STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115262	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appling Nursing and Rehabilitation Pavilion	163 East Tollison Street Baxley, GA 31513

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled, Medication Administration, the facility failed to ensure accurate administration of medications for two of 25 medication opportunities observed resulting in a medication error rate of eight percent (8%.) This deficient practice resulted in residents receiving incorrect medication dosages, which has the potential to cause adverse drug reactions, ineffective treatment, and adverse clinical outcomes.Findings include:Review of facility policy titled, Medication Administration documented: Purpose: The purpose of this policy is to assure proper transcription and administration of medication.Plan: It shall be the policy of [NAME] HealthCare System to provide guidelines for proper administration of medication.Scope: This policy includes all clinical departments systemˆwide.Procedure: D. Medication Administration: Medications are administered only after checking the following: allergies, hold or NPO {nothing by mouth} status, the (Right Drug, Right Dose, Right Time, Right Method of Administration, and Right Patient). Scanning of the medication and scanning the patient armband is required as a safety check feature and to document the medication administration in the electronic medical record. The nurse is to remain with the patient until medication is taken. The nurse should be familiar with the following information:a. Action/Use of the drugb. Possible side effectsc. Food and drug interactionsd. Drug compatibilitiese. Usual dosages If further clarification is needed, the medication should be looked up utilizing a PDR, medication resources such as LexiˆComp or Dynamic Health on the Intranet under Education, or other resources provided. A pharmacist should be contacted if further assistance is required.1. Review of the electronic medical record (EMR) revealed resident R48 was admitted to the facility on [DATE] and pertinent diagnoses included but not limited to unspecified osteoarthritis, unspecified site, and anemia unspecified.Review of R48 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00, which indicated R48 has severe cognitive impairment.Review of the Physician's Orders for R48 included, but was not limited to, an order dated 11/07/2025 for Caltrate 600+D3 Oral Tablet 600-20 MG-MCG {milligram-micrograms} (Calcium Carbonate-Cholecalciferol): Give one tablet by mouth two times a day.Review of the EMR revealed that R69 was admitted to the facility on [DATE], with pertinent diagnoses included, but not limited to, vitamin D deficiency (unspecified).2. Review of R69 annual MDS assessment dated [DATE] revealed a BIMS score of 10, which indicated R69 has moderate cognitive impairment.Review of the Physician's Orders for R69 included, but was not limited to: Order dated 11/07/2025: Caltrate 600+D3 Oral Tablet 600-20 mg/mcg (Calcium Carbonate-Cholecalciferol). Give one tablet by mouth two times a day for Vitamin D Deficiency, Unspecified.An interview on 05/21/2026 at 2:00 PM with Licensed Practical Nurse (LPN) BB confirmed that the calcium with vitamin D given during the medication pass did not have the correct dosage of vitamin D. She confirmed that, according to the Medication Administration Record (MAR), R69 had an order for Caltrate 600+D3 Oral Tablet 600-20 mg/mcg (Calcium Carbonate-Cholecalciferol), and that the medication she gave was Caltrate 600+D3 Oral Tablet 600-10 mg/mcg. She returned to the cart and stated that she spoke with hospice and that she was told the medication could be changed to what was available at the facility.An interview on (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/21/2026 at 2:09 PM with Unit Manager (UM) AA confirmed that the administered calcium-vitamin D dosage was incorrect. She confirmed that, according to the MAR, R48 had an order for Caltrate 600+D3 Oral Tablet 600-20 mg/mcg (Calcium Carbonate-Cholecalciferol), and that the medication she gave was Caltrate 600+D3 Oral Tablet 600-10 mg/mcg. She confirmed that the resident was not getting enough vitamin D. When the surveyor asked what the policy was when she found that the medication on hand did not match the order, UM AA stated that they notified the provider of what they had on hand. The provider would decide whether to change the medication to the available option or have it filled at the hospital pharmacy. They then entered a new order from the Medical Director (MD) to change it.An interview on 05/21/2026 at 4:46 PM with the Director of Nursing (DON) revealed that her expectation was that staff checked the label on medications against the MAR. Nurses should have given medications as ordered. If there was a discrepancy, they called the doctor and got clarification. The DON stated that a negative outcome could occur with a resident getting the wrong dosage.

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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, interviews, record review, and review of facility policies titled, Medication Storage and Medication Expiration (Pavilion), the facility failed to ensure all medications and biologicals were stored and labeled properly. Specifically, expired medications were found in one of two medication storage rooms. This deficient practice has the potential to affect resident health and safety because expired medications may undergo chemical changes, lose potency, or become ineffective.Findings include:Review of facility policy titled, Medication Storage, documented Purpose: To ensure medications and biologics at (Facility) are stored safely, securely, and orderly; maintained at appropriate temperatures; protected from contamination; and accessible only to authorized personnel to promote resident safety and regulatory compliance Procedure 14 of the policy stated outdated, contaminated or deteriorated medication or those in containers which are cracked, soiled, or without secure closures must be removed from stock and destroyed according to procedures for drug destruction.Review of facility policy titled, Medication Expiration (Pavilion), documented Purpose: The purpose of the policy is to ensure that a beyond use date is provided for all dispensed medications for pavilion residents that follow federal and state laws, and USP guidelines Procedure .3. Expiration dating will be dictated by manufacturer recommendations, infection control parameters, and standards of practice.a. Products commonly dispensed in the manufacturer's original multiple dose container (i.e., oral liquid antacids and laxatives, cough syrups, creams, and ointments) will expire one year after opening.b. Ophthalmic, otic, and nasal products containing preservatives (multiple dose packages) will expire based upon storage, stability, and facility policy.c. Multiple dose injectables containing preservatives will expire 90 days after opening.d. Insulin will expire 28 days after opening.Any product dispensed by the pharmacy whose expiration date is dependent on the date of opening shall bear a DATE OPENED sticker or a place on the label to accommodate the date opened. If nursing personnel fail to note the actual date of opening, the dispensing date will be considered the date of opening and will be so noted by the consultant pharmacist/consultant technician upon inspection.Any pharmacist or nurse may declare a product unfit for use at any time, regardless of the expiration date, if there is reason to believe that the preparation is no longer sterile, otherwise contaminated, decomposed, or subpotent. The circumstances should be noted, and the preparation should be destroyed immediately according to the facility's policy.Observation and interview on 05/21/2026 at 12:20 PM with Unit Manager (UM) AA during an audit of the medication storage room in 300 Hall revealed two expired bottles of Vitamin D. One bottle had an expiration date of 03/2026, and the second bottle had an expiration date of 04/2026. UM AA confirmed the expiration dates and stated she was unsure why the expired medications remained in the medication storage room, as medications are typically checked during restocking. During the observation, Licensed Practical Nurse (LPN) BB entered the medication storage room and stated all nursing staff are responsible for monitoring medications for expiration dates. LPN BB further stated that when expired medications were identified, they were documented in the discontinued/expired log and provided to Registered Nurse (RN) Supervisor DD. According to LPN BB, the RN supervisor secured expired medications in a locked box until they are retrieved by the pharmacy. LPN BB also stated that the drug destroyer bottle is used for medications that were dropped, wasted, or discontinued.Observation on 05/21/2026 at 12:35 PM of the medication cart on 300 South with LPN BB revealed one insulin pen and one insulin vial labeled with an open date but without an expiration date. LPN BB confirmed that the medication should have had an open date and expiration date. Interview on 05/21/2026 at 4:46 PM with the Director of Nursing (DON) revealed that nursing staff were responsible for ensuring medications are not expired. The DON stated that medication cart audits were conducted every Sunday and Wednesday and included checks of the medication storage room. She also stated that staff should (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	label insulin with the open date, and the expiration date should be 28 days after opening. The DON stated that medication storage areas should be maintained in a neat, clean, and orderly manner and that expired medications should be removed and discarded. The DON also stated that the pharmacy consultant conducted monthly medication audits.