STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115571	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cartersville Center for Nursing and Healing	78 Opal Street Cartersville, GA 30120

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policy titled, Pharmacy Services, the facility failed to provide routine and emergency drugs and biologicals to the facility residents for one of four halls sampled, and specifically for resident (R) (R82). This deficient practice had the potential to cause serious complications with resident health.Findings include:Review of the facility's policy titled Pharmacy Services revised June 2023, revealed under Compliance Guidelines: 1.The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. Section 8 subsection f. states Strive to assure that medications are requested, received, and administered on time as ordered by the authorized prescriber.Review of the electronic medical record (EMR) revealed resident R82 was admitted to the facility with pertinent diagnoses, including but not limited to chronic kidney disease, chronic obstructive pulmonary disease, diabetes mellitus with diabetic neuropathy, obstructive sleep apnea, paroxysmal atrial fibrillation, pain in right foot, syncope and collapse, bradycardia, chronic diastolic heart failure, sick sinus syndrome, cardiac pacemaker, malignant neoplasm of skin on face, atherosclerosis of native arteries of extremities with rest pain.Review of R82's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated R82 was cognitively intact. Section GG, functional status, revealed R82 required minimum assistance with meals and oral hygiene, dependent on staff for toileting hygiene and personal hygiene, was independent for dressing upper and lower body, and independent for footwear. R82 was independent for transfer from bed to wheelchair. Review of the Physician's Orders for R82 included, but was not limited to:Order dated 5/30/2025 Spiriva HandiHaler Inhalation Capsule 18 MCG (Tiotropium Bromide Monohydrate)Order dated 12/14/2025 Eliquis Oral Tablet 5 MG (Apixaban)Observation on 12/17/2025 at 9:53 am revealed on the medication pass on 200 hall with Licensed Practical Nurse (LPN) OO observing medication pass for R82. Two medications were missing: apixaban 5mg oral tablet, nine am dose, and Spiriva inhaler 18mcg capsule for inhalation. At 10:15 am LPN OO went to pull the apixaban from the emergency stock. 10:30 am LPN OO was still trying to find apixaban, and a Certified Nursing Assistant (CNA) came to the medication cart to report that another resident needed pain medication. At 10:43 am, LPN OO came back to the medication cart after calling the Nurse Practitioner (NP) and receiving orders to hold the apixaban, Spiriva, due to drugs being unavailable. At 10:49 am, LPN OO went to find R82 to give him his 9:00 am medication, but he had left his room and was in therapy. At 10:52 am, LPN OO came back to the medication cart with R82 and administered his 9:00 am medication that was available.An interview with LPN KK on 12/18/2025 at 8:10 am revealed that on the 200-hall medication cart, R82's apixaban did come in the night before, and he did receive his nine pm (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115571	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cartersville Center for Nursing and Healing	78 Opal Street Cartersville, GA 30120

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dose of apixaban last night, but the Spiriva did not come in, and the resident will not get it today at the 9:00 am medication pass.An Interview with Pharmacist MM from the providing pharmacy on 12/18/2025 at 8:37 am revealed that R82's apixaban was ordered on 12/14/2025 and was delivered last night on 12/17/2025. R82's Spiriva was ordered according to Pharmacist MM, on 12/14/2025, and for reasons that he could not explain, it had not been filled yet, and the resident did not have any available. Pharmacist MM also stated that they had been short-staffed but that in a perfect world, the medication turnaround was 24 hours from ordering to delivery.An interview with LPN KK on 12/18/2025 at 11:30 am revealed that the pharmacy called her and said that R82's insurance denied the Spiriva claim, and they were working on it.An interview with an unnamed pharmacist from the pharmacy provider on 12/18/2025 at 12:24 pm after multiple attempts to contact the pharmacy concerning the insurance denial for R82's Spiriva. She revealed that she was not going to give me her name because she didn't know anything, she was a PRN (as needed) pharmacist, and that I should call the insurance specialist, and she would be in at 1:00 pm.An interview on 12/18/2025 at 1:17 pm call conducted with the providing pharmacy, and a message was left on the insurance specialist's voicemail concerning the insurance denial on R82's Spiriva. An interview with LPN NN Unit Manager on 12/18/2025 at 10:29 am revealed that she expected the reordering of medications should be done a week before they are out. If medication was not available, they called the pharmacy, and if we couldn't get it, we would call the MD (Doctor of Medicine) and put the medication on hold until it was available. An interview with the Director of Nursing (DON) on 12/18/2025 at 10:40 am revealed that her expectation for pharmacy delivery from ordering to delivery should be 24 hours. We must keep following up and calling until the pharmacy sends the medication.

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NAME OF PROVIDER OR SUPPLIER: Cartersville Center for Nursing and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE: 78 Opal Street Cartersville, GA 30120	

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, staff and resident interviews, record review, and review of the facility's policies titled, Medication Administration, the facility failed to maintain a medication error rate below 5% (percent). The observed medication administration error rate was 17.24% with 5 errors of 29 opportunities for four residents (R) (R50, R15, R23, and R82) during medication administration. This deficient practice had the potential to cause health complications for residents on B hall.Findings include:Review of the facility's policy titled Medication Administration, revised 4/2/2025, section 10. revealed Ensure that the six rights of medication administration are followed. Right time Section 12b Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician.Review of the facility's policy titled Pharmacy Services, revised June 2023, section 8. f. states Strive to assure that medications are requested, received, and administered promptly as ordered by the authorized prescriber (in accordance with state requirements), including physicians, advanced practice nurses, pharmacists, and physician assistants.Observation on 12/17/2025 at 8:49 am of a medication pass with Licensed Practical Nurse (LPN) JJ revealed one omitted medication for R50, polyethylene glycol 3350 17000MG (milligrams) powder for oral solution, one packet daily mixed with 8 ounces of water or juice. Observation made on 12/17/2025 at 9:02 am of medication administration with LPN JJ revealed LPN JJ did not assist or instruct R15 to rinse his mouth after the use of fluticasone propionate and salmeterol inhaler 100 mcg/50mcg daily.Observation made on 12/17/2025, started at 9:19 am, of a medication administration with LPN OO revealed that LPN OO omitted R23's Nepro supplement that was scheduled at 7:30 am due to unavailability.An observation made on 12/17/2025, starting at 9:53 am and ending at 10:56 am with LPN OO revealed that at 10:08 am, while preparing medications for R82, she realized that R82's Blood Pressure was 101/57 and heart rate of 66. R82 had no visible signs of hypotension, and there were no parameters set for R82's lisinopril. She held the medication and continued to prepare the rest of R82's medications. At 10:15 am, OOLPN discovered that R82 was out of apixaban, and she left the medication cart to pull apixaban from emergency stock. At 10:43 am, OOLPN returned to the medication cart and stated that apixaban was not in the emergency stock, and she spoke with the provider, and who ordered to hold the lisinopril for low blood pressure and hold the apixaban and the Spiriva for one day due to unavailability of the medication. At 10:49 am, LPN OO had finished preparing R82's medication, but the resident had left and gone to therapy. LPN OO then labeled the cup of medications and locked them up in the top drawer of the medication cart and went to find R82. At 10:52 am, OOLPN returned to the medication cart with R82 in his wheelchair and proceeded to give the resident his medication in the hall and rubbed Naprosyn cream on his knees. LPN OO omitted the nystatin external powder 100000 units/GM (units per gram).An interview with LPN OO on 12/17/2025 at 10:47 am revealed that she usually gets through her 9:00 am medication pass at 10:30 am. She confirmed that she has more than half of the residents on B hall left to give 9:00 am medications too, and that she is more than an hour late with those medications. LPN OO confirmed that in the case of twice a day, three times a day, and every 8 and 12-hour timed medications, the residents could have complications due to these medications being given too close together or a drop in blood levels when too far apart. An interview with LPN KK on 12/18/2025 at 8:10 am revealed that LPN KK was working on the 200 hall today. She looked to see if R82 had his apixaban and Spiriva on the 200-hall medication cart, and R82 did have a full card of apixaban that came in last night, and his bedtime dose was administered. R82's Spiriva was not on the cart.An interview via telephone with the pharmacy provider on 12/18/2025 at 8:37 am, and spoke with Pharmacist MM who revealed that Apixaban was ordered 12/14/20205 and was delivered last night, and the resident did get his bedtime dose. The Spiriva was ordered according to (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pharmacist MM, 12/14/20205, and has not been filled yet, and the resident did not have any available. He stated that there was no drug shortage associated with apixaban or Spiriva.An interview on 12/18/2025 at 10:12 am with Registered Nurse (RN) GG, Unit Manager, revealed his expectations for appropriate time limits on medication passes were an hour before and an hour after the ordered time. He also expected that the residents get their medications on time and the correct medications. He also revealed that there were about 20-25 residents on each cart and that the 9:00 am med pass was the heaviest medication administration pass. An interview with LPN NN Unit Manager on 12/18/2025 at 10:29 am revealed that she expected medications to be given within an hour before and an hour after the rule. She also had about 25 residents per cart.An interview with the Director of Nursing (DON) on 12/18/2025 at 10:40 am revealed that her expectation was for the medication passes should be completed an hour before and an hour after the time the medication was ordered. Her expectation for pharmacy delivery from ordering to delivery should be 24 hours. The nursing staff were to order the medications one week before running out of the medication.