STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115771	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Post Acute Care Center	2020 McGee Road Snellville, GA 30078

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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 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** Based on observations, resident and staff interviews, record review, and review of the facility's policy titled, Care of Central Venous Catheters including provide Peripherally Inserted Central Catheters (PICC Lines), the facility failed to provide appropriate treatment and services to one of 10 sampled residents (R) (RB). Specifically, PICC line dressing protocol was not followed, a chest x-ray was not ordered or performed and the PICC line was used without confirmation of placement, and dressing changes were not done according to facility policy and physician's orders.Findings include:Review of facility's policy titled, Care of Central Venous Catheters including Peripherally Inserted Central Catheters (PICC Lines) revealed under Policy Interpretation and Implementation: . 8. Change central line catheter site dressing every week transparent dressing (or as ordered by physician). Change central line catheter site dressing Q48 (every 48 hours) hours with gauze dressing (or as ordered by physician)Review of the electronic medical record (EMR) revealed RB was admitted with diagnoses of but not limited to the following: Intraspinal abscess and granuloma, infection following a procedure, candidiasis, chronic obstructive pulmonary disease, asthma, depression, muscle weakness.Review of RB's most recent quarterly Minimal Data Set (MDS) dated [DATE] revealed a Basic Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Section D (Mood)-RB has minor insomnia, feelings of depression and hopelessness, answered yes to Poor appetite or overeating. Section E (Behavioral Symptoms)-revealed no indication of Psychosis. Section GG (Functional Abilities and Goals)-RB2 is independent with bathing, dressing and using the toilet prior to admission. He uses a walker for ambulation and has only generalized muscle weaknesses in upper and lower extremities. He requires partial assistance with hygiene, substantial assistance with bathing, Supervision with dressing upper body and partial assistance with dressing lower body and footwear. Section J (Assessments)-Resident is on a pain management schedule.Review of the care plans for RB revealed the care plan was updated 8/16/2025 to include: Focus: Enhanced barrier precautions (EBP) for IV (intravenous) and wound care, Outcome: Resident will have no complications related to barrier precautions through next review date, Interventions: Enhanced barrier precautions per facility protocol/policy.Enhanced barrier precautions: wear gown and gloves for high contact resident care activities and perform hand hygiene. readmission on [DATE] with s/p transfusion status. 8/16/2025 readmission with DX (diagnosis) of extraspinal abscess and granuloma, infection following procedure. Focus: Resident is receiving antibiotic/fluids intravenously via PICC related to sepsis. readmission on [DATE] with IV antibiotic therapy via PICC line for infection with status post spinal abscess of C2-C4 with s/p (status post) surgical procedure. 8/16/2025 readmission IV antibiotic therapy continue. Outcome: Resident will have a resolution in infection through next review date, Interventions: Administer Intravenous fluids as ordered per MD, Change IV site per facility protocol, Dressing changes to IV site per facility protocol. Monitor IV site for s/s of infection, Monitor/observe for adverse reaction to medication and report abnormal findings to MD (medical (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doctor)/RP/Resident, PICC line maintenance care as ordered.Review of the Physician's orders for RB revealed PICC line dressing 24 hours post insertion or on admission, then every week and prn (as needed). Reinsert PICC line for IV therapy written on 9/18/2025. On the 'name of company' IV company nursing form, an order for lidocaine was obtained by the facility but the requested chest x-ray to confirm PICC line placement is not present, and no results are in the chart.Review of the medication administration record, RB's PICC line dressing was changed on Monday September 22, 2025, but RB denies the dressing has ever been changed since September 19th, 2025 when the PICC line was inserted.An interview and observation with RB on 9/23/2025 at 1:28 pm revealed that the dressing on his PICC line had gauze under the transparent dressing and no date or time on the dressing. RB stated that the dressing was changed along with the new PICC line on Friday, 9/19/2025. He also stated that he told the nursing staff on Wednesday evening, 9/17/2025, that the tape was coming off and he was afraid the PICC line was going to come out. The PICC line came out on Thursday, 9/18/2025 in the morning, and he went without any of his IV medications for two days until the new PICC line was inserted on the afternoon of 9/19/2025.A telephone interview on 9/23/2025 at 2:12 pm with prior resident RA from complaint GA002580721 revealed the nurse told her that the facility was not equipped to handle PICC lines.An interview and observation on 9/24/2025 at 9:56 am revealed RB sitting in bed and stated that the PICC line dressing would not get changed until the tape came off, it had never been changed once a week. RB stated the dressing had not been changed since it was inserted on Friday, 9/19/2025. An interview on 9/24/2025 at 11:25 am with Unit Manager Licensed Practical Nurse (LPN) FF revealed that the Registered Nurses (RN)s did the PICC line dressing changes and if a PICC line became unusable for any reason, they called the doctor to get an order to reinsert. An interview on 9/24/2025 at 11:37 am with RN GG revealed when a PICC lines came out, they called the Doctor for an order for an x-ray before insertion to see what was going on then another order for x-ray after insertion. She stated that, we just wait until the PICC is inserted to restart the antibiotic. An interview on 9/24/2025 at 11:45 am with the Director of Nursing (DON) revealed her expectation when a PICC line was not usable for whatever reason, the nurse was to call the Doctor and request an alternative route for the medication. If there was no alternative, we got an order to reinsert and requested service and got an idea of when the PICC line could be re-inserted, this was considered a stat (immediate) procedure and notified the MD of the timeline. She also expected the dressing on the PICC line to be changed as ordered and per facility policy. An observation of RBs PICC line dressing change at 1:35 pm on 9/24/2025 with RN HH revealed masks were worn by the residents and RN HH. No gowns were used. RB did have an EBP sign on the room door. The resident was made comfortable and the bed raised, RN HH wiped down the bedside table with alcohol, removed the dressing with clean gloves, then removed gloves and performed hand hygiene and opened the sterile dressing change kit, then donned (put on) sterile gloves. RN HH broke the sterile field by touching RB's arm with her left hand while cleaning with her right hand. The Stat lock (Stabilization Device) was not changed, the antibacterial disk around the insertion site was not changed and was left in place. RN HH cleaned the site with alcohol and a chlorhexidine (antiseptic) swab, applied skin prep and a transparent dressing. The date and initials were written on the dressing.An interview on 9/25/2025 at 9:05 am with the Assistant Director of Nursing (ADON) verified that a follow up chest x-ray was not done after the PICC line placement on 9/19/2025 to verify PICC line placement and the line had been being used daily since insertion. An interview on 9/25/2025 at 9:28 am with dispatcher for the PICC line insertion company to get a message to the RN Supervisor for a return call to discuss the chest x-ray. At 9:49 am, the RN Supervisor and owner of the PICC line insertion company returned call and stated that they always requested that the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility call the provider and obtain an order for a chest x-ray, as the PICC line nurse could not write orders or call for a chest x-ray because they did not work for the facility.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and review of the facility's policy titled, Medication Delivery Expectations-Nurses, the facility failed to keep one of six residents (R) (RB) free from significant medication error.Findings include:Review of the facility's policy titled Medication Delivery Expectations-Nurses last revised June 2025 documented under Protocol: .8. Notify the physician if medication will be given late or obtain an alternative order or different start time, if appropriate.Review of the electronic medical record (EMR) revealed RB was admitted with diagnoses of but not limited to intraspinal abscess and granuloma, infection following a procedure, candidiasis, chronic obstructive pulmonary disease (COPD), asthma, depression, and muscle weakness.Review of RB's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive deficits.Review of the care plans for RB revealed the care plan was updated 8/16/2025: readmission on [DATE] with s/p (status post) transfusion status. 8/16/2025 readmission with DX (diagnosis) of extraspinal abscess and granuloma, infection following procedure. Focus: Resident is receiving antibiotic/fluids intravenously via PICC related to sepsis (life-threatening reaction to an infection). readmission on [DATE] with IV antibiotic therapy via PICC (peripherally inserted central catheter) line for infection with status post spinal abscess of C2-C4 (cervical vertebrae) with s/p (status post) surgical procedure. 8/16/2025 readmission IV antibiotic therapy continue. Outcome: Resident will have a resolution in infection through next review date. Interventions: Administer Intravenous fluids as ordered per MD (medical doctor). Change IV site per facility protocol. Dressing changes to IV site per facility protocol. Monitor IV site for s/s (signs/symptoms) of infection. Monitor/observe for adverse reaction to medication and report abnormal findings to MD/RP (responsible party)/Resident. PICC line maintenance care as ordered.Review of the Physician's orders for RB revealed an order for Micafungin Sodium-NaCl sodium chloride) intravenous Solution 100-0.9 mg (milligram)/100 ml (milliliter)-% (percentage) use intravenously every 24 hours for antibiotic therapy until 10/05/2025 23:59. Cefazolin Sodium injection solution reconstituted 2 GM (grams) Use 1 dose intravenously every eight hours for abscess to cervical spine until 10/6/2025.Review of the Medication Administration Record (MAR) for September 2025 for RB revealed Cefazolin doses were missed on 9/18/2025 at 1400 (2:00 pm), and 2200 (10:00 pm), 9/19/2025 at 0600 (6:00 am), and 1400 (2:00 pm), and on 9/22/2025 the dose at 1400 was missed. Number eight (8) was inserted in the MAR for these dates meaning the medication was not given. Micafungin Sodium-NaCl Intravenous solution 100-0.9 mg/100 ml dose was missed on 9/18/2025 and 9/19/2025. An interview with Registered Nurse (RN) GG on 9/24/2025 at 11:37 am revealed when a PICC line came out, we just wait until the PICC is inserted to restart the antibiotic. An interview on 9/24/2025 at 11:45 with the Director of Nursing (DON) revealed her expectation when a PICC line was not usable for whatever reason was the nurse was to call the Doctor and request an alternative route for the medication, if there was no alternative, we got an order to reinsert.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policies titled, Infection Control and Dressings, Non-Sterile, the facility failed to follow infection control practices related to Enhanced Barrier Precautions and consistent hand hygiene when providing wound care for two of 16 residents (R) (R4 and R15) receiving wound treatment. The deficient practice had the potential of transmission of communicable diseases and infections.Findings include: Review of the facility's policy titled, Infection Control dated June 2025 revealed in Section Enhanced Barrier Precautions (EBP): .4.b. All residents with any of the following conditions should use enhanced barrier precautions.2) Wounds and/or indwelling medical devices (e.g., central line, urinary catheter.) regardless of MDRO (multi drug resistant organisms) colonization status who reside on a unit.c. During high-contact resident care activities:1) Dressing 2) Bathing/showering 3) Transferring 4) Providing hygiene 5) Changing linens 6) Changing briefs or assisting with toileting 7) Device care use: central line, urinary catheter, feeding tube, tracheostomy/ventilator.d. Gloves and gown prior to the high-contact care activity. e. Perform hand hygiene and change PPE before caring for another resident. Review of the facility's policy titled Dressing, Non-Sterile, dated June 2025, revealed: This procedure may involve potential or direct exposure to blood, body fluids, infectious diseases, air contaminants, and hazardous chemicals. Protective Barriers That May Be Needed: Handwashing/Alcohol-based hand rub (ABHR), Gloves, Gown (as indicated), Designated Waste Disposal, Mask, Goggles (as indicated), Face Shield (as indicated). Steps in the procedure: .15. Put on clean gloves.17. Cleanse the wound. Use separate gauze for each cleansing stroke. Clean from the most contaminated area to the least contaminated area. 18. Use dry gauze to pat the wound dry. 19. Wash hands or sanitize hands with ABHR (if not visibly soiled) and apply new gloves.22. Remove gloves and discard into the designated container.26. Wash hands or sanitize hands with ABHR (if not visibly soiled). 1.Review of R4's electronic medical record (EMR) revealed that R4 was admitted with diagnoses that included, but were not limited to Alzheimer's disease, vascular dementia, anemia, insomnia, major depressive disorder, cerebral amyloid angiopathy, hypertension, a stage 4 pressure ulcer of the right hip, and peripheral vascular disease. Review of R4's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0, indicating significant cognitive impairment. Review of the care plan dated 6/15/2024 revealed R4 is on Enhanced Barrier Precautions (EBP) for wound care, with interventions to keep EBP per facility protocol: wear gown and gloves, perform hand hygiene. Review of R4's physician orders included the following related to a wound: Enhanced Barrier Precautions (EBP) related to wound care. Pressure Wound, Right Hip: Clean with NS or wound cleanser, pat dry, apply calcium alginate, and cover with bordered island gauze every Tuesday, Thursday, Saturday, and as needed for soilage/dislodgement. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R4's EMR revealed that R4 was followed by 'name of wound practice' wound physicians. On 9/18/2025, documentation revealed: Focused Wound Exam (Site 3): Stage 4 pressure wound of the right hip, full thickness. Dressing treatment plan: calcium alginate applied once daily and gauze island with border applied once daily. The physician documented the wound's progress as improved, evidenced by decreased surface area and decreased undermining (separation of the wound edges from the surrounding healthy tissue). Observation during wound care for R4 on 9/24/2025 at 11:32 am, the surveyor observed LPN AA perform a dressing change on the resident's right hip. The nurse followed infection control practices for EBP, including donning a gown and performing hand hygiene. However, no barrier was used for the supplies, and items including a large bottle of wound cleanser used for multiple residents were placed directly on the bedside drawer in the resident's room. After completing the dressing change, LPN AA returned the cleanser bottle to the treatment cart without sanitizing it. 2. Review of R15's EMR revealed diagnoses that included, but were not limited to, severe protein-calorie malnutrition, seizures, encounter for palliative care, local infection of the skin, severe sepsis, and pressure ulcers. Review of the Significant Change MDS assessment dated [DATE] revealed a BIMS score of 7, indicating severe cognitive impairment. Review of R15's care plan dated 4/20/2025 revealed a focus on Enhanced Barrier Precautions (EBP) for wound care and Foley catheter care, with interventions including wearing a gown and gloves for high-contact resident care activities and performing hand hygiene per facility protocol. The resident has an infection of the sacral wound, with interventions to maintain precautions when providing care. The care plan also identified the potential for further skin impairment related to fragile skin, impaired mobility, altered skin integrity, and incontinence. Review of R15's physician's orders revealed the following: Sacrum wound: Cleanse with wound cleanser once daily and as needed if saturated, soiled, or dislodged, for 12 days. Apply alginate calcium once daily and as needed if saturated, soiled, or dislodged, for 12 days. Secondary dressing: foam with border (silicone-sacrum) once daily and as needed if saturated, soiled, or dislodged. Left and right hip wounds: Primary dressing sodium hypochlorite solution (Dakin's) three times per week and as needed if saturated, soiled, or dislodged. Secondary dressing: gauze island with border three times per week and as needed if saturated, soiled, or dislodged. Enhanced Barrier Precautions (EBP): Related to wound care and Foley, every 12 hours. Hospice admission: [DATE] with diagnosis of unspecified severe protein malnutrition. Heel protector: While in bed. Right inner heel wound: Cleanse with normal saline or wound cleanser and apply hydrocolloid every third day. Foley catheter: Inserted on admission, with orders to change monthly and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of a dressing change for R15 on 9/24/2025 at 11:42 am, LPN AA entered R15's room to perform a dressing change. A sign for EBP precautions was posted on the door; however, LPN AA and Wound Tech II did not wear gowns prior to or during the procedure. When treating the right hip wound, LPN AA removed the soiled packing but did not change her gloves before applying Dakin's solution to gauze and covering the wound with a new bordered gauze island dressing. While still wearing the same contaminated gloves, she reached into her pocket to retrieve a marker to date the dressing and then returned the marker to her pocket without cleaning it. The same practice was observed during the sacral dressing change, when she again retrieved the marker from her pocket while wearing contaminated gloves and then returned it to her pocket. When changing the dressing on the left hip, LPN AA changed gloves after removing the soiled dressing from the right hip; however, hand hygiene was not performed after glove removal. In an interview following the observation, the surveyor asked LPN AA why she wore a gown for one resident prior to a dressing change but did not wear one for R15. LPN AA stated she forgot to do it and acknowledged she ignored the EBP signage on the door, explaining that there were no PPE supply boxes or a cart at the doorway to remind her. Wound tech II also confirmed that gowns should have been worn when providing high-contact care to the resident, but acknowledged they failed to do so. In an interview with the Infection Preventionist (IP)/Staff Development Nurse on 9/24/2025 at 12:33 pm, she stated that staff were frequently educated on EBP and the use of gowns during high-contact care to residents with wounds or catheters, both to protect residents and to reduce the risk of infection. In an interview with the Director of Nursing (DON) on 9/24/2025 at 12:35 pm, she stated her expectations were that staff consistently followed infection control practices, including frequent hand hygiene, sanitizing hands when changing gloves since glove changes do not substitute for hand hygiene, and adhering to EBP precautions for residents with wounds, central lines, or catheters.