STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36174 Based on observations, interviews, review of the facility's Center Contingency Plan, and review of the facility policy titled, Meal Service, the facility failed to treat residents with dignity by ensuring meals were not served on disposable dinnerware. This had the potential to affect 106 out of 110 residents served meal trays from the kitchen. Findings include: A facility policy titled, Meal Service, not dated, revealed, Associates will promote and maintain patient's dignity and respect during meal service. A homelike environment will be upheld during meal service. The center will provide meals and hydration that conserve nutritive value, flavor, and appearance, and that are palatable, attractive, and a safe and appetizing temperature. Review of the facility's Center Contingency Plan, dated 11/16/21, revealed that the use of disposables for all meals was related to staffing. A notification was to be documented on the use of disposables. On 1/12/22, there was no change. The facility was to continue using all disposables, except for water cups. A notification and documentation were to be in place with Resident Council. On 2/2/22, the plan was to continue with disposables. It was recommended to visit more patients to see if they were okay with disposables. On 3/14/22, the facility visited more patients regarding disposables, and they would start using regular silverware on two halls related to complaints. On 3/29/22, the plan indicated the facility was using all disposables. Notification and documentation were to be in place with Resident Council. On 3/31/22, the facility was continued to use disposables related to staffing. Staff were to check in with patients for concerns with disposables and change to regular dishware if needed for those patients. During concurrent observation and interview with the Certified Dietary Manager (CDM) GG on 4/5/22 at 9:25 a.m., the facility was serving all its meals using disposable dinnerware. This included a 3-compartment clam shell Styrofoam container, Styrofoam bowls, Styrofoam cups, and pre-packaged plastic cutlery sets. At 9:37 a.m., CDM GG stated, We are 100% Styrofoam due to the staffing in the kitchen. There is no one here that can wash over 100 plates and silverware for each meal. She stated it was voted on and approved at the Resident Council meeting. Six months of Resident Council meeting minutes were reviewed without mention of the residents voting to approve the use of disposable dinnerware. (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
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/5/22 at 11:36 a.m., Resident (R) #82, who was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14, stated they did not like eating from the disposable plates and utensils and wished they could eat with china and silverware. During an interview on 4/5/22 at 12:07 p.m., R#38, who was cognitively intact with a BIMS score of 13, stated that meals were served on Styrofoam. During an interview on 4/5/22 at 12:12 p.m., R#34, who was cognitively intact with a BIMS score of 13, stated that meals were served on Styrofoam. During an interview on 4/5/22 at 12:17 p.m., R#55, who was moderately cognitively impaired with a BIMS score of 9, stated that meals were served on Styrofoam. During the Resident Council meeting on 4/6/22 at 3:02 p.m., two alert and oriented residents stated there was never a vote brought before the Resident Council to approve the use of the Styrofoam/disposable dinnerware. They stated it was hard to cut meat with the plastic utensils and they would prefer eating off real plates with real silverware. During an interview on 4/6/22 at 5:07 p.m., [NAME] JJ stated it was easier for the kitchen staff to use the to-go containers. She stated there were a lot of evenings when it was only herself and CDM GG, and if they had to stay and wash dishes, they would not leave the facility until after 10:00 p.m. During an interview on 4/6/22 at 5:23 p.m., [NAME] JJ stated that the staff situation became worse about three months ago when a new business opened in town and the kitchen staff quit to go work there. During an interview on 4/7/22 at 12:30 p.m., the Regional Certified Dietary Manager RCDM AAA stated I'm going to have to get back to you on those answers, when asked about the prolonged use of Styrofoam containers. During a test tray observation on 4/7/22 at 12:57 p.m., the RCDM AAA stated the plastic knife made it hard to cut into the fried chicken due to the flimsiness and stated, I hope the residents were able to cut their food. During an interview on 4/8/22 at 12:42 p.m., the Director of Nursing (DON) stated that the use of the Styrofoam originally started during the COVID-19 pandemic. The DON stated their goal was to go back to what they were doing prior to the COVID -19 pandemic (referring to using china and flatware). During an interview on 4/8/22 at 1:29 p.m., the Administrator stated there was a convenience to using the Styrofoam due to the low number of staff working in the kitchen. She also stated she looked forward to the day when the facility would go back to using the china and flatware, that she preferred the appearance of real dishes versus the Styrofoam, and it was easier to eat a meal off a china plate versus a disposable plate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 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** 38514 Based on observations, record reviews, interviews, and review of the facility policy Patient's Plan of Care, the facility failed to ensure the care plan for two of 25 residents (R) R#48 and R#74 was implemented to prevent falls from occurring and failed to ensure one of 25 resident care plans were developed for R#41 to address vision impairment. Findings include: A review of the facility policy titled, Patient's Plan of Care, dated 2020, revealed, Each patient will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the patient's medical, physical, mental, and psychosocial needs. 1.A review of R#48's Consolidated Order, revealed the resident had diagnoses that included Alzheimer's disease, history of falling, epilepsy, restlessness, and agitation, unsteady on feet, cervical disc disorder (CDD), and tremor. A review of the quarterly Minimum Data Set (MDS) for R#48, dated 2/10/22, revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS revealed the resident was unsteady during transitions and walking, required extensive assistance from staff for ambulation and toilet use, required limited assistance from staff for transfers, and utilized a wheelchair as a mobility device. Further review of R#48's MDS revealed the resident had sustained two or more no injury falls and one fall with injury since the resident's last MDS assessment, which was dated 11/17/21. A review of R#48's Care plan, last updated on 1/10/22, revealed the resident was at risk for falls related to poor safety awareness, tremors, impulsive behavior, blindness, unsteady gait, and impaired cognitive status. The care plan review revealed the facility developed fall prevention interventions that included keeping the call light in reach, providing a wheelchair with anti-tip bars, a Dycem (non-slip material to prevent sliding) to the wheelchair, and a mat at the bedside. Observation on 4/5/22 at 10:51 a.m., revealed R#48 was sitting in a wheelchair in the resident's room, looking out the window. The observation revealed the resident's call light was not in reach. Observation on 4/6/22 at 11:33 a.m., revealed R#48 was in bed. There was no fall mat next to the resident's bed. Observation on 4/7/22 at 8:02 a.m., revealed R#48 was in a wheelchair in the hallway. Observation of the wheelchair revealed there were no anti-tip bars on the wheelchair. During an interview on 4/7/22 at 8:06 a.m., Certified Nursing Assistant (CNA) TT stated the staff becomes aware of what interventions were needed for fall prevention for residents based on the handheld POC (Point of Care). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/7/22 at 8:28 a.m., when asked what interventions were in place to prevent falls for R#48, CNA TT stated a fall mat and low bed were the interventions for R#48. During an interview on 4/7/22 at 8:20 a.m., CNA VV confirmed the handheld POC showed the staff what interventions were in place for fall prevention. During an interview on 4/7/22 at 8:47 a.m., CNA VV stated the resident was to have a fall mat and confirmed that interventions along with anti-tip bars and low bed were not on the POC. During an interview on 4/7/22 at 9:27 a.m., with MDS Nurse UU revealed they did not know how information from a resident's comprehensive care plan was transmitted to POC, and when residents were moved from different rooms or different units, sometimes things get missed. She confirmed there were no anti-tip bars on the R#48's wheelchair. During an interview on 4/7/22 at 10:34 a.m., the Director of Nursing (DON) stated they talked about each fall event in the PAR meeting where care plans were updated, and interventions were added to the care plan. However, the DON also stated they were not sure how resident care plan interventions were put into the POC system. The DON confirmed there were no anti-tip bars on the resident's wheelchair. During an interview on 4/7/22 at 10:34 a.m., with the Assistant Director of Nursing (ADON), it was revealed that the facility conducted huddle meetings with staff when interventions changed. According to the ADON, not all interventions from a care plan automatically moved to POC and had to be entered manually by management team members. The ADON also confirmed there was no dycem or anti-tip bars on the resident's wheelchair at that time. During an interview on 4/8/22 at 1:24 p.m., the Administrator stated they were not aware how information was communicated to the CNAs regarding interventions put in place by the PAR team. 2. A review of Resident (R) #74's Consolidated Order, included but are not limited to pain in right hip, pain in left hip, unspecified dementia, displace fracture of base of neck of right femur, osteoarthritis, and (CDD) cervical disc disorder. A review of the quarterly MDS for R#74, dated 2/26/22, revealed the Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The MDS also revealed the resident required extensive assistance from staff for ambulation and transferring and utilized a wheelchair and a walker as a mobility device. According to the MDS, the resident had sustained two falls with injury. A review of R#74's care plan, updated on 3/25/22, revealed the resident was at risk for falls related to poor safety awareness and dementia. Interventions in place for fall prevention included but were not limited to winged mattress, non-skid tape next to bed, and anti-roll backs on the wheelchair. Observation on 4/6/222 at 11:40 a.m., revealed R#74 was in bed. There were no non-skid strips on the floor on either side of the bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/7/22 at 8:25 a.m., revealed R#74 was in a wheelchair in the hallway. Observation of the resident's bedroom revealed there was a winged mattress on the resident's bed; however there continued to be no nonskid strips on the floor next to the bed. During an interview on 4/7/22 at 8:06 a.m., Certified Nursing Assistant (CNA) TT stated the staff becomes aware of what interventions were needed for fall prevention for residents based on the handheld POC (Point of Care). At 8:28 a.m., when asked what interventions were in place to prevent falls for R#74, she stated a low bed and to check frequently. During an interview on 4/7/22 at 8:17 a.m., with LPN XX, it was revealed that CNAs were told about interventions in place for residents on fall precautions through education and in-services. She stated fall mats, non-skid socks, call lights, and close monitoring should be in place for residents who were high risk for fall. During an interview on 4/7/22 at 8:20 a.m., CNA VV confirmed the handheld POC showed the staff what interventions were in place for fall prevention. At 8:23 a.m., CNA VV stated there were no extra interventions for safety for R#74. During an on 4/7/22 at 10:34 a.m.,with the ADON , it was revealed care plan information had to be entered manually into POC. The ADON stated management team members entered the information into POC; however, confirmed R#74 had no nonskid strips on the floor. During an interview on 4/7/22 at 10:34 a.m., the DON confirmed there were no nonskid strips on the floor on either side of the bed for R#74. The DON was not sure how resident care plan interventions were put into the POC system. 3. A review of R#41's Face Sheet revealed the resident had diagnoses that included vascular dementia, bipolar disease, and major depressive disorder. A review of R#41's annual MDS, dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating no impaired cognition. The MDS revealed R#41 had impaired vision and used corrective lenses. A review of the active Care Plan for R#41, revealed there was no documented evidence the facility developed a care plan regarding R#41's visual impairment, nor the need for corrective lenses. During an interview on 4/5/22 at 3:36 p.m. with R#41, it was revealed the resident stated they had poor vision and wanted new glasses. The resident stated they had been to the eye doctor and had cataracts. Observation and interview with R#41 on 4/6/22 at 11:34 a.m., revealed R#41 lying in bed. R#41 continued to state they wanted glasses because it was hard to see most things. A review of paperwork provided by the Social Worker (SW) for R#41 revealed the resident had a revisit exam for cataracts on 3/22/22. The exam note revealed the resident's cataracts were not mature enough for surgical evaluation. The document further stated a follow-up exam for cataracts was scheduled for five months. There was no documented evidence the exam addressed the resident's need for glasses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/22 at 11:53 a.m., MDS Nurse UU confirmed there was no care plan initiated for R#41 regarding the resident's vision concerns. The MDS nurse stated there should be a care plan related to the resident's use of glasses and diagnosis of cataracts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38514 Based on record review, interviews, and review of the facility policies Patient's Plan of Care and Fall Management, it was determined that the facility failed to ensure the care plan for one of 25 residents (R) R#48, reviewed for care planning was revised to prevent future falls from occurring. Findings include: A review of the facility policy titled, Patient's Plan of Care, dated 2020, revealed, The patient's care plan should be reviewed after each MDS (Minimum Data Set) assessment and revised based on changing goals, preferences and needs of the patient and in response to current interventions. The comprehensive care plan should also be updated as ongoing clinical assessments identify changes. A review of the facility policy titled, Fall Management, dated 2020, revealed, If a fall occurs, the interdisciplinary team conducts an evaluation to ensure appropriate measures are in place to minimize the risk of future falls. A review of R#48's Resident Consolidated Order revealed the resident had diagnoses that included Alzheimer's disease, history of falling, epilepsy, restlessness, and agitation, unsteady on feet, cervical disc disorder (CDD), and tremor. A review of the quarterly MDS for R#48, dated 2/10/22, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. Further review of the MDS revealed R#48 was unsteady during transitions and walking, required extensive assistance from staff for ambulation, required limited assistance from staff for transfers, and utilized a wheelchair as a mobility device. The MDS also revealed R#48 had sustained two or more no injury falls and one fall with injury since the resident's last MDS assessment, which was dated 11/17/21. A review of R#48's care plan, last updated on 1/10/22, revealed the resident was at risk for falls related to poor safety awareness, tremors, impulsive behavior, blindness, unsteady gait, and impaired cognitive status. The care plan review revealed the facility developed fall prevention interventions that included keeping the call light in reach; placing anti-tippers, a drop seat, a dycem (cushion to prevent sliding from a wheelchair), and anti-roll backs to the wheelchair; toileting and encouraging the resident to call for assistance; providing footwear or non-skid socks; keeping the bed in low position; bringing the resident out of the room to the nurses' station when up; placing a mat at the bedside; and keeping personal items within reach. A review of an Event-Initial Note for R#48 revealed the resident sustained a fall/near fall on 1/4/22 at 9:10 a. m. in a hallway. The note indicated the resident stood up to pick something up and tripped over the wheel on the wheelchair. Further review of the note revealed the resident sustained a bruise/discoloration to the head and the left eye. According to the note, R#48 had severely impaired cognition, impaired judgement, and the inability to understand directions. A review of PAR (Patient's Area of Risk) Review notes for R#48 dated 1/7/22 revealed the root cause of the fall was related to the resident transferring unassisted and the long-term intervention to prevent further falls was to verbally explain surrounding to resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of R#48's care plan revealed even though the resident was cognitively impaired, and the facility determined the resident had the inability to understand directions, the facility revised the care plan on 1/7/22 with an intervention to verbally explain surroundings to the resident to prevent further falls. A review of an Event-Initial Note for R#48, dated 1/8/22, revealed the resident got up unassisted, walked to the roommate's bed and fell at 4:01 p.m. The resident sustained no apparent injury. According to the note, the new intervention added after the fall to prevent future falls was to place the resident in an open area for maximum observation opportunities. Continued review of R#48's care plan revealed the intervention was added on 1/8/22. A review of an Event-Initial Note for R#48 revealed the resident sustained another fall on 1/15/22 at 12:15 a.m. The note stated the resident was ambulating to the bathroom without assistance and fell . Staff found the resident on their buttocks and the roommate stated the resident hit their head on a wheelchair. The note stated the resident had no injury. The staff assisted the resident into a wheelchair and brought R#48 to the nurse's station for observation. The note revealed the new intervention added to prevent future falls was to place the resident in open area for maximum observation opportunities, even though this was the same intervention implemented after the resident's fall on 1/8/22 and was not effective at preventing this fall. Continued review of Event-Initial Note for R#48 revealed the resident sustained another fall three days later, on 1/18/22. The note stated the resident was ambulating to the bathroom unassisted and fell . According to the note, the resident hit their head; however, the note revealed the resident sustained no injury. According to the PAR Review dated 1/19/22, the facility immediately assisted the resident to the bathroom and the long-term changes to the care plan were assess needs and to add a winged mattress (mattress with built up edges) to the resident's bed. Continued review of R#48's care plan revealed no documented evidence the resident's care plan was revised to include the interventions. During an interview on 4/8/22 at 11:53 a.m., MDS Nurse UU confirmed the care plans were not accurately revised after R#48 sustained falls and some of the interventions were ineffective. During an interview on 4/8/22 at 11:33 a.m. with the Director of Nursing (DON), revealed their expectations included care plans being updated regularly, being resident-centered, and focused on details. The DON stated care plans should be updated after falls for fall prevention. During an interview on 4/8/22 at 1:24 p.m., the Administrator stated they were not sure who was responsible for updating resident care plans. The Administrator stated it was the expectation that care plans should be updated after falls and the care plan should be person-centered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44524 Based on observations, record review, interviews, and review of a facility policy titled, ADL (Activities of Daily Living) Plan of Care, the facility failed to ensure ADL care related to nail care and shaving was provided for three of four sampled residents (Resident (R) #55, R#73, and R#91) reviewed for ADL care. Findings include: A review of the facility's policy titled, ADL Plan of Care, dated 2020, indicated, 1. Resident's ADL needs are assessed on admission and are addressed on the Baseline Care Plan and communicated to staff. 2. Nursing develops the patient's ADL care plan and will communicate the level of assistance required for the patient. 1. A review of the Face Sheet revealed R#55 had diagnoses which included acquired absence of left leg below knee, muscle weakness, and vascular dementia with behavioral disturbances. A review of a quarterly Minimum Data Set (MDS), dated [DATE], revealed R#55 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Further review of the MDS revealed R#55 was totally dependent on one staff for personal hygiene and totally dependent on two staff for bathing. A review of the Care Plan, with a review date of 8/25/21, revealed R#55 had limited mobility and required assistance with activities of daily living (ADL) and had a self-care deficit related to ADLs. The resident required staff intervention to remain clean, need, and free of body odors. Interventions included assisting with ADLs as needed. The ADL task sheet for personal hygiene and bathing for 3/22 was reviewed and indicated the resident received personal hygiene care for six of 31 days. Observation on 4/5/22 at 12:17 p.m., R#55 was lying in bed, on their back with the head of the bed elevated. R#55 had facial hair that was approximately 1/4 inch long. R#55 stated they always shaved at home and if the surveyor would just provide the resident with a razor, they would shave themself. Observation on 4/6/22 at 12:08 p.m., revealed R#55's appearance had not changed from the observation made on 4/5/22. Observation on 4/7/22 at 6:10 a.m., R#55's appearance had not changed from the observation made on 4/5/22. R#55 stated, They still haven't shaved me. Observation on 4/8/22 at 8:37 a.m., revealed that R#55 had been shaved by the facility staff last night and gave them a bath. During an interview on 4/6/22 at 4:06 p.m., Certified Nursing Assistant (CNA) AA stated that CNA's were responsible for shaving residents. She stated the resident was shaved whenever the resident requested their pricklies to be gone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA AA and the surveyor entered the resident's room. She acknowledged the resident had facial hair, and R#55 requested to be shaved. During an interview on 4/6/22 at 4:11 p.m., Nursing Assistant (NA) BB stated that any CNA that was assigned to the resident was responsible for shaving the resident. She also stated that she noticed that the resident had facial hair today, and that the resident's bed bath was scheduled tomorrow. She also stated, When it's days like today, I can't do them. I'm just really busy. During an interview on 4/6/22 at 4:21 p.m., Licensed Practical Nurse (LPN) CC stated the CNA should shave the resident's facial hair on their shower days and indicated R#55 received bed baths two times per week, on Tuesdays and Fridays. She stated CNA KK was responsible for shaving the residents and was at the facility four days a week. She also stated that if CNA KK was not able to provide the care, then any CNA should provide the care on the resident's shower days. During an interview on 4/7/22 at 4:21 p.m., CNA KK stated the resident should be shaved on their shower days, and that the resident should get three showers a week. During an interview on 4/8/22 at 12:13 p.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) stated that all staff were to ensure that residents had good hygiene, and R#55 should be shaved as often as needed. The DON stated that if staff observed the need, then staff should provide the care. She also stated that staff were to chart ADL care in a point of care (POC) system and should be charting every shift. During an interview on 4/8/22 at 1:14 p.m., the Administrator stated that CNA's were responsible for shaving the resident and did not know how often R#55 should be shaved. The expectation was that if a resident had facial hair, they should be cleaned. 2. A review of the Face Sheet revealed R#73 had diagnoses which included abnormalities of gait and mobility, muscle weakness, and post-traumatic stress disorder (PTSD). A review of a quarterly MDS, dated [DATE], revealed R#73 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. Further review of the MDS revealed the resident required limited assistance of one person for personal hygiene and bathing. A review of the Care Plan, with a review date of 3/30/22, revealed R#73 had limited mobility and required assistance with activities of daily living (ADL) and had a self-care deficit related to ADLs. Interventions included assisting with ADLs as needed. The ADL task sheet for personal hygiene and bathing for 3/22 was reviewed and indicated the resident received personal hygiene care for 10 of 31 days. During an observation on 4/5/22 at 11:14 a.m., R#73 was lying in bed, on their right side. The resident had facial hair. The resident declined to be interviewed at this time. The resident's nails were not visible, as they were tucked underneath their head. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A concurrent observation and interview on 4/6/22 at 12:17 p.m., R#73 was lying in bed, and their nails were approximately 1/4 inch long, with brown debris underneath all the resident's nails. The resident was still unshaven. The resident stated staff trimmed their nails for them and they had not trimmed them in awhile. Observation on 4/7/22 at 6:00 a.m., revealed that R#73 had the same appearance as the previous day with an unshaved face and long fingernails with debris underneath. During an interview on 4/6/22 at 4:03 p.m., CNA AA stated they were agency staff, and that CNAs were responsible shaving residents and for nail care, unless the resident was diabetic. She also stated they were unaware of how and when to chart that the resident was provided care. At this time, CNA AA and the surveyor went into the resident's room. CNA AA stated there was a bunch of dirt under the resident's nails. During an interview on 4/6/22 at 4:13 p.m., NA BB stated that any CNA that was assigned to the resident was responsible for shaving the resident and the resident normally had it done on the resident's shower day. The resident's shower days were Tuesday, Thursday, and Saturday. She stated CNA KK provided the resident's nail care and CNA KK came in one day a week. NA BB stated that CNA KK was responsible for providing nail care for the whole building and only had eight hours to do the entire building. During an interview on 4/6/22 at 4:24 p.m., with LPN CC stated that the CNA should shave the resident's facial hair and cut the resident's nails on their shower days. She also stated that CNA KK was responsible for providing nail care and shaving the residents and was at the facility four days a week. She then stated that if CNA KK was not able to provide the care, then any CNA should provide the care on the resident's shower days. During a concurrent interview and observation on 4/7/22 at 9:24 a.m., R#73 was lying in bed, alert, and stated that their fingernails were cleaned but they still haven't shaved me. During an interview on 4/7/22 at 4:21 p.m., CNA KK stated the resident should be shaved on their shower days, and that the last time they provided nail care and shaved the resident was approximately a week ago from 4/7/22. She also stated they were on light duty and completed nail care, passed meal trays, shaved residents, and answered the phone on the evening shift. CNA KK stated there was a notebook on each unit that indicated the resident's shower and if they were to receive nail care. It was revealed that they took a copy off each unit, crossed the resident's name out after the ADL task completed, and did not chart it in the electronic health record. CNA KK stated they provided the list of residents whose care was completed to the ADON for them to review. A concurrent interview and observation on 4/8/22 at 8:34 a.m., revealed R#73 was lying in bed, alert, and stated that the facility gave him a shower last night and finally shaved me. During an interview on 4/8/22 at 12:13 p.m., the DON and ADON, revealed that all staff were to ensure residents have good hygiene, and R#73 should be shaved as often as needed. The DON stated that if staff observed the need, then staff should provide the care. She also stated that staff were to chart ADL care in a point of care (POC) system and should be charting every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/8/22 at 1:18 p.m., the Administrator stated CNAs were responsible for shaving the resident and providing nail care. The Administrator stated their expectation was that if a resident had facial hair, they should be cleaned. 3. A review of the Face Sheet revealed R#91 had diagnoses which included muscle weakness and need for assistance with personal care. A review of a significant change MDS, dated [DATE], revealed R#91 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. Further review of the MDS revealed R#91 required extensive physical assistance of one person for personal hygiene and was totally dependent on two plus persons for bathing. A review of the Care Plan, with a review date of 9/21/21, revealed R#91 had limited mobility, required assistance with activities of daily living (ADL), and had a self-care deficit related to ADLs. Interventions included assisting with ADLs as needed. The ADL task sheet for personal hygiene and bathing for 3/22 was reviewed and indicated the resident received personal hygiene care for 11 of 31 days. Observation on 4/5/22 at 10:37 a.m., R#91 was lying in bed, with their eyes closed. The resident had facial hair. Observation on 4/8/22 at 8:32 a.m., R#91 was lying in bed, and their appearance related to the facial hair had not changed from 4/5/222. The resident's hands were under the covers, so the resident's nails could not be seen. During an interview on 4/6/22 at 3:58 p.m., CNA AA stated that she guessed the CNA was responsible for the resident to be shaved. She also stated that she did not know how often the resident had been shaved, and that she had never shaved the resident. She revealed that she did not know who provided nail care to the residents or how often. At this time, CNA AA and surveyor went into the resident's room and CNA AA stated the resident had a few nails that were long and jagged, with debris underneath them. She stated the resident had facial hair but was not aware if it was the resident's choice because the resident got confused. During an interview on 4/6/22 at 4:09 p.m., NA BB stated that any CNA that was assigned to the resident was responsible for shaving the resident and normally had it done on the resident's shower day. She stated that she did not know how often the resident was shaved. It was also revealed that CNA KK provided the resident's nail care and CNA KK came in one day a week. She stated that CNA KK was responsible for providing nail care for the whole building and only had eight hours to do the entire building. During an observation on 4/7/22 at 7:50 a.m., R#91 was lying in bed, and their appearance had not changed from 4/5/22. The resident still had facial hair. During an interview on 4/7/22 at 4:21 p.m., CNA KK stated the resident should be shaved on their shower days. She stated she had never shaved the resident and that the CNA had asked the resident a few times and the resident declined. She also stated they provided nail care to the resident the previous week. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the electronic health record revealed there was no documentation indicating the resident had declined or refused to be shaved. Observation on 4/8/22 at 8:32 a.m., R#91 was lying in bed, and their appearance related to the facial hair had not changed from 4/5/222. The resident's hands were under the covers, so the resident's nails could not be seen. During an interview on 4/8/22 at 12:13 p.m., the DON and ADON stated that all staff were to ensure that residents had good hygiene, and R#91 should be shaved as often as needed. The DON stated that if staff observed the need, then staff should provide the care. The DON stated that staff were to chart ADL care in a point of care (POC) system and should be charting every shift. During an interview on 4/8/22 at 1:19 p.m., the Administrator stated that CNA's were responsible for shaving the resident and providing nail care. The expectation was that if a resident had facial hair, they should be cleaned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43017 Based on observations, interviews, record review, and review of the facility's policy titled Moving A Patient Up in Bed, it was determined the facility failed to ensure one of one sampled resident (R) #90, received treatment and care in accordance with the resident's comprehensive person-centered care plan. Specifically, the facility failed to ensure R#90 maintained proper body alignment while in a geriatric chair (Geri-chair). Findings include: A review of the facility's policy titled, Moving A Patient Up in Bed, dated 2020, revealed, The intent of this center is to provide patients with care that promotes good body alignment. A review of R#90's Face Sheet revealed the resident had diagnoses which included cerebral vascular accident, history of transient ischemia attack (TIA or ministroke), and dementia. The quarterly Minimum Data Set (MDS), dated [DATE], indicated R#90 sometimes understood others and sometimes made self-understood. The resident had a Brief Interview for Mental Status (BIMS) score of three, indicating the resident had severely impaired cognition. Further review of the MDS revealed the resident required extensive assistance of two staff members for bed mobility (how a resident moves to and from lying positions, turns side to side, and positions body while in bed or alternate sleep furniture). A review of R#90's care plan, reviewed by the facility on 9/7/21, revealed the facility developed an intervention to position patient (resident)properly and to utilize pressure reducing or pressure relieving devices (pillows, positioning wedges) if indicated. Further review of the resident's care plan, last reviewed 3/13/22, revealed the facility also developed interventions to assist the resident with activities of daily living as needed and to provide the appropriate level of assistance to promote safety of the resident. Observation on 4/7/22 at 7:40 a.m., of R#90 occurred in the sunroom of Hall C. The resident was seated in a Geri-chair, slumped over to the left side of the Geri-chair. A pillow was behind the resident's head, but it was not providing any support since the resident's upper body was leaning off the Geri-chair arm. Observation on 4/7/22 at 8:13 a.m., revealed R#90 had slid further down the chair and their head was hanging off the arm of the chair. The resident's neck was observed hyperextended, with their face positioned toward the ceiling. Observation on 4/7/22 at 9:00 a.m. revealed R#90 was in a Geri-chair in their bedroom. The resident had a pillow to their back and had slid down in the Geri-chair. The resident's head was resting on the left armrest. Further observation on 4/7/22 at 9:19 a.m., revealed the resident was observed still slumped over the left side on the armrest of the Geri-chair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/7/22 at 9:27 a.m., R#90 was in the day room. A pillow was observed partially under the left side of the resident's head; however, the resident was leaning off the left side of the Geri-chair. Observation on 4/7/22 at 10:01a.m., R#90 was slumped over. A small corner of a pillow was under the left side of the resident's face while the resident's face was resting on the arm of the Geri-chair. Observation on 4/7/22 at 10:49 a.m., R#90 was lying diagonally across the Geri-chair with the right leg hanging off the right side of the chair and the resident's head resting on the left armrest of the Geri-chair. A corner of a pillow was under the resident's cheek. Observation on 4/7/22 at 11:07 a.m., a staff member was observed lifting R# 90 to a more upright position and the right leg was placed back on the Geri-chair. A pillow was behind the resident's head and left shoulder; however, the resident was still leaning to the left. Further observation on 4/7/22 at 11:36 a.m., revealed the R#90's position remained unchanged. Observation on 4/7/22 at 11:53 a.m. of R#90, staff transferred the resident outside to the porch; however, no repositioning was provided for the resident. Observation on 4/7/22 at 12:58 p.m., R#90 was at the dining table being assisted with eating. The head of the Geri-chair was upright, and the resident was leaning on the left arm of the Geri-chair. Observation on 4/7/22 at 1:33 p.m., R#90 was in the sunroom in a Geri-chair. The resident's head was slumped to the left and resting on the resident's upper arm that was lying on the arm of the Geri-chair. Observation on 4/7/22 at 1:39 p.m., revealed staff had placed a pillow behind the resident's back; however, the pillow did not provide support for the resident's head and shoulders and the resident's head had slumped to the left and was resting on the armrest of the Geri-chair. During an interview on 4/7/22 at 1:57 p.m., with Certified Nursing Assistant (CNA) AA, revealed R#90 usually leaned to the left when seated in a Geri-chair. CNA AA stated she was not aware of any interventions to provide proper body alignment for the resident. Observation on 4/8/22 at 8:30 a.m., R#90's head and left arm were observed hanging off the left side of the Geri-chair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/22 at 9:05 a.m., the Assistant Director of Nursing (ADON) and Director of Nursing (DON) were asked to observe the resident whose head and left arm remained hanging off the left side of the chair. They stated they thought the resident was comfortable with the armpit on the arm rest and the resident's head hanging over the chair without support. The interview with the DON revealed the facility had tried placing a pillow behind the resident's head; however, the resident returned to the left side. According to the DON, no other positioning devices had been attempted. She stated that R#90 had stated that they were comfortable in that position. The DON asked the resident if the resident was comfortable. The resident mumbled a response that sounded like yes. The DON asked the resident if they wanted to be repositioned. The resident again mumbled a response that sounded like, Yes, repositioned. The DON asked the resident again if that was how the resident was comfortable. The resident again mumbled a response that sounded like yes. During an interview on 4/8/22 at 1:30 p.m., the DON revealed her expectation was that staff would evaluate and find a way to keep the resident in the chair, if a resident was consistently leaning off their Geri-chair. During an interview on 4/8/22 at 3:55 p.m., with CNA KK revealed R#90 constantly leaned to the left side. The CNA stated the resident should have had positioning pillows, such as a wedge, on the left side to prevent the resident from leaning off the left side of the Geri-chair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 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. 38514 Based on observations, record reviews, interviews, and review of the facility policy, Fall Management, the facility failed to ensure that falls were thoroughly investigated, and appropriate interventions were put into place to prevent falls for two residents, Resident (R) #48 and R#78, of five residents reviewed for falls. Findings include: A review of the facility policy titled, Fall Management, revealed, Each patient is assisted in attaining/maintaining his or her highest practicable level of function. Each patient's risk for falls is evaluated by the interdisciplinary team (IDT). A care plan is developed and implemented based on this evaluation with ongoing review. If a fall occurs, the interdisciplinary team conducts an evaluation to ensure appropriate measures are in place to minimize the risk of future falls. When a fall occurs: Review the event and patient status at the next scheduled PAR (Patient at Risk) or UR meeting as indicated. 1. A review of the Face Sheet revealed the facility admitted R#74 on 2/3/21. Diagnoses included, but were not limited to, pain in right hip, pain in left hip, unspecified dementia, displace fracture of base of neck of right femur, osteoarthritis, and cervical disc disorder (CDD). A review of the quarterly Minimum Data Set (MDS) for R#74, dated 2/26/22, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. Further review of the MDS revealed R#74 required extensive assistance of one staff for ambulation and transferring and utilized a wheelchair and a walker as a mobility device. Further review of the MDS revealed R#74 sustained two or more falls with injury since the prior MDS, which was dated 12/3/21. A review of the Care Plan, updated 3/25/22, revealed the resident was at risk for falls related to poor safety awareness and dementia. Interventions in place for fall prevention included, but were not limited to, winged mattress, non-skid tape next to the bed, and anti-roll backs on the wheelchair. A review of the Electronic Health Record (EHR) indicated R#74 sustained falls on 1/18/22, 2/15/22, and 3/24/22. A review of the Event notes for a fall which occurred on 1/18/22 indicated R#74 was ambulating unassisted in the hallway. Injuries included a skin tear to the right wrist and a wound to the forehead. Interventions put into place immediately included to keep the resident in full observation. A review of the Patient at Risk (PAR) investigation revealed the new recommendations for the care plan interventions included providing activity. A review of the Event notes for a fall which occurred on 2/15/22 indicated R#74 was found on the floor next to the bed with pillows under their head. The immediate intervention added after the event was to add a fall mat to the right side of the bed and the left side of the bed. A review of the PAR investigation revealed the new recommendations for the care plan included a winged mattress. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Event notes for a fall which occurred on 3/24/22 indicated R#74 tried to get up from the wheelchair and slid down to the floor. This incident occurred in the resident's room. There was pain to the right leg. A follow-up x-ray indicated a fracture of the right hip. The resident was transported to the hospital for surgical repair. The immediate intervention added after the event was to add a fall mat to the right side of the bed. This intervention was added as a short-term intervention after the fall on 2/15/22. A review of the PAR investigation revealed the new recommendations for the care plan interventions included adding nonskid tape to the floor near the bed. The document also indicated the response to previous interventions had been good. Observation on 4/7/22 at 8:25 a.m., R#74 was in a wheelchair in the hallway outside their room. There were no nonskid strips on the floor next to the bed. During an interview on 4/7/22 at 8:06 a.m., Certified Nursing Assistant (CNA) TT revealed that the staff becomes aware of what interventions were needed for fall prevention for residents based on the handheld Point of Care (POC). During an interview on 4/7/22 at 8:17 a.m., LPN XX stated the CNA's were told about interventions in place for residents on fall precautions through in-services and education. She stated fall mats, non-skid socks, call lights, and close monitoring were in place for R#74. During an interview on 4/7/22 at 8:20 a.m., CNA VV confirmed the handheld POC showed the staff what interventions were in place for fall prevention. At 8:23 a.m., she stated there were no extra interventions for safety for R#74. During an interview on 4/7/22 at 8:28 a.m., with CNA TT, was asked what interventions were in place to prevent falls for R#74. She stated a low bed and to check frequently. During an interview on 4/7/22 at 10:34 a.m., with the Director of Nursing (DON), she stated the CNAs received a verbal report and would know what fall precautions were in place for residents through that report. When asked how interventions were put into the POC system, the DON stated they were not sure. She confirmed there were no nonskid strips on the floor on either side of the bed for R#74. She also stated each fall event was talked about in the PAR meeting where care plans were updated, and a root cause analysis was completed. The interventions were added to the care plan at that time. During an interview on 4/7/22 at 10:34 a.m., the Assistant Director of Nursing (ADON) stated they conducted huddle meetings with staff whenever the interventions changed. The POC information had to be entered manually, as not all interventions from the care plans moved over to the POC if it was outside the scope of practice for CNAs. When asked who entered information manually into the POC, the ADON stated management team members put information in. During an interview on 4/8/22 at 11:33 a.m., the DON revealed that expectations included care plans being updated regularly and should be resident centered. The goal was to provide great care and the DON stated interventions should be in place. She then stated communication to the CNA's and education was essential in providing good care. She also stated the expectation of fall prevention was to find the root cause of falls to prevent further falls. When asked if they thought the current fall risk program was adequate, the DON stated that the facility tried our best to ensure the safety of our patients. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/22 at 11:53 a.m., MDS Nurse UU confirmed the care plans were not updated accurately after falls for R#74. The fall mat intervention was not initiated on the care plan. During an interview on 4/8/22 at 1:24 p.m., the Administrator revealed that the nursing and facility leadership were responsible for the fall risk prevention. The Administrator stated they were not aware of how information was communicated to the CNA's regarding interventions put in place by the PAR team. The Administrator stated the expectation of the facility regarding falls and resident safety was to limit falls. 2. A review of the Face Sheet for R#48 revealed the facility admitted the resident with diagnoses that included, but were not limited to, Alzheimer's disease, history of falling, epilepsy, restlessness, and agitation, unsteady on feet, (CDD) cervical disc disorder, and tremor. A review of the quarterly MDS for R#48, dated 2/10/22, revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. Further review of the MDS revealed R#48 required extensive assistance of one staff for ambulation and utilized a wheelchair as a mobility device. The MDS also indicated R#48 sustained two or more falls without injury and one fall with injury since the prior MDS, which was dated 11/17/21. A review of the Care Plan, updated 1/10/22, revealed the resident was at risk for falls related to poor safety awareness, tremors, impulsive behavior, blindness, unsteady gait, and impaired cognitive status. Interventions in place for fall prevention included, but were not limited to, a mat at the bedside (implemented 12/7/21), wheelchair within reach when in the bathroom (implemented 12/06/2021), bed in low position (implemented 9/22/21), anti-roll backs on wheelchair (implemented 12/22/21), dycem (material to help keep cushion in wheelchair seat in place; implemented 10/01/19), and to keep the resident near the nurse's station (implemented 12/28/21). A review of the EHR indicated R#48 sustained falls on 12/05/21, 12/7/21, 12/21/21, 1/4/22, 1/8/22, 1/15/22 and 1/18/22. A review of the Event notes for a fall which occurred on 12/5/21 indicated R#48 decided to sit on the floor while ambulating to the bathroom. There was no injury. The immediate intervention added after the event was to maintain the wheelchair in reach of the resident. A review of the PAR investigation revealed the new recommendations for the care plan interventions included maintain the wheelchair in reach. A review of the Event notes for a fall which occurred on 12/7/21 indicated R#48 was found sitting next to their bed on the floor. The report indicated there was an injury, a skin tear to the left arm. The skin tear received treatment at the facility. The immediate interventions added included bed in low position, call light in reach, mat at bedside, offer snacks, and redirect. There was no PAR investigation for this fall provided. A review of the Event notes for a fall which occurred on 12/21/21 indicated R#48 was found at the nurse's station on the floor in front of their wheelchair. There was no injury. The intervention added at the time of the incident included encouraging the patient to call for assistance and implement a toileting schedule. A review of the PAR investigation revealed the new recommendations for the care plan interventions included adding anti-tip bars to the wheelchair (bars added to the front or back of the wheels of the wheelchair that prevent the chair from tipping backwards) and medication review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Event notes for a fall which occurred on 1/4/22 indicated R#48 was found sitting in the hallway in the wheelchair. The resident stood and bent down to pick up something off the floor and tripped over the wheel of the wheelchair. There was no injury. The intervention added at the time of the incident included other. A review of the PAR investigation revealed the new recommendations for the care plan interventions included to verbally explain surroundings to the resident and assist the resident to the chair. The document also indicated the response to previous interventions had been good. A review of the Event notes for a fall which occurred on 1/8/22 indicated R#48 got up unassisted and walked to the roommate's bed and fell . There was no injury. The intervention added at the time of the incident included to place the resident in open area for maximum observation opportunities. There was no PAR review for this fall. A review of the Event notes for a fall which occurred on 1/15/22 indicated R#48 ambulated to the bathroom unassisted and fell . The staff assisted the resident into a wheelchair and brought R#48 to the nurse's station for observation. There was no injury. The intervention added at the time of the incident included to place the resident in open area for maximum observation opportunities. This was also the intervention added after the 1/8/22 fall. There was no PAR review for this fall. A review of the Event notes for a fall which occurred on 1/18/22 indicated R#48 ambulated to the bathroom unassisted and fell . There was no injury. The intervention added at the time of the incident included bed in low position, call light in reach, and declutter room. A review of the PAR investigation revealed the new interventions included assess needs, take the resident to the bathroom, assist the resident to the wheelchair, and winged mattress (mattress with built up edges to help prevent falls). The document also indicated the response to previous interventions had been good. Observation on 4/5/22 at 10:51 a.m. R#48 was sitting in the room in a wheelchair, looking out the window. There was no call light in reach, as the wheelchair was at least five feet from the bed. There was a fall mat by the bed. Observation on 4/6/22 at 11:33 a.m. revealed R#48 was in bed with the bed in low position, and there was no fall mat next to the bed. Observation on 4/7/22 at 8:02 a.m., R#48 was sitting in a wheelchair in the hallway, with a breakfast tray in front of the resident on an overbed table. There were no anti-tip bars on the wheelchair. During an interview on 4/7/22 at 8:06 a.m., CNA TT stated the staff becomes aware of what interventions were needed for fall prevention for residents based on the handheld POC. During an interview on 4/7/22 at 8:17 a.m., LPN XX revealed that the CNAs were told about interventions in place for residents on fall precautions through in-services and education. LPN XX stated fall mats, non-skid socks, call lights, and close monitoring were in place for R#48. During an interview on 4/7/22 at 8:20 a.m., CNA VV confirmed the handheld POC showed the staff what interventions were in place for fall prevention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/7/22 at 8:28 a.m., CNA TT was asked what interventions were in place to prevent falls for R#48. She stated a fall mat and low bed were the interventions for R#48. During interview on 4/7/22 at 8:47 a.m., CNA VV revealed the resident was to have a fall mat and confirmed that interventions along with anti-tip bars and low bed were not on the POC. During an interview on 4/7/22 at 9:27 a.m., MDS Nurse UU stated she had worked at the facility as the MDS nurse for nine years. She confirmed there were no anti-tip bars on the wheelchair for R#48. When asked how the information and interventions from the care plans were transmitted to the POC, MDS Nurse UU stated they did not know. She also stated when residents were moved from different rooms or different units, sometimes things get missed. During an interview on 4/7/22 at 10:34 a.m., the DON revealed the CNA's received verbal reports and would know what fall precautions were in place for residents through that report. When asked how interventions were put into the POC system, the DON stated they were not sure. She confirmed there were no anti-tip bars on the wheelchair for R#48. She also stated each fall event was talked about in the PAR meeting where care plans were updated, and a root cause analysis was completed. The interventions were added to the care plan at that time. During an interview on 4/7/22 at 10:34 a.m., ADON stated they conducted huddle meetings with staff whenever the interventions changed. The POC information had to be entered manually, as not all interventions from the care plans moved over to the POC if it was outside the scope of practice for CNA's. When asked who entered information manually into the POC, the ADON stated management team members put information in. The ADON also confirmed there was no dycem in the wheelchair and no anti-tip bars on the wheelchair for R#48. During an interview on 4/8/22 at 11:53 a.m., the MDS Nurse UU confirmed the care plans were not updated accurately after falls for R#48. She also stated the interventions were sometimes duplicated and some were not resident-centered. When asked why there were no PARs for falls occurring on 12/7/21, 1/8/22, and 1/15/22 for R#48, MDS UU stated she did not know. When asked if they thought the interventions in place for R#48 regarding falls were appropriate and resident-centered, she stated no.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 36174 Based on observations, interviews, document reviews, and review of facility policy titled, Department Organization, undated, the facility failed to employ enough kitchen personnel to fully carry out the functions of the kitchen. Specifically, the facility failed to have enough staff to wash dishes for the 106 residents who ate meals from the kitchen, therefore, residents were using disposable dinnerware. Findings include: The facility policy titled, Department Organization, undated, revealed, Guidelines: The center should provide adequate staffing to carry out the functions of the Dining and Nutrition Services Department. The Dining and Nutrition Services Department should collaborate with all disciplines to ensure the patient's needs are met based on patient centered care. A review of the facility's Center Contingency Plan revealed as of 3/21/22, the facility had three open positions for full-time dietary aides, one open position for a full-time morning shift cook, and two open positions for full-time evening shift cooks. A review of the kitchen schedule for 4/5/22 revealed two cooks, a Dish room aide and Certified Dietary Manager (CDM) GG were scheduled to work the morning shift. A carts aide slot was listed on the schedule; however, there was no carts aide scheduled to work during the day shift on 4/5/22. During concurrent observations and interviews in the kitchen on 4/5/22 at 9:37 a.m., staff were observed serving meals in Styrofoam tableware. In the interview, CDM GG stated, We are 100% Styrofoam due to the staffing in the kitchen. There is no one here that can wash over 100 plates and silverware for each meal. A review of the kitchen schedule for the evening shift on 4/6/22 revealed one cook and a Dish room aide were scheduled to work. A carts aide was not scheduled to work on 4/6/22. Observation on 4/6/22 at 5:00 p.m., staff were observed in the kitchen plating the dinner meal. Further observation revealed [NAME] JJ and CDM GG were working in the kitchen. In addition, Housekeeper II, and Laundry Aide (LA) HH were present working in the kitchen in place of the dietary aides. Continued observation at 5:03 p.m., revealed dinner was being served in a 3-compartment clam shell Styrofoam container with a pre-packaged plastic cutlery set. During an interview at 5:07 p.m. on 4/6/22, [NAME] JJ revealed it was easier for kitchen staff to use to-go containers; otherwise, they would be working until after 10:00 p.m. washing dishes because there were only two kitchen staff. During an interview on 4/6/22 at 5:23 p.m., [NAME] JJ revealed the staffing situation became worse about three months ago when a new business opened in town and the kitchen staff quit to go work there. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/6/22 at 5:42 p.m. [NAME] JJ and CDM GG revealed it was often only the two of them during the evening and while [NAME] JJ was plating food, the CDM had to take food carts to the resident units. During an interview on 4/8/22 at 12:42 p.m., the DON revealed the facility initially began using Styrofoam during the COVID-19 pandemic. The DON stated the goal was to have more staff apply to work in the kitchen and go back to what they were doing prior (referring to using china and flatware.) During an interview on 4/8/22 at 1:29 p.m., the Administrator revealed it was a convenience for the facility to use Styrofoam due to the low number of staff working in the kitchen. The Administrator stated they looked forward to the day when the facility would go back to using china and flatware.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 36174 Based on observations, interviews, and review of the facility policy titled, Meal Service, the facility failed to ensure food was served at palatable temperatures. This had the potential to affect 106 out of 110 residents served meals from the kitchen. Findings include: A facility policy titled, Meal Service, undated, revealed, The center will provide meals and hydration that conserve nutritive value, flavor, and appearance, and that are palatable, attractive, and a safe and appetizing temperature. During an interview on 4/5/22 at 12:07 p.m., Resident (R) #38, who was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13, stated that breakfast was ice cold that morning. During an interview on 4/5/22 at 12:12 p.m., R#34, who was cognitively intact with a BIMS score of 13, stated that the food was sometimes cold, mainly at dinner. During an interview on 4/5/22 at 12:17p.m., R#55, who was moderately cognitively impaired with a BIMS score of 9, stated that the food was sometimes cold. During an interview on 4/5/22 at 3:47 p.m., R#207, who was cognitively intact with a BIMS score of 15, stated the food was always cold. During concurrent observations and interviews in the kitchen and on the 100 Hallway on 4/6/22 between 5:42 p.m. and 6:32p.m., a test tray was prepared, followed, and temped. The 100 Hallway was the last hallway to be served. The facility was serving their meals using a 3-compartment clam shell lid Styrofoam container. Dinner was a cream-based tortellini soup and a biscuit. On the steam table at 5:42 p.m., the soup was 168 degrees Fahrenheit (F). The test tray was plated by [NAME] JJ at 5:56 p.m., and the temperature was 158.5 degrees F. This was the first tray to be loaded onto the 100 Hallway cart. Twenty-two residents lived on the 100 Hallway. All other trays were plated, and the cart left the kitchen at 6:12 p.m. The cart arrived on the 100 Hallway at 6:16 p.m. Trays started getting passed to the residents at 6:20 p.m. With four trays left on the cart for those who were awaiting assistance with dining, the test tray was pulled from the cart, and at 6:32 p.m., the temperature of the tortellini soup was 120 degrees F. Certified Dietary Manager (CDM) GG was present during the observation and stated the food was palatable, but not hot. CDM GG stated hot food was supposed to be served at 135 degrees F or higher. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent observations and interviews in the kitchen and on the 100 Hallway on 4/7/22 between 12:25 p.m. and 12:57 p.m., a test tray was prepared, followed, and temped. The 100 Hallway was the last hallway to be served. The facility was serving fried chicken, steamed carrots, steamed broccoli, and cheesecake for dessert. The test tray was plated by [NAME] JJ at 12:26 p.m., and the temperatures were as follows: fried chicken was 178 degrees F, steamed carrots were 176 degrees F, steamed broccoli was 146 degrees F, and the cheesecake was 37 degrees F. The cart with the test tray left the kitchen at 12:40 p.m. The last tray off the cart on the 100 Hallway was at 12:57 p.m. The test tray temperatures were obtained as follows: fried chicken was 133 degrees F, steamed carrots were 127 degrees F, broccoli was 102.7 degrees F, and the cheesecake was 54.5 degrees F. Regional Certified Dietary Manager (RCDM) AAA was present during the observation and stated the food was not served at proper temperatures. The hot food should be served at 135 degrees or higher and the cold food should be served at 41 degrees F or lower.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 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. 36174 Based on observations, interviews, document reviews, review of Centers for Disease Control (CDC) guidelines, and review of the facility's policies, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 106 of 110 residents that received meals from the kitchen. Specifically, the facility failed to ensure proper hand hygiene practices were utilized during meal distribution, failed to ensure hot and cold foods were held and served at appropriate temperatures, failed to ensure cross contamination of ice from clothing, failed to ensure hair was covered in the food preparation area of the facility and failed to ensure food preparation equipment was properly maintained. Findings include: 1. Review of the facility policy titled, Food Preparation and Distribution, dated 2/2/03, revealed, It is the intent of this center to prepare and distribute food in a manner that minimizes the risk of food borne illnesses and promotes safe food handling practices. The policy further revealed good hand washing techniques should be practiced and gloves should be changed between tasks. A review of the training records revealed a training dated 1/6/20, titled, Hand Washing. The syllabus for the in-service training indicated hands and arms should be scrubbed vigorously for 10-15 seconds. This training did not meet the current guidelines. This was the last documented training for hand washing that was found. Review of the Techniques for Washing Hands with Soap and Water, retrieved from: https://www.cdc.gov/handhygiene/providers/index.html, dated 1/8/21, revealed the following: When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers; Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet; Avoid using hot water, to prevent drying of skin; Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds; Either time is acceptable. The focus should be on cleaning your hands at the right times. Observations in the facility kitchen on 4/6/22 from 5:00 p.m. until 6:12 p.m., revealed [NAME] JJ was plating the food on the tray line. She was using an 8-ounce scoop to plate the soup in a Styrofoam container and using her gloved hand to pick up a biscuit and place it in the container. At 5:18 p.m., [NAME] JJ was observed picking up a biscuit with her gloved hand, then adjusted her mask, touched her hair, and adjusted her hair net, picked up the temperature logbook and a pen, and was then carrying trays back to the tray line. She came back to the tray line where she resumed picking up biscuits with her gloved hand. [NAME] JJ did not remove and/or change her gloves or wash her hands. At 5:21 p.m., she left the tray line to bring back sandwiches from the walk-in cooler, still wearing the same gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation in the facility kitchen on 4/6/22 at 5:57 p.m., revealed Housekeeper II was helping in the kitchen and dropped her glasses on the kitchen floor. Observations further revealed she picked up her glasses and, without washing her hands, proceeded to bring food items back to the tray line. At 6:02 p.m., Housekeeper II was observed washing her hands for nine seconds. When throwing out the paper towel used to dry her hands, she dropped one of the paper towels on the floor. She picked up the paper towel off the floor, placed it in the trash, and did not wash her hands again. Further observations in the kitchen on 4/6/22 at 6:12 p.m. revealed [NAME] JJ was observed washing her hands for approximately 11 seconds. She stated she was trained to sing the Happy Birthday song two times while scrubbing her hands with soap. She stated she did not sing the Happy Birthday song, nor did she wash her hands for at least 25 seconds. . Concurrent observation and interview on 4/7/22 at 12:35 p.m., while in the kitchen, Regional Certified Dietary Manager (RCDM) AAA was observed washing his hands for seven seconds. When interviewed, he stated he thought he had washed his hands for 30-60 seconds. RCDM could not state how he was trained to wash his hands and was unable to produce evidence that he had attended hand-washing training. During an interview with [NAME] JJ on 4/6/22 at 5:21 p.m., revealed she did not realize how many things she had touched with her gloved hands and then returned to the tray line and touched the biscuits with the same gloved hand. She then proceeded to remove her gloves, wash her hands, and don a new pair of gloves. Certified Dietary Manager (CDM) GG provided [NAME] JJ with tongs to use to pick up the biscuits. During an interview on 4/6/22 at 6:02 p.m. Housekeeper II revealed she was not sure but thought she was supposed to wash her hands for about 15 seconds. She stated she touched the clean part of the paper towel when she picked it up off the floor and that her hands were clean. During an interview on 4/8/22 at 5:03 p.m., with Regional Nurse (RRN) LL and Assistant Director of Nursing (ADON) WW, RRN LL stated any handwashing training the dietary staff received should be in their individual transcript from the facility online training system. ADON LL stated personal protective equipment (PPE) training should have been assigned to all employees in their online training system and the PPE training included handwashing. A review of the transcripts provided, and the facility in-person training records indicated the last time the kitchen had received a designated hand-washing training was on 1/6/20. 2. The facility policy titled, Food Preparation and Distribution, dated 2/2/03, revealed, It is the intent of the center to prepare and distribute food in a manner that minimizes the risk of food borne illness and promotes safe food handling practices. Tray line: Hot foods should be held at [greater than or equal to] 135 [degrees] F [Fahrenheit]; Cold food should be held at [less than or equal to] 41 [degrees] F. Corrective Action: Hot items should be pulled from the tray line and re-heated until an internal temperature of 165 [degrees] F for 15 seconds is reached. Items should be re-checked, and proper temperature verified before beginning to serve. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations in the kitchen on 4/6/22 at 5:00 p.m., the temperature log was reviewed for the dinner meal. The dessert was an ambrosia salad and the temperature of the salad had not been checked. Interview with CDM GG at the time of the observation stated she did not understand why the cold dessert needed to be temped when it came straight out of the cooler. An observation revealed four trays of ambrosia salad were on a rack near the tray line. At 5:13 p.m., CDM GG checked the temperature of the ambrosia salad, and it was 44 degrees F. The trays were returned to the cooler. She confirmed that one of the ingredients of the ambrosia salad was whipped cream and should be refrigerated and maintained below 41 degrees F. Concurrent observation and interview on 4/6/22 at 5:40 p.m. in the kitchen, revealed cold deli sandwiches were being placed on top of a resident's Styrofoam lid and then placed in the insulated meal cart. The temperature of the sandwiches was not checked when they were removed from the cooler or prior to being placed on the tray line. Interview with CDM GG on 4/6/22 at 5:40 p.m., revealed she could not explain how she would ensure the cold deli sandwiches would be served at 41 degrees or below. She stated that would be up to the staff on the units to get the trays passed as soon as possible. During concurrent observations and interviews in the kitchen and on the 100 Hallway on 4/6/22 between 5:42 p.m. and 6:32p.m., a test tray was prepared, followed, and temped. The 100 Hallway was the last hallway to be served. The facility was serving their meals using a 3-compartment clam shell lid Styrofoam container. Dinner was a cream-based tortellini soup and a biscuit. On the steam table at 5:42 p.m., the soup was 168 degrees Fahrenheit (F). The test tray was plated by [NAME] JJ at 5:56 p.m., and the temperature was 158.5 degrees F. This was the first tray to be loaded onto the 100 Hallway cart. Twenty-two residents lived on the 100 Hallway. All other trays were plated, and the cart left the kitchen at 6:12 p.m. The cart arrived on the 100 Hallway at 6:16 p.m. Trays started getting passed to the residents at 6:20 p.m. With four trays left on the cart for those who were awaiting assistance with dining, the test tray was pulled from the cart, and at 6:32 p.m., the temperature of the tortellini soup was 120 degrees F. Certified Dietary Manager (CDM) GG was present during the observation and stated the food was palatable, but not hot. CDM GG stated hot food was supposed to be served at 135 degrees F or higher. During concurrent observations and interviews in the kitchen and on the 100 Hallway on 4/7/22 between 12:25 p.m. and 12:57 p.m., a test tray was prepared, followed, and temped. The 100 Hallway was the last hallway to be served. The facility was serving fried chicken, steamed carrots, steamed broccoli, and cheesecake for dessert. The test tray was plated by [NAME] JJ at 12:26 p.m., and the temperatures were as follows: fried chicken was 178 degrees F, steamed carrots were 176 degrees F, steamed broccoli was 146 degrees F, and the cheesecake was 37 degrees F. The cart with the test tray left the kitchen at 12:40 p.m. The last tray off the cart on the 100 Hallway was at 12:57 p.m. The test tray temperatures were obtained as follows: fried chicken was 133 degrees F, steamed carrots were 127 degrees F, broccoli was 102.7 degrees F, and the cheesecake was 54.5 degrees F. During an interview on 4/7/22 at 12:25 p.m. with Regional Certified Dietary Manager (RCDM) AAA, revealed it was his expectation for the hot food to be served at 135 degrees F and the cold food to be served at 41 degrees F or below. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Concurrent observation and interview on 4/7/22 at 12:25 p.m. in the kitchen, four trays of cheesecake were observed on a rack and not on ice or refrigerated during preparation of the meal. During an interview on 4/7/22 at 12:25 p.m., RCDM revealed that only one tray should be removed from the cooler at a time, and they should not use it if it went above 41 degrees F. Continued observation of the test tray on 4/7/22, revealed the cheesecake dessert was 37 degrees F when it was plated and when the temperature was checked for service, it was 54.5 degrees F. During an interview on 4/8/22 at 12:42 p.m., the Director of Nursing (DON) confirmed the kitchen started using the all-disposable trays (clam shell Styrofoam boxes, prepackaged cutlery, Styrofoam cups, and Styrofoam bowls) during the COVID-19 pandemic. She stated it was her expectation that when the tray carts arrived on the floors it was an all hands-on deck situation, and trays were to be passed as soon as possible to keep the food hot. 3. Observation on 4/6/22 at 6:00 p.m., revealed Laundry Aide (LA) HH was assisting in the kitchen. She was asked to fill up four Styrofoam cups with ice and iced tea. She was wearing a large baggy sweatshirt and the sleeve came below her wrists. LA HH was observed scooping ice into the four cups. Each time she put the scoop down into the ice chest, the sleeve from her sweatshirt was also touching the ice. During an interview on 4/6/22 at 6:00 p.m., CDM GG stated the laundry and housekeeping staff who were helping had not been specifically trained for duties in the kitchen. The facility was unable to produce a policy regarding the handling of ice. 4. Review of the policy titled, Personal Appearance and Conduct, not dated, revealed, A hairnet and/or beard restraint should be worn while in the food prep, production and serving areas. Concurrent observation and interview in the kitchen on 4/7/22 at 12:33 p.m., revealed Dietary Aide (DA) DDD was assembling the trays for the lunch tray line. She was wearing her hair in a bun on top of her head. DA DDD had whisps of hair that came down over the back of her neck, ears, and face that were not covered by a hair net. DA DDD was wearing a hair net that only covered the bun part of her hair. The additional whisps of hair were all exposed from under the hair net. Interview with the RCDM at this time, revealed he did not even notice that her hair was not all up in the hairnet. A review of the in-service completed on 4/6/22 indicated DA DDD had attended and signed off on an in-service titled, Personal Hygiene. On the syllabus of the in-service, it indicated, #3 Hair Restraints: all associates should always wear a clean hat or hair restraint when in the kitchen and all hair including bangs, must be underneath the hat if all hair isn't restrained. This in-service was taught by the RCDM. 5. Review of the policy titled, Food, Supply, and Equipment Purchasing and Maintenance, dated 2/2/09, revealed, It is the intent of the center to have the necessary food, supplies, and equipment available for patient meal service. Organization approved reputable vendors will be utilized for food and supply ordering. Small wares and capital equipment will be coordinated by the center, with assistance provided by organizational support staff, as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observations during the initial tour of the kitchen, on 4/5/22 at 9:30 a.m., revealed cutting boards on a storage rack. There were two red cutting boards with gouges and worn areas in the center of the board so that it was no longer red, two green cutting boards with gouges and worn areas in the center of the board so that it was no longer green, one blue cutting board with gouges and worn areas in the center of the board so that it was no longer blue, and one yellow cutting board with gouges and worn areas in the center of the board so that it was no longer yellow. During an interview with CDM GG on 4/5/22 at 9:30 a.m. revealed it was at least two years since the facility had ordered new cutting boards. CDM GG stated, My expectation is they [the cutting boards] would be replaced when they looked this rough.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 38514 Based on observations, interviews, and review of the facility policies Personal Protective Equipment PPE and COVID-19 Visitation Guidelines, the facility failed to ensure that staff wore masks appropriately. Seven staff members were not wearing a mask appropriately covering the nose and mouth. This failure had the potential to affect all residents. Findings include: Review of the facility policy titled Personal Protective Equipment (PPE), updated February 2022, revealed, PPE should be used in accordance with infection prevention guidelines. Review of the facility policy titled COVID-19 Visitation Guidelines, updated February 2022, revealed, Core Principles of COVID-19 Infection Prevention: 3. Face covering or mask (covering mouth and nose). 1. Observation on 4/5/22 at 8:30 a.m. while entering the facility, all surveyors were screened by Secretary SS. She wore a surgical mask under their nose and mouth throughout the entire screening process. Observation on 4/5/22 at 11:57 a.m. Secretary SS was at the front desk screening staff and visitors as they entered. Her surgical mask was noted to be under their nose and mouth while screening people into the building. During an interview conducted on 4/5/22 at 12:56 p.m., Secretary SS stated that they had received training on how to wear a mask properly. She also stated that she had allergies and suffered facial skin breakouts from the mask. Secretary SS did place the surgical mask over their nose and mouth after being questioned about the mask. 2. Observation on 4/5/22 at 11:54 a.m. Environmental Services (EVS) QQ was walking down the 400 Hallway on the first floor to give an item to another staff member. She was seen with a KN95 mask being worn under her nose, only covering their mouth. During an interview on 4/5/22 at 11:54 a.m., EVS QQ acknowledged that she was not wearing her mask correctly. She confirmed the facility had instructed them how to wear a mask properly. EVS QQ apologized and placed her mask over her nose. 3. During a concurrent observation and interview on 4/5/22 at 1:04 p.m., Registered Nurse (RN) RR was observed for two full minutes, standing at the medication cart in the hallway with her N95 mask resting below her nose. RN RR stated that she was drinking water and forgot to pull her mask back into position. She then placed her mask in the correct position after the interview. Observation on 4/5/22 at 3:55 p.m., revealed RN RR was in the hallway near the nursing station with an N95 mask below their nose. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Observation on 4/5/22 at 11:35 a.m., revealed Certified Nursing Assistant (CNA) AA walking down the 100 Hallway with a child. Neither CNA AA nor the child were wearing a mask. During an interview conducted on 4/5/22 at 11:35 a.m., CNA AA, stated she had just returned from lunch and forgot to get a mask. 5. Observation on 4/7/22 at 5:30 a.m., Licensed Practical Nurse (LPN) DD was in the hallway at the medication cart preparing medications for administration and was not wearing a mask. There was a mask sitting on top of the medication cart. Further observation of LPN DD on 4/7/22 at 5:38 a.m., revealed she was still working at the medication cart and was not wearing a mask. During an interview on 4/7/22 at 5:38 a.m., LPN DD stated they just removed their mask to get some air. 6. During an observation on 4/7/22 at 5:58 a.m., LPN EE was sitting at the nurses' desk on the second floor and was not wearing a mask. When the surveyor approached the desk, LPN EE put the mask on over her nose and mouth. During an interview on 4/7/22 at 5:58 a.m. LPN EE revealed they had just returned from the bathroom and forgot to put their mask back on. 7. During an observation on 4/7/22 at 9:11 a.m., LPN FF was sitting at the nurses' desk on the second floor wearing a face shield and an N95 mask below her chin. When the surveyor walked up to the desk, she pulled the mask over their nose. During an interview on 4/7/22 at 9:11 a.m. LPN FF revealed they had trouble breathing and was claustrophobic. She stated she removed the mask for a minute or two to catch their breath. During an interview on 4/8/22 at 11:33 a.m. the Director of Nursing (DON) revealed their expectations were that all staff should wear masks properly and the mask should cover the nose and mouth. She stated all staff, including EVS and dietary personnel, were to wear masks. The DON stated that in-servicing was provided often regarding the proper way to wear masks. During an interview on 4/8/22 at 1:24 p.m., the Administrator revealed that the expectation was that all staff were to wear masks. The Administrator stated there were no exceptions for staff wearing masks. When asked what the correct way to wear a mask was, the Administrator stated masks should always be worn by staff and should be over the nose and mouth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43017 Based on record review, interviews, and review of the facility policy titled, Pharmacy Services - Antimicrobial Stewardship Program Center Mission and Commitment Statement, the facility failed to implement antibiotic use protocols related the Antibiotic Stewardship Program for one resident (R) #101, of six sampled residents whose clinical records were reviewed for the use of unnecessary medications. Specially, R#101 had an order for antibiotics to be administered; however, the facility failed determine if antibiotics were necessary for the resident prior to beginning antibiotics. Findings include: Review of the facility policy titled, Pharmacy Services - Antimicrobial Stewardship Program Center Mission and Commitment Statement, dated 2019, revealed, We are committed to the prudent use of antimicrobials on behalf of all patients we serve through a sustainable antimicrobial stewardship program. We will fuel the day-to-day needs of the program by supporting our physicians, nurses, and pharmacists, and we will ensure they have the time, tools, staff, budget, and education necessary to promote the safe and appropriate use of antibiotics with the goal of decreasing utilization and antibiotic resistance. Review of the Face Sheet revealed R#101 had diagnoses that included peripheral venous insufficiency, dementia, and chronic atrial fibrillation. Review of the quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident had a Brief Interview for Mental Status (BIMS) score of 6, indicating the resident had severe cognitive impairment. The MDS further revealed the resident required extensive assistance of two staff for toileting and was occasionally incontinent of bladder and frequently incontinent of bowel. A Nurse's Progress Note, dated 3/22/22 at 12:16 p.m., indicated the resident had been complaining of back pain. The resident had three episodes of vomiting and was complaining of pain when urinating. A urinalysis (UA) was collected by clean catch, using aseptic technique. The physician and family were notified. They were awaiting results. The resident's vital sign records, dated between 3/22/22 and 4/5/22, indicated the resident's temperatures were within the base line range of 97.2- and 98.6-degrees Fahrenheit (F), with one exception. On 3/22/22 at 9:26 p.m., the resident's temperature was 99.1 degrees F. A urine analysis result, dated 3/25/22, indicated the resident's urine contained Leukocytes 3+, bacteria 2+, and the culture growth indicated Escherichia coli (E. coli) greater than 100,000. A handwritten note at the bottom of the page indicated no ABT [antibiotic] ordered and there was no date on the note. Also, another handwritten note at the bottom of the page revealed a note ordering Keflex (an antibiotic) 500 milligrams (mg), to be administered three times a day, orally, for five days. There was no date on the note. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. Building B. Wing	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Health and Rehabilitation	100 Medical Center Drive Commerce, GA 30529

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record contained no additional documentation the facility had continued to assess the resident for signs and symptoms of a urinary tract infection (UTI) between 3/22/22 and 4/5/22. There was no indication the resident had continued to complain of painful urination or had run an elevated temperature. There was no evidence in the record that an Infection Report Form - Urinary Tract Infections form was completed. A Nurse's Progress Note, dated 4/5/22 at 9:48 a.m., indicated the facility started the resident on Keflex (antibiotic or antimicrobial medication) for a urinary tract infection (UTI). During an interview on 4/7/22 at 9:33 a.m., R#101 denied having bladder pain or the need for an antibiotic. During an interview on 4/8/22 at 10:54 a.m., the Administrator revealed that the nurses did not determine if a resident needed to be placed on antibiotic therapy; the physician did that. She was asked if the facility had some guidelines or utilized an algorithm to help determine if a resident should be treated with an antibiotic. The Administrator stated that the facility did not have guidelines, or an algorithm and that the physician determined whether a resident needed antibiotics or not. She stated the reason the resident was not started on antibiotics until 4/5/22 was because the physician wanted to see the resident before starting antibiotics. She was asked why the physician had ordered antibiotics. She stated she did not know. During an interview on 4/8/22 at 12:41p.m., the Director of Nurses (DON) and the Assistant Director of Nurses (ADON) were asked about the facility's Antibiotic Stewardship Program. They were asked what signs and symptoms R#101 had exhibited on 3/22/22 through 4/5/22 that would warrant the use of an antibiotic. The DON stated the resident complained of painful urination on 3/22/22 so a clean catch UA was obtained. The ADON stated the nurse would assess the resident and fill out a facility Infection Report Form - Urinary Tract Infection form that had an algorithm to help determine if the resident should receive an antibiotic. She was asked if the form was part of the facility's Antibiotic Stewardship Program. The ADON stated it was. She was asked if the facility had completed the assessment form for R#101 on 3/22/22 or at any other time before starting the resident on the antibiotic. They did not answer. They were asked to provide any information related to an assessment for the need for an antibiotic for R#101; however, no information was provided prior to exit. During the same interview, the DON was asked why the physician had ordered antibiotics for the resident on 4/5/22. She stated it was for a UTI. She was asked what information the facility had provided to the physician about the resident's symptoms. She stated she did not know. She was asked who determined the resident should be administered an antibiotic. She stated the physician determined that. During an interview on 4/8/22 at 3:47 p.m., the Infection Control Preventionist Licensed Practical Nurse stated he was not directly involved in deciding if a resident met the criteria to receive antibiotics. He stated, I don't know if the nurses are filling out the UTI infection Control Criteria Form or any other antibiotic stewardship form. I just review the labs and physician orders for antibiotics at the end of the month and provide the information to the DON.