| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115542 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/02/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Sadie G. Mays Health & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1821 Anderson Avenue NW Atlanta, GA 30314 | |

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

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>Based on observation, record review, and interview, the facility failed to maintain the dignity of one out of 21 Resident (R) (R14) reviewed in the sample. Specifically, the facility did not have any urinary drainage bags available and R14 was placed in an adult incontinence brief. This had the potential for the resident to have a diminished quality of life. Findings include:Review of R14 Medical Diagnoses located in the electronic medical record (EMR) tab titled Medical Diagnosis revealed the resident was admitted to the facility with diagnoses that included cerebral infarction (stroke) with left sided hemiplegia and hemiparesis, and chronic kidney disease stage three.Review of R14's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/10/2025 located in EMR tab titled MDS revealed the resident has a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. The resident was dependent on staff for all activities of daily living (ADLs). The resident was incontinent of the bladder and bowel and wore an external catheter.Review of R14's physician's Orders dated 6/24/2025 located in the EMR tab titled Orders revealed the resident was to wear condom catheter and change daily and monitor skin for changes.During an interview on 6/30/2025 10:18 am with R14 revealed he had complained several times about wearing the adult incontinence brief; that he did not like having that wetness next to his skin which could cause his skin to break down. R14 stated that the physician had left orders for him to wear a condom catheter with a drainage bag. R14 stated that the facility did not have any large urinary drainage bags, only the leg bags. The resident stated the leg bags were not good enough in that urine would back up and cause the condom to leak. R14 further stated that wearing the adult incontinence brief made him feel like he was a baby.During an interview on 7/1/2025 at 8:45 am Licensed Practical Nurse (LPN)4 revealed at one time the facility was out of urinary drainage bags but was unsure if there was still a shortage of drainage bags.During an observation and interview on 7/1/2025 at 11:45 am revealed Certified Nursing Assistant (CNA)4 had finished providing R14's morning care. R14 was observed wearing an adult incontinence brief. CNA4 revealed the facility was out of urinary drainage bags and she did not know when the next supply was to be delivered.During an interview on 7/1/2025 at 1:00 pm the Central Supplier and Scheduler (CSS) revealed the facility was running low urinary drainage bag in fact she only had the leg drainage bag available. CSS stated that she was just made aware of the situation with R14 and had applied a condom catheter with a leg drainage bag. CSS stated that the new delivery was due later today and she would change the leg drainage bag to a bedside drainage bag. CSS stated there was no reason why the resident had to wait that long for urinary drainage bag. |

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 |
|---|---|---|

Printed: 03/16/2026
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No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 115542 | A. Building<br>B. Wing | 07/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Sadie G. Mays Health & Rehabilitation Center | 1821 Anderson Avenue NW<br>Atlanta, GA 30314 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on staff interview, record review, and review of the facility's policy titled, Administering Medications, the facility failed to ensure the provider and the resident representative were notified when seven out of 21 sampled Residents (R1, R2, R3, R4, R5, R6, and R7) were not administered their medications, as ordered by the provider. This failure placed the provider and the resident's representatives of potential complications from not receiving their medications.Findings include:Review of the facility's policy titled, Administering Medications, dated 2001 revealed, .Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including any required time frame.1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R1 was admitted to the facility with diagnoses that included stroke, diabetes, end-stage renal disease (ESRD) and was dependent on dialysis.Review of the December 2024 Medication Administration Record (MAR) located in the Orders tab of the EMR revealed the following prescribed medications were not documented as administered on 12/26/2025, as ordered:Phenytoin Sodium Extended Capsule 100mg [milligrams] Give 2 capsules by mouth every 12 hours for seizures.Atorvastatin 40 mg. Give 1 tablet by mouth in the evening for hypercholesterolemia [high cholesterol].Buspirone 10mg. Give 1 tablet by mouth two times a day for anxiety.Carvedilol 2025mg. Give 1 tablet by mouth two times a day for hypertension [elevated blood pressure].Clonidine 0.2mg. Give 1 tablet by mouth two times a day for hypertension. Divalproex 500mg. Give 1 tablet by mouth two times a day for behaviors.Eliquis 5mg. Give 1 tablet by mouth every 12 hours for deep vein thrombosis [blood clot prevention].Trazadone 50mg. Give 1 tablet by mouth at bedtime for insomnia.Spironolactone 25mg. Give 1 tablet by mouth at bedtime for hypertension.Hydralazine 100mg. Give 1 capsule by mouth every 8 hours for hypertension.There was no documentation to show that R1's provider and resident representative were notified of the medications that were not administered.2. Review of the admission Record located in the Profile tab of the EMR revealed R2 was admitted to the facility with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) and chronic pain syndrome.Review of the December 2024 MAR located in the Orders tab of the EMR revealed the following prescribed medication that was not administered on 12/26/2024, as ordered:Gabapentin 100mg. Give 1 capsule by mouth three times a day for chronic pain syndrome.There was no documentation to show that R2's provider and resident representative were notified of the medication that was not administered.3. Review of the admission Record located in the Profile tab of the EMR revealed R3 was admitted to the facility with diagnoses that included COPD, and arthritis.Review of the December 2024 MAR located in the Orders tab of the EMR revealed the following prescribed medications that were not administered on 12/26/2024, as ordered:Famotidine 40mg. Give 1 tablet by mouth at bedtime for acid indigestion.Pravastatin 40mg. Give 1 tablet by mouth at bedtime for increased lipids.There was no documentation to show that R3's provider and resident representative were notified of the medications that were not administered.4. Review of the admission Record located in the Profile tab of the EMR revealed, R4 was admitted to the facility with diagnoses that included cancer, a stroke, and diabetes.Review of the December 2024 MAR located in the Orders tab of the EMR revealed the following prescribed medications that were not administered on 12/26/2024, as ordered:Atorvastatin 80mg. Give 1 tablet by mouth at bedtime for high cholesterol.Carvedilol 12.5mg. Give 1 tablet by mouth every 12 hours for high blood pressure.Tamsulosin 0.4mg. Give 1 capsule by mouth at bedtime for prostate.There was no documentation to show that R4's provider and resident representative were notified of the medications that were not administered.5. Review of the admission Record located in the Profile tab of the EMR revealed R5 was admitted to the facility with diagnoses that included a stroke and depression.Review of the December 2024 MAR located in the Orders tab of the EMR revealed the following prescribed medications that were not administered on 12/26/2024, as ordered. Atorvastatin 10mg. Give 1 tablet by mouth at bedtime for hyperlipidemia [increased lipids].Duloxetine 60mg. Give 1 capsule by mouth at bedtime for depression.There was no documentation to show that R5's provider and resident representative were notified of the medications that were not administered.6. Review of the admission Record located in the Profile tab of the EMR revealed R6 was admitted to the facility with a diagnosis of Alzheimer's dementia.Review of the December 2024 MAR located in the Orders tab of the EMR revealed the following prescribed medication that was not administered on 12/26/2024:Levetiracetam 750 mg. Give 1 tablet twice daily for seizures.There was no documentation to show that R6's provider and resident representative were notified of the medication that was not administered.7. Review of the admission |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on record review, resident and staff interviews, and review of the facility’s policy titled, “Policy and Procedure, the facility failed to timely report allegations of abuse to the required agencies and physician within the state reporting time frame for two of 21 sampled Residents (R) (R12 and R9). This failure has the potential to increase the risk of abuse.<br><br>Findings include:<br><br>Review of the facility’s undated policy titled “Policy and Procedure revealed Abuse and Neglect” directs staff as follows: “…. Notify the shift supervisor immediately upon identification of actual or suspected abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of resident property… Report the incident to the Director of Nursing and Administrator immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury… Report the incident to the State Agency and the adult protective services immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury per the guidelines established in the state reporting guidelines and any other required agency, including the Ombudsman and local law enforcement as required by law…”<br><br>1.Record review of R12’s “Medical Diagnoses” sheet located in the electronic medical record (EMR) tab titled “Medical Diagnoses” revealed the resident admitted to the facility with diagnoses that included but not limited to metabolic encephalopathy, end stage renal disease with dialysis, major depressive disorder, and anxiety disorder.<br><br>Review of R12’s annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/4/2025 located in the EMR tab titled MDS revealed the resident had Brief Interview for Mental Status (BIMS) score of 10 out of 15 points which indicated the resident had moderately impaired cognition.<br><br>Review of R12’s Nurses Notes dated 2/26/2025 located in the EMR tab titled “Progress Notes” revealed the facility received a call from the Director at the dialysis center stating the resident had voiced a concern about being abused by a staff member at the nursing home.<br><br>Review of the facility’s grievance form dated 2/26/2025 revealed R12 voiced concerns to the dialysis’s center staff that she was being abused at the facility by a day shift Certified Nursing Assistant (CNA) who put her hand near the resident’s vaginal area. The grievance form was forwarded to the Interim Director of Nursing (DON) for investigation.<br><br>Review of the facility’s “Incident Report” dated 2/26/2025 completed by the Interim DON revealed the report was completed on 2/27/2025. R12’s responsible party was notified of the incident. However, the local law enforcement and facility’s physician were not notified. The Day One report was submitted to the State Agency 24 hours after the incident was reported to the facility.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 7/1/2025 at 1:30 pm with the Infection Control Preventionist (IP) who was the Interim DON at the time of the incident, confirmed the local law enforcement agency and facility’s physician were not notified of the incident and the incident was not reported within the two-hour time frame. The IP stated the incident was identified as staff to resident abuse when the report was filed. The IP stated the Day One report was submitted on 2/27/2025.<br><br>During an interview with the current Administrator on 7/1/2025 at 10:35 am and after she reviewed the grievance investigation dated 2/26/2025 and the incident report dated 2/26/2025 completed by the Interim DON confirmed the incident was not reported timely to the appropriate agencies.<br><br>2. Review of the admission Record located in the Profile tab of the EMR revealed R9 was admitted to the facility with diagnoses that included vascular dementia, a stroke, and seizures.<br><br>Review of the quarterly MDS located in the MDS tab of the EMR with ARD of 6/13/2025 revealed R9 had a BIMS score of eight out of 15 which indicated R9 was moderately impaired in cognition.<br><br>During an interview on 7/2/2025 at 11:19 am, R9 was observed lying in bed awake. He was asked if anyone had abused him, physically. R9 stated, Yes. R9 was asked if he remembered when the abuse occurred. R9 stated, About six months ago. R9 was asked if he remembered who the person was who physically abused him. R9 stated, It was a lady, I did tell the nurse, I think she was let go.<br><br>Review of the 12/1/2024 through 2/1/2025 Nursing Progress Notes located in the Progress Notes tab of the EMR showed no documentation of an allegation of staff to resident physical abuse.<br><br>During an interview on 7/2/2025 at 1:00 pm, the Administrator stated, I reviewed the previous Administrator's records, and this allegation was on the reportable list, but there is no investigation that I can find. We don't even know if the allegation of physical abuse was actually sent to the State or not. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to conduct a thorough investigation of alleged abuse of two (Residents (R)12 and R9) out of 21 sampled residents. This failure had the potential to provide a safe environment for all residents against abuse.<br><br>Findings include:<br><br>A review of the facility’s undated policy titled “Policy and Procedure: Abuse and Neglect” revealed …An Accident/Incident Report will be initiated immediately upon identification of actual or suspected abuse, neglect, mistreatment, injuries of unknown origin, and/or misappropriation of resident property…The Administrator or designee will oversee the internal investigation…the investigative process includes but it not limited to the following: completed accident/incident report, witness statements, assessment of injuries, resident interviews, interview with the alleged perpetrator, interviews with staff, including those on duty at the time of the incident or those who may have significant information or contact with resident during the identified time frame….Abusive acts of sexual nature may warrant a thorough physical examination by the attending physician or an emergency room visit…The results of all investigations must be reported to the Administrator or his/her designee and to other officials, including state Agency, Adult Protective services (APS) and the local ombudsman, in accordance with State law within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken…<br><br>1.Record review of R12’s “Medical Diagnoses” sheet located in the electronic medical record (EMR) under the tab titled “Medical Diagnoses” revealed the resident was initially admitted to the facility with diagnoses that included but not limited to metabolic encephalopathy, end stage renal disease with dialysis, major depressive disorder, and anxiety disorder. The resident was discharged from the facility 4/29/2024<br><br>Review of R12’s annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/4/2025 located in the EMR tab titled MDS revealed the resident had Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident had moderately impaired cognition. The resident was dependent on staff for activities of daily living (ADLs) and on dialysis.<br><br>Review of R12’s Nurses Notes dated 2/26/2025 located in the EMR tab titled “Progress Notes” revealed the facility received a call from the Director at the dialysis center stating the resident had voiced a concern about being abused by a staff member at the nursing home.<br><br>Review of the facility’s grievance form provided by the facility dated 2/26/2025 revealed R12 voiced concerns to the dialysis’s center staff that she was being abused by a facility day shift Certified Nursing Assistant (CNA) who put her hand near the resident’s vaginal area. The grievance form was forwarded to the Interim Director of Nursing (DON) for investigation<br><br>Review of the facility’s “Incident Report” dated 2/26/2025 completed by the Interim DON revealed the report was completed on 2/27/2025. R12’s responsible party was notified of the incident. However, the local law enforcement and facility physician were not notified.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility was unable to provide an investigation with witnesses statements and interviews with the residents regarding feeling safe and secure against abuse.<br><br>During an interview on 7/1/2025 at 1:30 PM with the Infection Control Preventionist (IP) who was the Interim DON at the time of the incident, revealed the local law enforcement agency and facility were not notified of the incident. requirement. The IP stated that statements were obtained from the staff assigned to R12 the day of the alleged sexual abuse. The IP also stated that interviews were conducted with residents in the area to ensure they felt safe. The IP stated that all the documentation she had was turned over to the Interim Administrator and placed in an abuse manual that he maintained in his office. The IP identified CNA1 and CNA2 as being interviewed during the abuse investigation.<br><br>During an interview on 7/1/2025 at 10:35 AM with the current Administrator on and after she reviewed the grievance investigation dated 2/26/2025 and the incident report dated 2/26/2025 completed by the Interim DON confirmed the investigation was incomplete. The Administrator stated that an Abuse Manual was maintained in the former Administrator’s office. Since the former interim Administrator suddenly resigned, the Abuse Manual had disappeared.<br><br>An interview on 7/2/2025 at 10:00 AM with CNA2 revealed that she remembered R12 but was not assigned to the resident. CNA2 stated that she was not asked to provide a witness statement even though she heard about the incident.<br><br>An interview on 7/2/2025 at 10:55 AM with CNA1 revealed that she was not assigned to the resident and had not been interviewed about the abuse incident.<br><br>2. Review of the admission Record located in the Profile tab of the EMR revealed R9 was admitted to the facility on [DATE].<br><br>Review of the annual MDS located in the MDS tab of the EMR with an ARD of 12/24/24 revealed R9 had a BIMS score of five out of 15, which indicated R9 was severely impaired in cognition.<br><br>On 6/30/2025 at 3:25 PM, the Administrator was asked to provide the facility investigation on the alleged abuse by a staff member towards R9.<br><br>During an interview on 7/2/2025 at 11:19 AM, R9 was asked if any staff member had physically abused him. He stated, Yes. R9 was asked if he remembered when the abuse occurred. R9 stated, About six months ago. R9 further stated, It was a lady, and I told the nurse, she was let go. R9 was asked if he felt safe in the facility. He stated, Yes. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, and review of facility policy, the facility failed to revise the care plans related to falls for four (Residents (R)9, R10, and R15) from a sample of 21 residents. This failure had the potential for residents to continue to fall and possibly result in injuries.<br><br>Findings include:<br><br>Review of the facility policy titled Care Plans – Comprehensive Person Centered with a revision date of March 2022 revealed, …Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change…The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS [Minimum Data Set] assessment…<br><br>1. Review of R10’s “Medical Diagnosis” located in the EMR tab titled Medical Diagnosis” revealed the resident was re-admitted to the facility on [DATE] with diagnoses that included but not limited to cerebral infarct (stroke) with hemiparesis and hemiplegia, and repeated falls.<br><br>Review R10’s quarterly MDS with an ARD of 5/15/2025 located in the EMR tab titled MDS revealed the resident has Brief Interview for Mental Status (BIMS) score of 15 out 15, which indicated the resident was cognitively intact. The resident had a limited range of motion of one upper extremity and limited range of motion of both lower extremities. The resident required substantial to maximum assistance with activities of daily living (ADLs); and resident has sustained a fall during the assessment period.<br><br>Review of R10’s “Care Plan” with an initial date of 11/14/2024 located in the EMR tab titled “Care Plans” identified the resident had actual fall incidents on 12/1/2024 and 1/22/2025. However, the Care Plan did not reflect the incident that occurred on 5/11/2025 due to the resident’s poor balance.<br><br>Review of R10’s “admission Fall Risk Assessment” dated 5/9/2025 located in the EMR tab titled Assessments” revealed the resident a had a fall risk score of 17, which indicated the resident was a high risk for falls and had not sustained any falls in the past three months. Review of the resident’s Fall Risk Assessment” dated 5/11/2025 revealed the resident had a fall risk score of five and had not sustained any falls in the past three months.<br><br>Review of R10’s “Nurses Notes” dated 5/11/2025 located in the EMR tab titled Progress Notes documented the resident was found lying face down on the bed after attempting to stand up unassisted. The resident complained of left shoulder pain which was later x-rayed with negative results. The resident’s physician and responsible party were notified.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of R15’s “Medical Diagnosis” located in the EMR tab titled Medical Diagnosis revealed the resident was admitted to the facility with diagnoses that included but not limited to cerebrovascular disease (stroke) with hemiplegia and hemiparesis, unsteadiness, and difficulty walking.<br><br>Review of R15’s annual MDS with an ARD of 2/3/2025 located in the EMR tab titled MDS revealed the resident had BIMS score of eight out of 15, which indicated the resident had moderately impaired cognitive function. The resident was assessed to have a limited range of motion of the lower extremities and was dependent on staff for all ADLs. The resident was assessed to have one fall without injury since admission to the facility.<br><br>Review of R15’s quarterly MDS with an ARD of 5/3/2025 located in the EMR tab titled MDS revealed the resident now had a BIMS score of five out of 15, which indicated the resident’s cognition was severely impaired. During the assessment period the resident sustained one fall without injury and one fall with injury.<br><br>Review of R15’s “Nurses Notes” dated 12/21/2024 located in the EMR tab titled Progress Notes revealed the resident was found on the floor in the resident’s bathroom with no visible injuries noted.<br><br>Review of “Nurses Notes” dated 3/31/2025 revealed the resident was lowered to the floor by staff in his room without injury.<br><br>Review of Nurses Notes dated 4/4/2025 revealed the resident experienced a coughing episode and slipped out of his wheelchair to the floor. The resident complained of some back pain but did not feel it was related to the fall and refused to be sent to the hospital for an examination.<br><br>Review of R15’s “Care Plan” with an initiation date of 7/27/2023 located in the EMR tab titled Care Plans revealed the resident had an actual fall without injury related to unsteady gait and hemiparesis. However, the care plan did not identify the date of this fall; nor did the Care Plan address the falls that occurred on 3/31/2025 and 4/4/2025.<br><br>During an interview on 7/2/2025 at 9:30 AM with the Director of Nursing (DON) revealed the MDS nurses were responsible for the care plan development. However, it was an expectation that any floor nurse would revise or update the resident’s care plans and changes in the resident’s condition occurred or new interventions were needed. The DON stated R10 and R15’ care plans should have been updated to reflect the falls as they occurred, and any new interventions were required.<br><br>3. Review of the admission Record located in the Profile tab of the EMR revealed R9 was admitted to the facility with a diagnosis that included but not limited to vascular dementia.<br><br>Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 6/13/2025 revealed R9 had a BIMS score of eight out of 15, which indicated R9 was moderately impaired in cognition, required substantial/maximum assistance for activities of daily living (ADLs) and had two non-injury falls during the observation period.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115542 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/02/2025 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Sadie G. Mays Health & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 1821 Anderson Avenue NW Atlanta, GA 30314 | |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the 8/13/2023 and revised on 6/9/2025 Falls Care Plan located in the Care Plan tab of the EMR revealed, The resident has had falls. Interventions included, but not limited to: Non-skid footwear (12/24/2024), Encourage resident not to get on floor and scoot to reach other areas (11/4/2024), Frequent check while in bed and provide assistance as needed (6/2/2024), Provide cue for resident to let staff assist him with obtaining foods and going into room (10/4/2023), PT (physical therapy) consult for strength and mobility (8/13/2023), Reinforce frequent checks by staff and offer rest periods as needed (2/17/2024), Reenforce with staff to observe frequently and provide rest period (1/28/2025), Staff to frequently check on resident whereabouts and provide assistance as needed (10/1/2024).<br><br>During an observation and interview on 7/1/2025 at 10:54 AM, R9 was observed in the dining room during an activity and was reclined with feet up in a Geri chair (a specialized chair).<br><br>During an interview on 7/2/2025 at 9:20 AM, the Director of Rehab Services (DOR) stated, We put him on Occupational therapy [OT] and Physical therapy [PT] as he was not safe in the wheelchair. We went to a Geri chair (a specialized chair designed for individuals with mobility limitations) as his trunk control was not very good, it is improving. The DOR was asked why the Geri chair was not care planned. He stated, I don't know, but it should have been. The DOR was asked how long has R9 been in the Geri chair. He stated, More than 30 days.<br><br>During an interview on 7/2/2025 at 11:09 AM, Licensed Practical Nurse (LPN) 1 stated, The Geri chair was an intervention by therapy. LPN 1 was asked who was responsible for updating the care plan. LPN1 stated, Anyone can put interventions in the care plan and the Geri chair should have been in the care plan. It has been a successful intervention, and the falls have decreased. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>The facility failed to ensure activities of daily living (ADLs) were provided for one of three residents (Residents (R)9) who was dependent on staff for assistance with ADLS out of a total sample of 21. This failure placed R9 at risk of a diminished quality of life.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R9 was admitted to the facility with diagnoses that include but not limited to vascular dementia, stroke, and right-sided paralysis.Review of the 6/7/2024 ADLs Care Plan located in the Care Plan tab of the EMR revealed, The resident has an ADL self-care performance deficit r/t (related to) Hemiplegia [paralysis], Limited mobility, Limited ROM [range of motion]. Interventions included, Bathing/Showering: The resident requires assistance by (2) staff with bathing/showering 3 times weekly and as necessary. Dated 6/7/2024.Review of the EMR under the Task tab revealed, a shower was documented in the EMR on 3/7/2025. 3/29/2025, 4/10/2025, and 4/15/2025 (refusal). There was no other documentation in the Task tab for May 2025. The documentation showed that for each shower, R9 was dependent on staff for the task.Review of the June 2025 Bath Book located at the C-Hall nurses station revealed R9 had documentation to show a shower had been given on 6/3/2025, 6/14/2025, and 6/19/2025 and on 6/17/2025 it was documented the resident refused. The Unit Manager (UM) was asked what the policy was regarding showers. She stated, There is a shower schedule at the desk, and the showers are to be given three times a week, either Monday, Wednesday, Friday or Tuesday, Thursday, Saturday. The Certified Nurse Aides (CNAs) are responsible for showering. The UM was shown the four shower sheets that were in the June Bath Book with only the four documented shower sheets. The UM stated, That can't be right, I will check on this. The UM was asked if the CNAs are to document the shower on the Task sheet in the EMR. The UM stated, Well, I think so.The UM did not provide any additional shower sheets for R9 by the time of the exit of the survey.During an interview on 7/2/2025 at 1:58 PM, The Director of Nursing (DON) was asked about the lack of documentation in the Task tab of the EMR and the June Shower Sheets. The DON stated, I spoke to the CNAs [on the phone] and they confirmed that they did not do any shower sheets. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of facility policy, the facility failed to ensure medications were administered per the provider's order for seven of 21 sampled (Residents (R)1, R2, R3, R4, R5, R6, R7 reviewed. This failure placed the residents at risk of health complications and a diminished quality of life.Findings included:Review of the facility policy titled, Administering Medications, dated 2001 revealed, .Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including any required time frame.Medication administration times are determined by resident need and benefit, not staff convenience.1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R1 was admitted to the facility with diagnoses that included but not limited to stroke, diabetes, end-stage renal disease (ESRD) and was dependent on dialysis.Review of the discharge-return anticipated Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 1/24/2025 revealed, R1 had a Brief Interview of Mental Status (BIMS) score that was assessed by staff of severely impaired in cognition.Review of the December 2024 Medication Administration Record (MAR) located in the Orders tab of the EMR revealed the following prescribed medications that were not administered on 12/26/2025, as ordered:Phenytoin Sodium Extended Capsule 100mg [milligrams] Give 2 capsules by mouth every 12 hours for seizures. Start date: 2/20/2024.Atorvastatin 40 mg. Give 1 tablet by mouth in the evening for Hypercholesterolemia [high cholesterol]. Start dated: 2/20/2024.Buspirone 10mg. Give 1 tablet by mouth two times a day for anxiety. Start Date: 2/20/2024.Carvedilol 25mg. Give 1 tablet by mouth two times a day for Hypertension [elevated blood pressure]. Start Date: 2/20/2024.Clonidine 0.2mg. Give 1 tablet by mouth two times a day for Hypertension. Start Date: 6/7/2024.Divalproex 500mg. Give 1 tablet by mouth two times a day for behaviors. Start Date: 2/20/2024. Eliquis 5mg. Give 1 tablet by mouth every 12 hours for deep vein thrombosis [blood clot prevention]. Start Date: 2/20/2024.Trazadone 50mg. Give 1 tablet by mouth at bedtime for insomnia. Start Date: 2/20/2024.Spironolactone 25mg. Give 1 tablet by mouth at bedtime for Hypertension. Start Date: 2/20/2024.Hydralazine 100mg. Give 1 capsule by mouth every 8 hours for Hypertension. Start Date: 2/20/2024.Per the investigation, the atorvastatin, buspirone, carvedilol, clonidine, divalproex were not administered on 12/26/2025 at 5:00 PM. The hydralazine was not administered on 12/26/2024 at 10:00 PM. The Eliquis, Phenytoin, spironolactone, and Trazadone were not administered on 12/26/2024 at 9:00 PM. The Medication was discovered as not given on 12/30/2024 by the supervisor at 8:30 AM, during a cart check. The investigation further revealed that Licensed Practical Nurse (LPN)7 had signed the medications as administered.2. Review of the admission Record located in the Profile' tab of the EMR revealed R2 was admitted to the facility with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD) and chronic pain syndrome.Review of the discharge-return anticipated MDS located in the MDS tab of the EMR with an ARD of 12/29/2024 revealed R2 had a BIMS score that staff assessed to be independent in cognition.Review of the December 2024 MAR located in the Orders tab of the EMR revealed the following prescribed medication that was not administered on 12/26/2024, as ordered:Gabapentin 100mg. Give 1 capsule by mouth three times a day for Chronic Pain Syndrome. Start Date: 2/9/2024.Per the facility investigation, the gabapentin was not administered on 12/26/2025 at 8:00 PM. The Medication was discovered as not given on 12/30/2024 by the supervisor at 8:30 AM, during a cart check. The investigation further revealed that LPN7 had signed the medications as administered. During an interview on 6/30/2025 at 1:30 PM, R2 stated, I don't remember anything about this. 3. Review of the admission Record located in the Profile tab of the EMR revealed R3 was admitted to the facility on [DATE] with diagnoses that included but not limited to COPD, and arthritis.Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 2/4/2024 revealed R3 had a BIMS score of 14 out of 15, which indicated R3 was cognitively intact.Review of the December 2024 MAR located in the Orders tab of the EMR revealed the following prescribed medications that were not administered on 12/26/2024, as ordered:Famotidine 40mg. Give 1 tablet by mouth at bedtime for acid indigestion. Start Date: 1/26/2024. Pravastatin 40mg. Give 1 tablet by mouth at bedtime for increased lipids. Start Date: 8/1/2023.Per the investigation, the famotidine and the pravastatin were not administered on 10/26/2024 at 9:00 PM. The medications were discovered as not given on 12/30/2024 by the supervisor at 8:30 AM, during a cart check. The investigation further revealed that LPN7 had signed the medications as administered During an interview |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and review of facility policy, the facility failed to ensure adequate supervision to potentially prevent accidents for two of four residents (Residents (R)9 and R11) reviewed for accidents in a total sample of 21. These failures placed the residents at risk of injury and unmet care needs. Findings include:Review of an undated facility policy titled Falls and Injury Program revealed, .Each resident's care plan will include specific fall prevention and management strategies tailored to their individual needs and risk factors.1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R11 was admitted to the facility with diagnoses that included but not limited to Alzheimer's disease, dementia.Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 1/21/2025 revealed R11 had a Brief Interview of Mental Status (BIMS) score of zero out of 15, which indicated R11 was severely impaired in cognition. Review of a 1/9/2025 Nurses Note located in the Progress Notes tab of the EMR revealed, approximately at 11:45 AM, assigned CNA [certified nurse aide] was in the process of transferring resident out of the room and the crew guy was moving the cabinets. The CNA verbally asked the crew guy to stop for a minute, and he didn't and he put the doors up against the wall, then part of the cabinets fell on the resident's chest and arms. The crew guys removed the doors and the nurse was notified. Nurse assessed the resident [R11] and the provider gave an order for an x-ray of the sternum. The resident's family was notified.Review of an 1/10/2025 Nurses Note located in the Progress Notes tab of the EMR revealed, the on-call physician was notified that the Xray of the resident's sternum was questionable for a dislocation. The physician gave an order to send the resident out for a follow up x-ray. The results revealed the resident did not have a sternum fracture.On 7/1/2025 at 8:00 AM, an attempt to contact Licensed Practical Nurse (LPN)8 regarding the incident was made. No return contact was received.On 7/1/2025 at 8:32 AM, the Administrator was asked to assist in identifying the CNA. However, the Administrator was unable to identify the CNA.During an interview on 7/1/2025 at 12:45 PM, the current Administrator was asked if there was an investigation done at the time of the incident. The Administrator stated she could not find an investigation regarding the accident.During an interview on 7/2/2025 at 11:22 AM, the Maintenance Director stated, At the time of the accident, I was not the Director, but just a maintenance employee. It was the contract company who was working in the room. The Maintenance Director denied being asked for a statement regarding the incident as well as the third party vendor.2. Review of the admission Record located in the Profile tab of the EMR revealed R9 was admitted to the facility on [DATE] with diagnoses that included but not limited to vascular dementia, stroke, and right-sided paralysis.Review of the annual MDS located in the MDS tab of the EMR with an ARD of 12/16/2024 revealed R9 had a BIMS score of five out of 15, which indicated R9 was severely impaired in cognition and had two non-injury falls since the previous assessment.Review of the 8/13/2023 and revised on 6/9/2025 Falls Care Plan located in the Care Plan tab of the EMR revealed, The resident has had falls. Interventions included, but not limited to: Non-skid footwear (12/24/2024), Encourage resident not to get on floor and scoot to reach other areas (11/4/2024), Frequent check while in bed and provide assistance as needed (6/2/2024). Provide cue for resident to let staff assist him with obtaining foods and going into room (10/4/2023), PT (physical therapy) consult for strength and mobility (8/13/2023). Reinforce frequent checks by staff and offer rest periods as needed (2/17/2024), reinforce with staff to observe frequently and provide rest period (1/28/2025), Staff to frequently check on resident whereabouts and provide assistance as needed (10/1/2024).Review of a 1/2/2025 at 3:35 PM Nurses Note located in the Progress Notes tab of the EMR revealed, at 9:00 AM resident was on the floor near his w/c [wheelchair], in his room. No injuries were noted. Review of a 1/10/2025 at 3:04 PM Nurses Note located in the Progress Notes tab of the EMR revealed that the resident was found on the floor without injury.Review of a 1/18/2025 at 6:31 PM Incident Note located in the Progress Notes tab of the EMR revealed the resident used the wall rail to intentionally put himself to the floor. No injuries noted.Review of a01/20/2025 at 3:38 PM Nurses Note located in the Progress Notes tab of the EMR revealed that the nurse was called into the resident's room by a family member. The resident was found on the floor due to falling from his chair. The Nurse notified Nurse Practitioner (NP)2 who gave an order to send the resident to the emergency room (ER) for an evaluation.Review of a 3/8/2025 at 4:20 PM, Nurses Note located in the Progress Notes tab of the EMR revealed, the resident was observed on the floor near the nursing station. He was leaning over trying to get into the shower room. After being told several |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observation, record review, interview, and review of facility policy, the facility failed to properly position urinary drainage bags to promote adequate drainage and to potentially prevent recurring urinary tract infections (UTIs) for two residents (R)16 and R14 from four residents with urinary drainage bags out of a total sample of 21 residents. This failure has the potential for residents to develop recurring UTIs.Findings include:Review of the facility policy titled, Urinary Catheter Care Policy (undated) revealed, .Proper catheter care is essential to prevent infections, promote comfort, and maintain the dignity of residents.Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks.The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.Be sure the catheter tubing and drainage bag are kept off the floor. 1. Review of R16's Medical Diagnosis sheet located in the resident's electronic medical records (EMR) tab titled Medical Diagnosis revealed the resident was admitted to the facility with diagnoses that included but not limited to multiple sclerosis, hemiplegia, hemiparesis, and neuromuscular dysfunction of the bladder.Review of R16's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/4/2025 revealed the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. The resident was dependent on staff for all activities of daily living (ADLs); incontinent of bladder and bowel and required an indwelling catheter.Review of R16's physician's Orders dated 5/3/2025 located in the resident's EMR tab titled Orders revealed an order for a Suprapubic Foley 20 French five milliliter balloon.During an observation and interview on 6/30/2025 at 11:30 AM revealed R16 was on a stretcher headed for shower. There was a urine odor present. Certified Nursing Assistant (CNA)3 uncovered the resident's urinary catheter to show the resident was wearing a leg strap. However, the resident's urinary drainage bag was flat in the stretcher with the resident; amber colored fluid was backing up in the tubing towards the resident's bladder area. CNA3 confirmed that R16's urinary drainage bag should be positioned below the resident's bladder to prevent urinary tract infections from occurring.During an observation on 7/1/2025 at 9:42 AM revealed R16 was in a low bed with the urinary drainage bag laying flat on the floor. There was a strong urine odor present in the room and the drainage bag was near a puddle of yellow colored liquid on the floor. At 10:05 AM the drainage bag remained on the floor. At 11:16 AM an observation with the Assistant Director of Nursing (ADON) and CNA3 revealed the urinary drainage bag was about an inch above the floor. There was still the strong smell of urine present in the room.During an interview on 7/1/2025 at 11:16 AM, CNA3 verified that she just repositioned the drainage bag from the floor to a higher position. CNA3 also stated that she noticed the drainage port of the drainage bag was not properly clamped off and more urine had spilled on the floor. During the interview, the ADON agreed that the resident's urinary drainage had not been positioned properly to promote drainage and would replace the drainage bag since it was leaking urine.2. Review of R14 Medical Diagnoses located in the resident's EMR tab titled Medical Diagnosis revealed the resident was admitted to the facility with diagnoses that included but not limited to cerebral infarction with left sided hemiplegia and hemiparesis, and chronic kidney disease stage three.Review of R14 quarterly MDS with an ARD of 6/10/2025 located in the resident's EMR tab titled MDS revealed the resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The resident was dependent on staff for all ADLs. The resident was incontinent of the bladder and bowel and wore an external catheter.Review of R14's physician's Orders dated 6/24/2025 located in the EMR tab titled Orders revealed the resident was to wear condom catheter and change daily and monitor skin for changes.During an observation on 7/2/2025 at 8:45 AM revealed R14 was in a low bed with the urinary drainage bag resting on the floor. At 9:15AM an observation with the Director of Nursing (DON) revealed the resident's urinary drainage remained in the same position. The DON donned (put on) a pair of gloves and repositioned the resident's drainage bag of the floor and adjusted the tubing to promote adequate urinary drainage. The DON confirmed that the resident's drainage was not positioned properly to promote drainage. |