

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115022	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER William Breman Jewish Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE 3150 Howell Mill Road N.W. Atlanta, GA 30327	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of facility's policy titled, Advanced Directives, the facility did not properly maintain record of and the correct orders for one of 47 sampled residents (R) (R12) related to Advanced Directive choice. The deficient practice had the potential to result in the residents' wishes not being honored in the event of a medical emergency or end-of-life situation.</p> <p>Findings include:</p> <p>A review of the facility's policy titled Advanced Directives revealed under the section titled Policy Statement: Advanced Directives will be respected in accordance with the state law and facility policy. Under the section titled Policy Interpretation and Implementation revealed: Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the electronic medical record. a. Residents electronic medical record, including advanced directives must be audited on a quarterly basis. b. If the resident has a Do Not Resuscitate directive, it must be displayed at the front of the resident Chart.</p> <p>Review of the electronic health record (EHR) for R12 revealed he was admitted to the facility with diagnoses including but not limited to dementia, psychotic and mood disturbance, chronic lymphocytic leukemia of B-Cell type in remission, and major depressive disorder.</p> <p>Review of R12's quarterly Minimum Data Set (MDS) dated [DATE] documented in section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 14, indicating R12 was cognitively intact.</p> <p>Review of the R12's EHR profile revealed he had an advanced directive for Cardiopulmonary Resuscitation (CPR).</p> <p>Further review revealed the following documents related to Advance Directives:</p> <p>[DATE]: Advance Directives - Do Not Resuscitate (DNR) Physician Orders for Life-Sustaining Treatment (POLST)</p> <p>[DATE]: Advance Directive and DNR Order</p> <p>[DATE]: Advance Directive</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R12's EHR revealed a Physician Order for Advanced Directive: CPR with an order date of [DATE]. On [DATE] at 01:09 pm, RN (Registered Nurse) AA confirmed that she created the order.</p> <p>An interview conducted on [DATE] at 1:09 pm with RN AA, she stated that typically the Social Worker provided the POLST forms, uploaded them, and sent a message to the nursing team. Once the information was received, they created an order in their EHR system for the physician to sign. RN AA explained that when patients were transferred from the hospital, they initially came in as a full code. The facility updated the code status as needed. RN AA acknowledged that she forgot to update the code status from CPR to DNR in this instance, taking full responsibility for the oversight. RN AA stated that this was a mistake and should not have happened. RN AA stated a potential negative outcome was that the resident's wishes could be disregarded, such as performing CPR against their DNR order.</p> <p>An observation and interview were conducted on [DATE] at 9:17 am with the Director of Nursing (DON) and revealed that Social Services typically communicated with the family to complete the POLST form, which was then forwarded to the nursing team for entry into the EHR system. The DON reviewed the incorrect advanced directive orders and confirmed that the information should be entered accurately according to the orders. The DON stated that a potential negative outcome could be resuscitating a patient who does not wish to be resuscitated, which would go against their expressed wishes.</p> <p>An interview on [DATE] at 9:26 am with the Administrator, she emphasized that her team's protocol was to obtain a copy of the patient's POLST form, determine the patient's wishes, and ensure the appropriate orders (DNR or full code) were entered into the chart and profile. The Administrator stated that the goal was to ensure the patient's wishes were honored, and that a negative outcome could occur if the orders were not accurately followed, potentially resulting in actions that did not align with the patient's preferences.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observations, record review, staff interview, and review of the facility policy titled, Medication Administration, the facility failed to ensure the medication error rate was less than five percent (%). There were three medication errors of 30 opportunities made by two of four nurses for a medication error rate of 10 %.</p> <p>Findings include:</p> <p>Observation on 12/11/2024 at 9:37 am with Licensed Practical Nurse (LPN) BB during medication administration for Resident (R) (R50) morning medications revealed R50 had several medication in the prefilled pharmacy pouch which included acetaminophen 650 mg (milligrams) one tab and aspirin 81 mg. LPN BB proceeded to take two 325 mg acetaminophen and one aspirin 81 mg from the floor stock medication drawer and placed them in the medication cup. LPN BB proceeded and attempted to administer the incorrect medications before intervention by the surveyor. This action resulted in two medication errors.</p> <p>Review of the December 2024 Physician Orders for R50 revealed to administer aspirin 81 mg daily and acetaminophen 650 mg daily.</p> <p>During an interview on 12/11/2024 at 10:00 am with LPN BB, she reviewed the order for the acetaminophen 650 mg and aspirin 81 mg and verified the order stated R50 should receive aspirin 81 mg and acetaminophen 650 mg daily. LPN BB confirmed that there were three extra pills in the medication cup.</p> <p>Observation on 12/12/2024 at 9:19 am of LPN DD giving R19 his morning medications revealed LPN DD giving vitamin C 500 mg daily. Vitamin C was already in the prefilled medication pouch when LPN DD pulled another vitamin C from the floor stock medications. LPN DD proceeded to attempt to administer the vitamin C to R19 until the surveyor intervened.</p> <p>Review of the December 2024 Physician Orders for R19 revealed a medication order for vitamin C 500 mg daily.</p> <p>An interview on 12/12/2024 at 9:45 am with LPN DD, she verified that she had too many pills in the medication cup. LPN DD confirmed that she had one too many vitamin C tablets in the medication cup.</p> <p>An interview on 12/12/2024 at 9:50 am with the Administrator and the Director of Nursing (DON) revealed their expectations were that medication would be given according to physician's orders. They expect staff to abide by the five rights of medications. They also expect nurses to compare what was in the prefilled medications to the Medication Administration Record (MAR) before administering medications.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interviews, and review of facility's policies titled, Food Storage, Date and Label, and Cleaning Instructions: Ice Machine and Equipment, the facility failed to ensure proper food labeling, dating, and storage in the reach in cooler, failed to discard dry storage food items by the expiration date, and failed to maintain sanitary condition of the ice machine. The facility census was 85 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled Food Storage dated August 2021 revealed in section Refrigerated food storage: F. All foods should be covered, labeled, and dated. All foods will be checked to ensure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded.</p> <p>Review of the facility policy titled Date and Label dated March 2024 revealed in section Dry Storage: 7. Discard food that has expired or passed the used by date.</p> <p>Review of the facility policy titled Cleaning Instructions: Ice Machine and Equipment dated August 2021, revealed the purpose to ensure that ice machine and equipment (scoops and receptacles that are used to hold or transport ice) will be cleaned and sanitized on a regular basis. Procedures explained: 2. Wash the interior thoroughly using a detergent solution. Rinse and drain the interior with clean hot tap water. 6. Clean the exterior of the machine with detergent solution daily. Rinse and allow to air dry. Clean the area underneath and around the machine.</p> <p>Observation on 12/10/2024 at 9:45 am during the initial kitchen tour with the Chef/Dietary Manager (DM) revealed the following:</p> <p>Uncleaned ice machine with brown/red like substance found inside.</p> <p>Three fruit cups of yellow sliced peaches found in the cooler, unwrapped and not labeled or dated.</p> <p>Two one-gallon pitchers of brown liquid found in the cooler, not labeled or dated.</p> <p>A one-gallon pitcher of orange liquid found in the cooler, not labeled or dated.</p> <p>Ten single serving condiment cup/with lids found in the cooler, not labeled or dated.</p> <p>One wrapped plate with assorted fruits and a scoop of white like substance in center of the assortment found in the cooler, not labeled or dated.</p> <p>Three packages of 24 count flour tortillas found in dry storage were expired.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 12/12/2024 at 1:05 pm with Dietary Supervisor/Cook HH revealed he followed procedure, checked temperatures, cleaned, conducted labeling/dating, cooked food, or whatever the resident needed. Dietary Supervisor HH confirmed labeling and dating was everyone's responsibility, but supervisors did a walk through to catch errors. Dietary Supervisor HH confirmed maintenance was responsible for cleaning the ice machine.</p> <p>Interview on 12/12/2024 at 1:55 pm with Facility Tech II revealed her kitchen responsibilities included cleaning vents, painting, fixing leaks, making sure hot water comes through, drainage, etc. Facility Tech II mentioned she also cleaned the ice machine which was usually cleaned on the first of every month or within the first week of the month. Facility Tech II explained how she would clean the ice machine by taking all the ice out, using chemicals, wiped the inside/outside boarder and seals, and discarded the first batch of ice. Facility Tech II confirmed she cleaned the ice machine this Tuesday and in November, but probably did not get into those seals properly, maybe due to rushing.</p> <p>Interview on 12/12/2024 at 2:20 pm with DM revealed he checked for products with labeling/dating every day after the supervisor. The DM confirmed the labeling/dating/expiration of food items identified during the survey and shared that one of the servers was responsible for the reach in refrigerator items.</p>