STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115265	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Satilla	1600 Riverside Ave Waycross, GA 31501

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interviews, record review, and review of the facility's policy titled, Comprehensive Care Plans, Facility A failed to implement the comprehensive care plan for one of 63 sampled Residents (R) (R112). Actual harm occurred on 12/5/2025 when Certified Nurse Assistant (CNA) LL failed to transfer R112 using two people to assist, which resulted in a left humerus fracture.Findings include:Review of the facility's policy titled, Comprehensive Care Plans, dated 1/1/2023 under the Policy section revealed, It is the policy of this facility to develop and implement comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a residents' medical, nursing, mental, and psychosocial needs and all services that are identified in the residents' assessment.Review of the quarterly Minimum Data Set (MDS) assessment for R112, dated 11/29/2025, revealed that Section C (Cognitive Patterns) documented that R112 had a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented that a chair-to-bed-to-chair transfer and a tub or shower transfer were not attempted due to medical condition or safety concerns. Section I (Active Diagnoses) documented diagnoses of, but not all inclusive, dementia, muscle weakness, congestive heart failure, osteoarthritis, and hypertension.Review of the care plan for R122, date initiated 6/8/2022 and revised 2/7/2024, revealed that R112 needed assistance with grooming, bathing, and personal hygiene related to mobility impairment and self-care impairment, and required two people at all times when giving care. Interventions included bathing assistance of two people, must have two people for all care provided, and transfer assistance of two people with a mechanical lift.Review of a Facility Incident Report Form, dated 12/7/2025, revealed R112 complained of pain to left shoulder post transfer to the shower chair. Resident noted to have bruising under left axilla and left arm. X-ray results showed fractured left proximal humerus.In an interview on 2/12/2026 at 5:15 PM, Certified Nurse Aide (CNA) LL confirmed that R112 required a mechanical lift transfer with two people. She reported that on 12/5/2025, she transferred R112 without assistance. She reported that R112 complained of pain during the last round at approximately 12/5/2025 at 5:30 PM. In an interview on 2/12/2026 at 4:59 PM, the National Director of Risk Management confirmed that the care plan interventions for R112 documented the resident required two-person assistance with a mechanical lift for transfers.In an interview on 2/12/2026 at 5:02 PM, the Administrator confirmed the care plan documented R112 required two persons assistance with a mechanical lift for transfers. Cross-Reference F-689

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on staff interviews, record review, and review of the facility's policy titled, Safe Resident Handling/Transfer, Facility A failed to ensure safe transfer to a shower chair for one of 68 sampled residents (R) (R112). Actual harm occurred on 12/5/2025 when Certified Nurse Assistant (CNA) LL failed to transfer R112 using two people to assist, which resulted in a left humerus fracture.Review of the facility's policy titled, Safe Resident Handling/Transfer, dated 1/1/2026, under the Policy section stated, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risk of injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines.Review of the quarterly Minimum Data Set (MDS) assessment for R112, dated 11/29/2025, revealed that Section C (Cognitive Patterns) documented that R112 had a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented that a chair-to-bed-to-chair transfer and a tub or shower transfer were not attempted due to medical condition or safety concerns. Section I (Active Diagnoses) documented diagnoses of, but not all inclusive, dementia, muscle weakness, congestive heart failure, osteoarthritis, and hypertension.Review of the Progress Notes for R112 revealed an entry dated 12/7/2025 of Bruising observed under resident's left axilla. Resident reported tenderness to the affected area. MD [medical doctor] notified; received order to obtain an X-ray.Review of a Radiology Results Report, dated 12/7/2025, for R112 revealed that the procedure was left humerus, 2+ views, and the findings were a fracture of the proximal humerus (upper bone of the arm).Review of a Facility Incident Report Form, dated 12/7/2025, revealed R112 complained of pain to left shoulder post transfer to the shower chair. Resident noted to have bruising under left axilla and left arm. X-ray results showed fractured left proximal humerus.In an interview on 2/12/2026 at 5:15 PM, Certified Nurse Aide (CNA) LL confirmed that R112 required a mechanical lift transfer with two people. She reported that on 12/5/2025, R112 was insistent on getting a shower to wash her hair, but all the mechanical lift pads were in use. She confirmed that she transferred R112 without assistance. CNA LL stated that another CNA was there to hold the shower chair during the transfer, but did not touch R112. She reported that R112 complained of pain during the last round at approximately 12/5/2025 at 5:30 PM. She states she reported it to the nurse.In an interview on 2/12/2026 at 5:29 PM, CNA MM confirmed that she held the shower chair while CNA LL transferred R112 without using the mechanical lift. She confirmed that R112 required two staff during transferring with the Hoyer lift. CNA MM stated that she did not physically transfer the resident, and that CNA LL picked the resident up under the resident's arms for the transfer.In an interview on 2/12/2026 at 4:53 PM, the Administrator revealed that the incident happened on 12/5/2025, and on 12/7/2025, the Director of Nursing (DON) notified the Administrator when bruising was identified under R112's left axilla.In an interview on 2/12/2026 at 4:59 PM, the National Director of Risk Management confirmed that R112 was a two-person assist for transfer using a mechanical lift. He stated he was unsure who the other person was who assisted the CNA.In an interview on 2/12/2026 at 5:02 PM, the Administrator confirmed that there should have been a second CNA. She confirmed that R112 required two-person assistance with transfers.

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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, record review, and review of facility's policy titled, Date Marketing for Food Safety Policy, Facility A failed to ensure food was stored, sealed, and labeled correctly. This deficient practice affected the facility kitchen and had the potential to cause food contamination and foodborne illness among all residents consuming facility-prepared food. Facility A had 75 sampled residents that received an oral diet from the kitchen.Findings include:A review of the facility's policy titled, Date Marketing for Food Safety Policy, dated 1/1/2026, revealed that the facility adheres to a date marketing system to ensure the safety of ready-to-eat, time/temperature control for safety food.During an observation and walk through of the kitchen on 2/10/2026 at 10:20 AM with the Dietary Manager (DM) revealed the following:1. In the walk-in freezer a bag of filet fish was observed freezer burned, undated, and unlabeled.2. In the walk-in freezer sweet potato waffle fries were observed unsealed and unlabeled. 3. In the walk-in freezer a bag of chicken fingers was observed opened, unsealed, and undated. 4. In the walk-in freezer a bag of chicken fingers was observed opened, unsealed, and undated.Interview on 2/10/2026 at 1:50 PM with the DM confirmed the findings and stated that moving forward he and the kitchen staff would routinely monitor the dates and labels of all foods stored in the walk-in freezer.-in freezer.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, record review, and review of the facility's policy titled, Disposal of Garbage and Refuse, Facility A failed to ensure trash and garbage refuse for one of two dumpsters was maintained in a sanitary manner, creating a potential of harboring pest and insects. The facility's census was 75 residents. Findings include:Review of the facility's policy titled, [Name of Facility] Disposal of Garbage and Refuse Procedure revealed containers shall be durable, cleanable, and free from cracks or leaks and covered when not in use.Observation on 2/12/2026 at 2:15 PM with the Dietary Manager revealed that the dumpster lid was open with no staff observed in the area.Interview on 2/12/2026 at 2:25 PM with the Dietary Manager confirmed the findings and acknowledged that the dumpster lid should be closed when not in use.Interview on 2/12/2026 at 5:50 PM with the Administrator confirmed the findings and acknowledged that the dumpster lid should be closed when not in use.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interviews, record review and review of the facility's policy titled Promoting/Maintaining Residents Dignity, Facility A failed to provide one of 59 sampled Residents (R) (R22) privacy during wound care. This deficient practice had the potential to place R22 at risk of diminished quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life.Findings Include:Review of the facility's policy titled, Promoting/Maintaining Residents Dignity, dated 1/1/2026 under the Policy section revealed that it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.Review of the significant change Minimum Data Set (MDS) assessment for R22, dated 12/23/2025, for Section C (Cognitive Patterns) revealed, R22 had a Brief Interview for Mental Status (BIMS) score of 10 (indicating moderate cognitive impairment). Section I (Active Diagnosis) documented diagnosis of, but not all inclusive, Alzheimer's disease, stage three sacral pressure sore, psychotic disturbances, and malignant neoplasm of stomach.Review of the care plan for R22, dated 12/9/2025, revealed that R22 had a pressure ulcer due to needing assistance with bed mobility, bowel and bladder incontinence.Observation on 2/11/2026 at 10:30 AM revealed the Wound Care Nurse, knocked on the R22's door, introduced herself, and explained the procedure to R22. She returned to obtain supplies. Further observation revealed, R22 in a private room with blinds open. Certified Nursing Assistant (CNA) EE, who was assisting the Wound Care Nurse proceeded to remove and change R22's soiled brief while the blinds remained opened, exposing R22 during the wound care.In an interview on 2/11/2026 at 11:03 AM, the Wound Care Nurse confirmed that the blind was open and that she should have closed the blind for the residents' privacy. In an interview on 2/11/2026 at 11:05 AM, CNA EE confirmed that the open blinds were exposing R22 during the entire care.In an interview on 2/12/2026 at 10:00 AM, the Unit Supervisor FF stated that the staff were to close blinds and pull curtains when providing care to residents to provide privacy.In an interview on 2/12/2026 at 12:36 PM, the Director of Nursing (DON) confirmed that when staff provide care to include wound care the blinds should be closed and curtains pulled.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled, Abuse Neglect and Exploitation, Facility A failed to protect the residents' right to be free from resident-to-resident abuse for one of two residents (R) (R151) reviewed for abuse. Specifically, R119 touched R151 on the breast. This deficient practice had the potential to affect other residents at the facility.Findings include:Review of the facility's policy titled Abuse Neglect and Exploitation, dated 7/15/2025 under Policy revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. VI. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:1.Responding immediately to protect the alleged victim and integrity of the investigation.2. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed.1. Review of the Electronic Medical Records (EMR) revealed R151 had diagnoses that included but not limited to down syndrome, mild neurocognitive disorder due to known physiological condition without behavioral disturbance, and mild neurocognitive disorder due to known physiological condition with behavioral disturbance.Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed that R151 had a Brief Interview for Mental Status (BIMS) of three, which indicated the resident had severe cognitive impairment.Review of R151's care plan included a focus area initiated on 2/12/2025, that indicated difficulty with making daily decisions (related to) r/t: down syndrome, and mild neurocognitive D/O (disorder).Review of R151's Progress Notes, revealed the following:On 1/2/2026 at 2:22 pm A staff member reported that upon returning from his break, he saw another resident (R119) touch this resident's (R151) left breast over her clothing while she was seated in a common area. Staff members quickly stepped in and redirected the residents away from the other individual. The involved resident was tearful but denied pain or injury when assessed. No redness, bruising, or marks noted to left breast. Both residents were separated and safety measures were reinforced. Administrator notified per facility policy. Voicemail left for RP (responsible party) to return call back. [Name] Police Department notified. Medical Doctor notified via on-call service. Awaiting call back from Medical Doctor at this time.On 1/2/2026 at 3:12 pm Family notified of state reportable filed today. She stated that she would notify the other siblings.2. Review of the EMR revealed R119 had diagnoses that included but not limited to, Alzheimer's disease, dementia, unspecified severity, with other behavioral disturbances.Review of the Quarterly MDS assessment dated [DATE], revealed R119 had a Brief Interview for Mental Status (BIMS) of 0, which indicated the resident had severe cognitive impairment. Review of R119's care plan included a focus area initiated on 7/14/2025, that indicated R119 displayed behaviors which included urinating in floor and other inappropriate areas. Further review indicated wandering, walking in hallway naked and going into other residents' rooms. Touched a female resident's breast (State reportable filed). Appropriate interventions in place. Revision completed on: 1/5/2026.Review of the police report dated 1/2/2026 at 1:00 pm indicated the officer responded to [Name] Nursing Home, in reference to R119 touching the breast of R151. The report further revealed when the officer arrived and spoke with Licensed Practical Nurse (LPN) FF. LPN FF revealed R119, who has a diagnosis of dementia and Alzheimer's disease, was rubbing the stomach of R151, who has a diagnosis of down syndrome. Staff at the nursing home told R119 to stop rubbing the stomach of R151, his hand rubbed across the outer clothing of her breast area as he was moving it away. LPN FF revealed R151 became upset and she needed the incident reported. LPN FF was unsure if R119 touched R151's breast on accident or not. A case card was given.Review of orders for R119 revealed an order dated 2/5/2026 for (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medroxyprogesterone Acetate Oral Tablet 10 MG (Medroxyprogesterone Acetate); give one tablet by mouth two times a day related to high-risk heterosexual behavior. During an interview on 2/10/2026 at 11:13 am with R151 confirmed that she knew R119 and that she does not like it when he comes into her room. She confirmed that R119 touched her, saying, Bad touch, and pointed to her right breast. Interview on 2/12/2026 at 3:00 pm with R100 revealed that she has been R151 roommate since her admission to the facility and has become her big sister. She revealed that R119 did touch R151's breasts, but she was not around when it happened. She further revealed, R119 wanders all the time and it seems like no one can control his wandering and that staff make excuses for him due to his diagnoses.Interview on 2/12/2026 at 9:00 am with LPN FF revealed that she worked with both residents (R119 and R151). She revealed that R151's communication was like a child but she was able communicate her needs, likes, and dislikes in her own way. She further revealed R119 touched her while in wheelchair by nurses' station. She stated that R119 was redirected and they were both separated LPN FF revealed that R119 was a very sweet touchy person when he talks to you and that was his character and he does not mean any harm. She stated R119 began to console R151 because she was complaining about her knee and patted her on the shoulder and then her breast while saying it's going to be alright.Interview on 2/12/2026 at 11:45 am with the Administrator confirmed R119 did touch R151 on her breast but feels that the resident did not mean it sexually. The Administrator further revealed, R151 was crying and that R119 told her she was going to be alright patting her on her shoulder first and then breast. R119 was redirected and both residents were separated and it was immediately reported to the State. Both residents' family was contacted. The physician was contacted and ordered skin assessments which were completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policy titled, MDS 3.0 Completion, Facility B failed to complete and transmit a Minimum Data Set (MDS) discharge assessment to the Center for Medicaid Services (CMS) for one of two residents (R) (R137) reviewed for discharge.Finding include:Review of the Electronic Medical Record (EMR) revealed that R137 was admitted to the facility on [DATE] with diagnoses that included but was not limited to streptococcal sepsis, cellulitis of right lower limb, and chronic obstructive pulmonary disease.Review of the EMR under the progress notes section revealed, a progress note dated 11/14/2025 that indicated R137 discharged home.Review of the EMR under the MDS section revealed, a discharge assessment had not been completed for R137. Review of the care plan dated 10/26/2025 for R137 revealed a focus of R137 wishes to discharge on ce antibiotic therapy is completed. Interventions included but not limited to Contact MD for discharge orders prior to anticipated discharge, make arrangement with required community resources to support independence post discharge. (i.e. home health, PT, OT, MD, wound nurse), review all meds and (Medical Doctor) MD Orders prior to discharge with resident and family.Interview on 2/12/2026 at 4:58 pm with the MDS/Resident Assessment Director revealed she sends the transmittal as soon as the discharge was completed. She confirmed that R137 was discharged on 11/14/2025 but the discharge assessment was not completed. She revealed that typically when she know that a resident was going to discharge, she would complete a paper that organizes them by payor source however she was unsure why the discharge assessment was not completed.Interview on 2/12/2026 at 5:15 pm with the Administrator revealed that she was unsure of why the discharge had not been completed because of all of the steps the MDS department goes through.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and review of the facility's policy titled Medication Administration via Enteral Tube, Facility A failed to ensure services provided met the professional standards of quality care for one of five Residents (R) (R 124) with gastrostomy tubes. This deficient practice had the potential to result in an adverse drug reaction, ineffective treatment, and medical complications.Findings include:Review of the facility's policy titled, Medication Administration via Enteral Tube, date reviewed 3/1/2025 under the Policy revealed, It is the policy of this facility to ensure the safe and effective administration of medication via enteral feeding by tubes utilizing best practices. Under Policy Explanation and Compliance Guidelines revealed, 6. Each medication will be administered separately, not combined or added to an enteral feeding formula.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Section C (Cognitive Patterns) revealed, R156 had a Brief Interview for Mental Status (BIMS) score of 13 indicating minimum to no cognitive impairment; Section I (Active Diagnoses) revealed diagnoses that included but not limited to psoriasis and hip fracture; Section GG (Functional Abilities and Goals) revealed that R156 was totally dependent on staff for activities of daily living (ADLs) with two persons-assist.A review of the Quarterly MDS assessment dated [DATE] revealed that R124 had a BIMS score of nine, indicating moderate cognitive impairment; that R124 had diagnoses of, but not limited to, cerebral palsy, asthma, protein-calorie malnutrition, gastrostomy tube, and dysphagia; and that R124 required maximal assistance from staff for ADL care with one person assistance.Review of the physician order dated 4/10/2023 for R124 revealed a diet order for nothing by mouth. An additional order on 4/10/2023 revealed that residents were to receive 60 milliliters (ml) of water before and after each medication pass.Observation on 2/11/2026 at 8:37 AM revealed that LPN CC crushed all R124 medications in the medication pouch. After flushing the tube with 100 ml of water, she administered the crushed medications in the tube. During the interview, LPN CC confirmed that she crushed all the medications together and administered them. She acknowledged that she should have crushed and administered them separately.An interview with the Director of Nursing (DON) on 2/11/2026 at 3:25 PM revealed that nurses were to crush each medication separately and administer them separately through a feeding tube.

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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. **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, Medication Storage and Controlled Substance Administration & Accountability, Facility A failed to ensure that three of three medication carts ([NAME] Hall, Sunflower Hall, and Dogwood Trail) did not have expired, unlabeled, and discontinued medications stored on the medication carts. The deficient practice had the potential to place residents at risk of receiving expired medications.Findings include:Review of the facility's policy titled, Medication Storage, dated 3/1/2025 revealed, all medications housed on premises will be stored in pharmacy or medication rooms according to the manufacturer's recommendations.Review of the facility's policy titled, Controlled Substance Administration & Accountability, dated 5/1/2025 under the Policy section revealed, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure.1. An observation and concurrent interview with Licensed Practical Nurse (LPN) AA on 2/11/2026 at 12:22 PM revealed, on the [NAME] Hall medication cart had a bottle of (Name) eye drops that had expired on 1/18/2026. In addition, there was a Lantus pen that was not labeled with a resident's name. LPN AA confirmed that the eye drops were expired and the Lantus pen was not labeled and did not have a resident name on it. She revealed that Lantus pen came from emergency box.2. An observation and concurrent interview with LPN AA on 2/11/2026 at 2:30 PM of the Sunflower Hall medication cart revealed that Insulin Aspartate had been opened on 1/10/2026 and expired on 2/7/2026. LPN AA confirmed that the insulin was expired.3. An observation and interview with LPN AA on 2/11/2026 at 2:49 PM of the Dogwood Trail medication cart revealed, morphine liquid, tramadol, and lorazepam in the third drawer lock box for a resident that had expired on 1/26/2026.Interview with Pharmacist Consultant (PC) on 2/12/2026 at 1:32 PM revealed that his last visit was on 1/15/2026 to the facility. The PC revealed that medication should be labeled with open and expiration dates. He revealed that insulin aspart was good for 28 days after it was opened stated that insulin from the emergency kit should be labeled with an open date, expiration date, patient's name, and room. He further revealed eye drops were good for 30 days after opening and that Narcotics were to be turned in immediately to the DON after the resident expired. The PC explained, narcotics that had been discontinued should not be left in medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115265	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Satilla	1600 Riverside Ave Waycross, GA 31501

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and review of the facility's policy titled, Enhanced Barrier Precautions, Facility A failed to ensure infection control practices were followed for one of two sampled Residents (R) (R22) reviewed for pressure ulcers. This deficient practice had the potential to place R22 at risk of infection due to cross-contamination and exposure.Findings include:Review of the facility's policy titled, Enhanced Barrier Precautions, dated 3/1/2025 under the Policy Explanation and Compliance Guidelines section revealed, an order for enhanced barrier precautions (EBP) will be obtained for residents with wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers) and /or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO (multi-drug resistant organism). Implementation of EBP included making gowns and gloves available immediately near or outside of the resident's room, is only necessary when performing high-contact care activities.Review of the Significant Change Minimum Data Set (MDS) for R22 dated 12/23/2025 for Section C (Cognitive Patterns) revealed, R1 had a Brief Interview for Mental Status (BIMS) score of 10 (indicating moderate cognitive impairment); Section I (Active Diagnosis) revealed diagnoses that included Alzheimer's disease, stage three sacral pressure sore, psychotic disturbances, and malignant neoplasm of the stomach.Review of the care plan for R22 dated 12/9/2025 revealed, that R22 had a pressure ulcer due to assistance needed with bed mobility, bowel and bladder incontinence.Review of physician order dated 1/26/2026 revealed, that R22 had an order for enhanced barrier precautions r/t (related to) wound every shift.Observation on 2/11/2026 at 10:30 AM revealed, the Wound Care Nurse knocked on the resident's door, introduced herself, and explained the procedure to R22. She cleaned the bedside table then she returned to her treatment cart to obtain supplies. The Wound Care Nurse obtained assistance from Certified Nursing Assistant (CNA) EE who was wearing gloves and no gown. CNA EE proceeded to remove and change R22's soiled brief. CNA EE then washed her hands, changed gloves, and continued to assist the Wound Care Nurse with no gown on.Interview with CNA EE on 2/11/2026 at 11:05 AM confirmed that she was not wearing a gown and that R22 was under enhanced barrier precautions. She acknowledged that she should have worn a gown. Interview with the Director of Nursing (DON) on 2/12/2026 at 12:36 PM revealed, that nurses and CNA's were to check the sign on the door and that staff should read what the sign says before entering. The DON further revealed that staff were to wear gowns and gloves for residents under enhanced barrier precautions.