2024 revealed that R98's left hip pressure ulcer was assessed with 100% thick adherent black necrotic tissue (eschar). The wound was debrided and assessed as a stage IV pressure ulcer. Observation on 1/17/2024 at 11:54 am during a dressing change for R98, the pressure ulcer on the left hip wound bed contained slough and necrotic tissue. Interview on 1/17/2024 at 10:59 am, the Director of Nursing (DON) confirmed that LPN 1 failed to transcribe the physician's verbal order on 1/1/2024 to the EMR physician orders and to the TAR for treatment to R98's left hip pressure ulcer. The DON confirmed that there was no documentation that a treatment was administered to the resident's left hip pressure ulcer as ordered from 1/1/2024 through 1/9/2024. The DON further confirmed that there was not a Skin and Wound Evaluation of the resident's left hip wound after 1/2/2024 through 1/15/2024. The DON confirmed that there was a delay of assessment by the Wound consult. The DON stated the Wound consult was in the facility on 1/8/2024; however, was not asked to assess R98's left hip pressure ulcer. The DON stated that it was his expectation that nurses complete the Rapid Skin Assessment weekly, and if a resident's skin is not intact, the nurse is expected to complete a Skin and Wound Evaluation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 1/17/2024 at 11:04 am, LPN 1 stated when R98's left hip pressure ulcer opened on 1/10/2024, the physician gave an order for a new treatment to the resident's wound, however a Skin and Wound Evaluation was not completed for the resident's left hip pressure ulcer on 1/10/2024. Interview on 1/17/2024 at 11:50 am, Hospice Registered Nurse (RN) 1 revealed that she assessed R98 on 1/3/2024. She recalled that the resident's left hip pressure ulcer was open to air and was about half the size it is now. She stated the left hip pressure ulcer on 1/3/2024 was more of a skin tear that had scabbed over. Interview on 1/18/2024 at 2:25 pm, Medical Director/attending physician for R98 revealed that the resident was totally dependent on care and was bed bound. The Medical Director stated that when he assessed the resident's left hip pressure ulcer on 1/2/2024, it was a dark, reddened area. The Medical Director stated that the resident was in an end stage condition and was not eating or drinking well due to dysphagia. The resident's responsible party consented to hospice services, at which time an order was given for a hospice consult and hospice services starting on 1/2/2024.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on observations, interviews, record review, and review of the policy titled Range of Motion, the facility failed to apply a left-hand splint to prevent further contractures, as ordered for one of two residents (R) (R53) reviewed for limited range of motion and contractures. This failure had the potential to cause R53's contractures to worsen. Findings include: Review of the facility's policy titled Range of Motion, dated 9/15/2004, indicated Purpose: [name of facility] is committed to ensuring that each resident reaches and maintains his or her highest level of range of motion and to preventing avoidable decline in range of motion (ROM). Implementation of this program is to maintain joint mobility and muscle strength, minimize contractures, increase strength and activity tolerance, reduce pain and minimize complications of mobility. Adequate preventive care may include and the application of splints and braces when appropriate. Review of the clinical record revealed R53 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, affecting left dominant side, and contracture of muscle of left hand. Review of Occupational Therapy (OT) Discharge Summary dated 10/23/2023, provided by the Therapy Director (TD), indicated Restorative Programs . Splint and Brace Program Established/Trained Application of L (Left) wrist/hand splint for four (4) hours on and (4) hours off. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of six out of 15, which indicated severely impaired cognition, had functional limitation in range of motion - impairment on one side of his upper extremities, and required substantial/maximal assistance with upper body dressing. Review of the care plan reviewed on 12/14/2023 revealed resident may have resting hand splint to left hand up to four hours daily as tolerated. Skin and circulation checks while in use. The care plan indicated the staff responsible for implementing the resident's left-hand splint included, Licensed Practical Nurse (LPN), Registered Nurse (RN), Certified Nursing Assistant (CNA), and Restorative Nursing Assistant (RNA). Review of the Clinical Physician Orders dated 1/2024, revealed the order: Wear comfort splint on left hand for four hours and off for for{sic} hours every day. This physician's order had a start date of 10/7/2023 and a revised date of 10/9/2023. Observation on 1/17/2024 at 9:22 am, CNA 2 rolled R53 in his wheelchair from his room into the hallway. Observation of R53's left hand revealed it was contracted with all fingers tightly fisted together. No splint or other device was observed in R53's contracted left hand. Additional observations on 1/17/2024 at 9:50 am, 10:35 am, 11:50 am, 1:28 pm, 2:20 pm, and 3:32 pm, revealed R53 did not have a splint or other device in his contracted left hand. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115697	A. Building B. Wing	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountainview Ctr for Alzheimer	2631 North Druid Hills Road N E Atlanta, GA 30329

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/18/2024 at 9:04 am, CNA 2 stated she regularly cared for R53 and that she did not recall when she last applied R53's hand splint and stated she did not know where the resident's left-hand splint could be located. Interview on 1/18/2024 at 9:07 am, LPN 2 stated she had not seen R53's left hand splint for a while and did not know where the resident's left-hand splint could be located. Interview on 1/18/2024 at 10:35 am, the Therapy Director (TD) stated the CNAs were responsible for applying R53's left hand splint daily, since there was no Restorative Aides (RAs) on the hall R53 resides on. Interview on 1/18/2024 at 10:55 am, LPN 2 stated she located R53's left hand splint. She stated she found the left-hand splint in his room on a shelf behind some of the resident's personal items. Interview on 1/18/2024 at 3:00 pm, the MDS Coordinator (MDSC) stated the physician's order for R53's left hand splint was originally written on 10/7/2023. The MDSC explained on 10/9/2023 the intervention for the daily use of the left-hand splint was placed on R53's plan of care and had remained as an intervention on the care plan from 10/9/2023 to 1/18/2024. The MDSC verified the resident's care plan listed the CNA, RNA, LPN, and RN staff as being responsible for applying the resident's left-hand splint each day.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06401 Based on observations, interviews, manufacturer instruction review, and review of facility policies, the facility failed to discard containers of buttermilk with expired manufacturer's expiration dates, failed to date nutritional supplements when removed from freezer storage and when opened, and failed to clean drawers that contained food products. These failures had the potential to affect all 114 residents who resided in the facility. Findings included: Review of the policy titled, Storage, dated [DATE], indicated Refrigerated Storage 1. Store perishable food in refrigerator and/or foods marked 'Keep Refrigerated' by the manufacturer . 3. Use FIFO [first in first out] when stocking and rotating shelves. Review of the policy titled, Routine Cleaning Programming Rooms, dated [DATE], indicated the policy of (the facility) is to ensure the provision of routine cleaning in order to provide a safe environment in all Programming Rooms . 3. Routine surface cleaning will be conducted with detailed focus on visibly soiled surface and high touch areas to include, but not limited to: . g. Drawers as needed. 1. During the initial kitchen inspection, an observation on [DATE] at 8:35 am revealed two half gallon containers of buttermilk (one opened and one unopened) with expired manufacturer's expiration dates of [DATE], in the facility's walk-in refrigerator. Interview on [DATE] at 8:35 am, [NAME] (C) 1 confirmed the two half gallon containers of buttermilk had an expired manufacturer's expiration date of [DATE]. 2. During the initial kitchen inspection, an observation on [DATE] at 8:35 am revealed three thawed and undated four-ounce cartons of nutritional supplements stored in the kitchen's walk-in refrigerator. During a second observation on [DATE] at 9:40 am, the three thawed and undated four-ounce cartons of nutritional supplements remained stored in the kitchen's walk-in refrigerator. Interview on [DATE] at 9:40 am, the Dietary Manager (DM) confirmed the three thawed four-ounce cartons of nutritional supplements stored in the walk-in refrigerator were not dated. The DM stated staff should date the cartons of nutritional supplements when they are removed from the freezer and placed in the refrigerator to thaw. The DM stated she was unable to determine when the three thawed cartons of nutritional supplements should be discarded because they were not dated. Interview on [DATE] at 1:25 pm and review of the manufacturer's information, provided by the (DM), it was confirmed that the nutritional supplements had a 14-day shelf life when thawed and refrigerated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. On [DATE] at 9:50 am, an observation with the DM was conducted of the 200-Hall Programming Room (which was utilized as a resident dining room). This observation revealed an opened and undated 33. 8-ounce container of an oral nutritional supplement was stored on a countertop. Approximately 12 ounces of the supplement were left in the undated container. Also, a drawer in the 200-Hall Programming Room which contained pepper packets, salt packets, jelly packets, and margarine packets had a heavy accumulation of a sticky substance, which appeared to be syrup, in the bottom of the drawer. Pepper packets, salt packets and margarine packets stored in the drawer were observed stuck in the sticky substance. Interview on [DATE] at 9:50 am, the DM confirmed the opened 33.8-ounce container of oral nutritional supplement was not dated and stored on the counter, and the drawer in the Programming Room was not clean. The DM stated staff should date containers of nutritional supplements when opened, and store opened containers of supplements in a refrigerator. The DM also stated staff should keep the drawers in the Programming Room clean. 4. On [DATE] at 9:55 am, an observation with the DM was conducted of the 300-Hall Programming Room (which was utilized as a resident dining room). This observation revealed a drawer which contained pepper packets, salt packets, jelly packets, and opened and unopened margarine packets had a heavy accumulation of a sticky substance, which appeared to be syrup, in the bottom of the drawer. Pepper packets, salt packets, margarine packets, and a music compact disc stored in the drawer were observed covered in and stuck in the sticky substance. Interview on [DATE] at 9:55 am, the DM confirmed the drawer in the 300-Hall Programming Room was not clean, and that opened margarine packets were stored inside this drawer. The DM stated staff should keep the drawers in the Programming Room clean and discard opened packages of margarine. 5. On [DATE] at 10:00 am, an observation with the DM was conducted of the 100-Hall Programming Room (which was utilized as a resident dining room). This observation revealed an opened and undated 33. 8-ounce container of an oral nutritional supplement was stored in the room's refrigerator. Approximately 12 ounces of supplement remained in the undated container. Interview on [DATE] at 10:00 am, the DM confirmed the opened container of nutritional supplement was not dated in the 100-Hall Programming Room refrigerator. The DM stated staff should date containers of nutritional supplements when they are opened.

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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. 28604 Based on documentation review and staff interviews, the facility failed to have a documented water management program that included measures to monitor and prevent the growth of opportunistic water-borne pathogens. This had the potential to affect all 114 of 114 residents that resided at the facility. Findings included: Review of facility documents provided by the Administrator revealed a lack of a water management program to monitor and prevent the growth of opportunistic water-borne pathogens. Interview on 1/18/2024 at 11:39 am, the Maintenance Director confirmed the facility did not have a documented water management system in place to prevent the growth of Legionella in the facility. The Maintenance Director stated Legionella was a bacterium that grew in water, and he was aware of the areas in the building that needed to be checked for Legionella, such as showers and sinks not in use in resident rooms. The Maintenance Director indicated he was running water in the vacant resident room showers monthly but did not document it in his electronic maintenance software program. Interview on 1/18/2024 at 11:59 am, the Administrator verified that he was not aware that the facility had to have a water management program in place for the prevention, monitoring and outbreak of Legionella and other water-borne pathogens.