STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115290	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Place at Deans Bridge, The	3235 Deans Bridge Road Augusta, GA 30906

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 - 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 policy titled Medication Labeling and Storage, the facility failed to ensure that expired medications were removed from active medication storage in one medication storage room and one of two medication carts. This deficient practices had the potential to place the residents at risk of receiving expired medications and had the potential to allow unauthorized access to controlled medications. Findings include:Review of the facility's policy titled Medication Labeling and Storage, revised February 2023, included, . If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.During an observation on 7/1/2025 at 4:55 pm of the medication storage room, medication cart, and medication refrigerator, with the Assistant Director of Nursing (ADON), the following were observed:In the medication storage room: One bottle of magnesium oxide 400milligram (mg), with an expiration date of 6/2025.One bottle of vitamin D 10mcg with an expiration date of 5/2025. Two bottles of milk of magnesium 16 fluid (F) ounce (oz) with an expiration date of 5/2025.One bottle of Geri Lanta 12oz, with an expiration date of 6/2025. One bottle of iron tablets, 325mg, with an expiration date of 6/2025. Three bottles of docusate sodium liquid 50mg/5 milliliter (ml), with expiration dates of 6/2025. One bottle of aspirin 81mg, with an expiration date of 7/2024.One bottle of folic acid 1000 micrograms (mcg) tablets, with an expiration date of 6/2025, was observed in one of two medication carts. During the observations, the ADON revealed that she had checked the storage room herself only a few days prior to the survey. She stated that she had removed all the expired medications and was very surprised at what was found. She added that a thorough reassessment would be done and all drugs checked and restocked.During an interview on July 2, 2025, at 12:46 p.m., the Director of Nursing (DON) revealed that a pharmacy consultant audits the medication carts and completes medication passes monthly. The DON stated that during the audits, all expired medications were removed and discarded. She stated that the supply clerk was responsible for auditing and stocking the medication supply room. She further stated that the nurses and managers were responsible for discarding expired medications.

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
	115290	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Place at Deans Bridge, The	3235 Deans Bridge Road Augusta, GA 30906

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 observation, policy review, and staff interviews, the facility failed to ensure that open food items in the dry storage area were securely wrapped, labeled, and dated, and also failed to discard food items by their expiration dates. This deficient practice had the potential to place residents who received an oral diet from the kitchen at risk of foodborne illness. The census was 78.Findings include:Review of facility policy titled Food Safety Handling Policy, included, . Notes labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date or discarded. Foods covered and in air-tight containers.1. Observation on 6/30/2025 at 10:23 am revealed a white plastic container of chicken bouillon concentrate in the walk-in freezer, with a use-by date of 12/11/2024. Further observation in the walk-in freezer revealed a bag of opened and undated breaded chicken tenderloin strips.2. Observation on 6/30/2025 at 10:45 am in the kitchen revealed two floor dry storage bins, unmarked and undated. The Dietary Manager (DM) stated the bins contained sugar and flour.3. Observation on 7/1/2025 at 11:15 am in the walk-in freezer revealed an opened and undated bag of sliced squash, an opened and undated bag of tater tots, and an opened and undated bag of chopped broccoli. In an interview on 6/30/2025 at 10:45 am, the DM verified that the bouillon was expired, and the frozen chopped broccoli was left over from the previous lunch meal, and had not been labeled. He stated that all staff were responsible for discarding expired food items and rotating stock.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115290	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Place at Deans Bridge, The	3235 Deans Bridge Road Augusta, GA 30906

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 - Some	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and review of the facility's policies titled Handwashing/ Hand Hygiene, Infection Prevention and Control Program, and Laundry Policy, the facility failed to ensure staff follow proper hand hygiene techniques when performing blood glucose testing on one resident (R) (R5). In addition, the facility failed to ensure the infection control process was followed when transporting clean linen to residents' rooms and for clean clothing in the laundry room. These deficient practices had the potential to place the residents at risk of infections due to cross-contamination. Findings include:Review of the facility's policy titled Hand Washing/ Hand Hygiene, revised August 2019, included, .Use an alcohol based hand rub containing at least 62% [percent] alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: after removing gloves. Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/ hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.Review of the facility's policy titled Infection Prevention and Control Program, reviewed November 2022, included . Standard Precautions, Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. All staff shall use personal protective equipment (PPE) according to established facilities policy governing the use of PPE. The Linens section included .Clean linen shall be delivered to resident care units on covered linen carts with covers down.Review of the facility's policy titled Laundry Policy, included . Staff shall consider all previously worn clothing and use linens as potentially contaminated. The facilities laundry area will provide hand washing, PPE. Laundry staff will be in service on handling linens and laundry on a regular basis.1. Review of R5 clinical record revealed diagnoses including, but not limited to, type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene.Observation on 7/2/2025 at 11:40 am revealed Licensed Practical Nurse (LPN) JJ performed a finger stick blood glucose test on R5. Observation revealed LPN JJ changed gloves without performing hand hygiene during the procedure.During an interview on 7/2/2025 at 12:04 pm, LPN JJ revealed that she should have performed hand hygiene between glove changes and stated that she was overwhelmed. 2. During an observation of the laundry area on 7/2/2025 at 12:12 pm, with the Maintenance and Housekeeping Manager, observation revealed a laundry attendant transporting clean linen in a covered laundry cart with resident clothing on hangers and hanging from the outside of the cart's handlebars. The clothing was uncovered and was observed brushing against the walls and handrails of the hallway. The Maintenance and Housekeeping Manager confirmed that the resident's clothing was uncovered and that they were brushing the walls and handrails in the hallways. He stated the clothing would have to be rewashed. Further observation of the laundry room revealed a basket containing clean clothing sitting by the folding table. The leg of a pair of pants was observed hanging from the basket and resting on the floor. The Maintenance and Housekeeping Manager stated the pants would have to be rewashed. During an interview on 7/2/2025 at 12:30 pm, the Laundry Attendant revealed that she did not return the soiled resident clothing to the laundry room. She stated that she was unaware that the resident's clothing on the cart needed to be covered, and did not realize the clothing had brushed against the walls in the hallway. The Laundry Attendant confirmed that they had transported the resident's laundry uncovered several times before.