STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115138	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newnan Health and Rehabilitation	244 East Broad Street Newnan, GA 30263

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and review of the facility's Storage Areas policy, the facility did not ensure food was labeled, dated, and stored correctly. Specifically, opened items were not dated or discarded when they expired. These deficient practices had the potential to place 77 residents at risk of foodborne illness.Findings include:Review of the facility's policy titled Storage Areas last review dated 12/27/2025 documented that It is the intent of this center to store food in a manner that maintains quality and safety. The guidelines stated: Items should be inspected for quality and temperature control upon receipt. Items should be covered, sealed, labeled, and dated appropriately.Observation on 02/10/2026 at 8:48 AM with [NAME] CC revealed that the dry, freezer, and cold storage areas contained food items on the floor, and several opened items were not properly dated. [NAME] CC stated they had just received a delivery and had not yet had time to store the items. Bread was also found past the labeled date, and [NAME] CC acknowledged she had forgotten to update the dates. During the tour, the Kitchen Manager joined and confirmed that staff did not have time to put away the delivery. In the refrigerator, multiple trays of tea, water, juice, and soda were observed without dates.Interview on 02/12/2026 at 11:30 AM with the Kitchen Manager revealed that staff do not date boxes if the manufacturer's label already includes a date. She acknowledged that if staff forget to label opened food items and they expire, residents could get sick.Interview on 12/12/2026 at 11:38 AM with the Assistant Kitchen Manager BB stated that they usually pick the food items up off the floor, label and date them within 45 minutes of delivery and that it is either her, the kitchen manager or cook AA who is responsible for putting up the truck. She revealed that a negative outcome could be residents getting sick.Interview on 12/12/2026 at 11:39 AM with [NAME] AA revealed when a truck comes with a delivery, the items should be labeled and dated.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the policy titled SKILLED NURSING SERVICES Preventative Maintenance Schedule, the facility failed to ensure that resident room equipment and furnishings, specifically Packaged Terminal Air Conditioner (PTAC) unit filters and window blinds were maintained for one of two halls. These deficient practices had the potential to place residents at risk for unsanitary conditions and a reduced quality of life.Findings include: Review of the facility policy titled SKILLED NURSING SERVICES Preventative Maintenance Schedule dated 12/27/2025 documented that it was the intent of the center to develop preventative maintenance schedules to facilitate the maintenance of the building and equipment to ensure a safe and operable environment for residents.Review of the facility records titled DIRECT SUPPLY TELS Logbook Documentation for PTAC Inspections revealed that PTAC units were cleaned every six months and as needed. Further review revealed that the last facilityˆwide cleanings were documented on April 14, 2025, and September 9, 2025.Observations on 02/10/2026 at 9:26 AM, and again on 02/12/2026 at 10:47 AM, on the 200 Hall revealed that four of the 13 resident rooms, rooms 217, 219, 221, and 227, had PTAC unit mesh filters with a buildup of dirt and debris. Further observations on these dates revealed that one room, room [ROOM NUMBER], had torn window blinds in need of repair in one of the 13 resident rooms.Observations/interview on 02/12/2026 at 10:53 AM revealed that the Maintenance Director viewed the filters and acknowledged they should have been cleaned. The Maintenance Director stated he was uncertain of the specific schedule for filter cleanings at that time but confirmed that rooms were inspected regularly and blinds should not have been in disrepair. During a followˆup interview at 11:46 AM, the Maintenance Director stated that the PTAC units were cleaned every six months and as needed and verified that the last facilityˆwide cleaning occurred on September 9, 2025. He further stated that the cleaning schedule required more frequent intervals to prevent the heavy buildup of dirt and debris that was observed.Interview on 02/12/2026 at 1:10 PM with the Administrator revealed that it was her expectation that PTAC filters were cleaned on a regular basis. The Administrator stated the facility had already changed the schedule from every six months to every month starting that day. The Administrator further stated that dirty filters could lead to the worsening of resident allergies.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, record review, and review of the facility's policies titled Pharmacy Services, the facility failed to ensure that one of six medication carts were securely locked. This deficient practice had the potential to compromise medication security and integrity, placing residents as risk for harm related to medication diversion, tampering, or administration errors. Findings include:Review of the facility's policy titled Pharmacy Services, reviewed 12/31/2025, Medication Storage in the Care Center: Intent to facilitate safe, secure, and proper storage of medications and biologicals following manufacturer's recommendations or those of the supplier. GUIDELINE . Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. Medication Cart security: The Director of Nursing (DON) is responsible for controlling access to the medication care. Medication Cart Keys: Medication Cart keys must be in possession of the assigned nurse or certified medication aid, as applicable. An extra set of medication cart keys should be stored in a secure area managed by the DON. A document process should be in place to track keys issued for each medication cart in the center.Interview/Observation on 02/11/2026 at 9:31 AM revealed that Certified Medication Technician (CMT) DD walked away from an unlocked medication cart to enter a resident's room to perform a blood pressure check. The surveyor remained by the cart until CMT DD returned. CMT DD confirmed that she had left the cart unlocked. She further stated that the cart is left unlocked because she does not have the key to lock it, explaining that the otherˆshift CMTs sometimes take the key home. When asked what the disadvantages would be of leaving the medication cart open, CMT DD stated that someone could come and take medications out of the cart.Interview on 02/12/2026 at 11:53 AM with the Director of Nursing (DON) confirmed that her expectation was that medication carts should always be locked unless they were in active, visible use. The DON stated that the facility did not have backup keys and that keys should not be taken home.Interview on 02/12/2026 at 11:54 AM with the Administrator confirmed the same expectations was that medication carts should always be locked unless they were in active, visible use.