STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115289	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Comer Health and Rehabilitation	2430 Paoli Road Comer, GA 30629

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, and review of the facility policy titled, Medication Storage in the Care Center, the facility failed to label and date an opened multidose medication vial, leaving no way for staff to determine its beyond-use date for one of one Medication Storage Rooms observed. This deficient practice could have caused the administration of expired or contaminated medication, placing 67 residents at risk for infection, reduced medication effectiveness and incorrect administration of medication.Findings include:A review of the Facility's Pharmacy Services Policy titled Medication Storage In the Care Center dated [DATE] showed under Intent: To facilitate safe, secure, and proper storage of medications and biologicals following manufacturer's recommendations or those of the supplier. The Policy further states under Guideline: . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or otherwise compromised are promptly removed from stock, disposed of according to procedures for medication destruction, and recorded from the pharmacy, if a current order exist.Observation on [DATE] at 02:03 PM of medication storage in the facility's Medication Storage Room located behind the nurses station between the A Hall and B Hall revealed the following:One (half-full) lidocaine HCL (hydrochloride) multiuse injection vial was found opened, unlabeled with no open date.Interview on [DATE] at 02:04 PM with Licensed Practical Nurse (LPN) CC, Charge Nurse for the A Hall, confirmed that the lidocaine vial, if opened, should be labeled with an open date or beyond-use date.Interview on [DATE] at 02:20 PM with LPN FF, Charge Nurse for the B Hall confirmed that the lidocaine vial should be discarded. As a result, LPN FF placed the lidocaine vial in a container filled with items to be properly discarded.During an interview on [DATE] at 4:57 PM with both the Director of Nursing (DON) and the Facility Administrator, the DON stated that it was the expectation that any medication vial that was opened required dating upon first puncture with either the beyond-use date or the opened date so that staff could safely administer medication to residents. Both the DON and Facility Administrator confirmed that it was unacceptable practice for the lidocaine vial to be opened without being labeled and dated with a beyond-use date or an opened date. Per the DON, potential outcomes included, but not limited to infection, incorrect administration of medication, and harm to residents.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on record review and staff interviews, the facility failed to provide appropriate infection control surveillance and to execute an organized and effective infection control prevention program to include surveillance monitoring. The deficient practice posed the potential for all 67 facility residents to be at increased risk for infection and medication ineffectiveness.Findings include:Review of the Infection Prevention Surveillance Binder for fiscal years 2025 and 2026 revealed surveillance monitoring reports titled HAI (Health Impact Assessment) Summary Reports were incomplete for 12 of 12 months reviewed. There was no analysis for specific trends or documented actions taken. There was no HAI Summary report for October 2025. The tab for October had a blank page and did not list any statistics for the month, infection analysis rates nor actions taken. There also were no HAI reports for August 2025, January 2026 nor February 2026. Interview on 02/26/2026 at 1:13 PM with the Infection Preventionist (IP), who is also the Assistant Director of Nursing (ADON), and two Surveyors revealed the IP had worked in the role of IP for the prior six months. The IP provided a description of the Infection Prevention Program, surveillance and monitoring activities, and report processes. She stated she regularly reported to the facility QAPI (quality assurance performance improvement) Meeting on a monthly basis. The IP confirmed that the Surveillance Logs for the 2025 calendar year and January 2026 were incomplete and had blanks for infection monitoring and assessment sections. She stated she was still orienting to her new role and her attention to surveillance reporting and IP activities were deferred due to her working medication carts due to staff shortages. During an interview on 02/26/2026 at 4:57 PM with both the Director of Nursing (DON) and the Administrator, the DON stated the facility regularly discussed resident change of condition, infection control protocols, and any observed variances, including inservice expectations in a number of venues including morning meetings, at change of shifts and other meetings including the QAPI Meeting. It was the expectation that surveillance communication was fluid across shifts and departments. Both the DON and the Administrator confirmed that it was unacceptable practice for records to be left blank. Infection control monitoring and staff education was important to keep people safe and having the ability to monitor for success.