

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Berrien Oaks Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 405 Laurel Street Nashville, GA 31639	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on observations, staff and resident interviews, record review, and review of the facility policy titled, Resident Rights, the facility failed to promote care in a manner that maintained or enhanced each resident's dignity and respect for two of 48 sampled residents (R) (R50 and R40). Specifically, staff provided personal hygiene and bathing assistance to R50 without providing full visual privacy and failed to ensure proper placement of a dignity bag for R40's catheter bag.</p> <p>Findings include:</p> <p>Review of the facility policy titled Resident Rights dated 8/30/2017 stated under 5. Respect and dignity: The resident has a right to be treated with respect and dignity, including: . (8). Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>1. Review of R50's electronic medical record (EMR) revealed diagnoses of but not limited to chronic kidney disease, diabetes mellitus type 2, and absence of left leg.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Intensive Mental Status (BIMS) score of 15, indicates little to no cognitive impairment.</p> <p>During an observation on 4/14/2025 at 2:31 pm of R50, who resides in a two-bed room, Certified Nursing Assistant (CNA) GG was observed assisting R50 with a bed bath and personal hygiene care. R50 was observed naked sitting on the side of the bed. During the process CNA GG entered the room without completely pulling the privacy curtain and closing the window blinds to ensure R50, who was in Bed A, received privacy from anyone who entered the room and her roommate who resided in bed B.</p> <p>During an interview at the time of observation on 4/14/2025 at 2:31 pm, CNA GG verified failing to pull the privacy curtains to ensure privacy and close the window blinds. CNA GG reported not receiving training that privacy curtains should completely encircle the bed to provide full visual privacy.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 4/14/2025 at 4:09 pm with Registered Nurse (RN) FF and R50, R50 verified that CNA GG failed to pull the privacy curtains or pull the window blinds while assisting her with her bath. R50 confirmed that she was completely naked. R50 reported that her preferences were to have full visual privacy without being exposed to anyone entering the room or visible to others who had open view from the parking lot (due to open window blinds). RN FF informed R50 and the Surveyor that privacy curtains and window blinds should have been pulled to ensure privacy during her bath.</p> <p>2. Review of R40's EMR revealed diagnoses of but not limited to chronic kidney disease stage four (Stage 4). R40 had an order for a foley catheter dated 4/8/2025.</p> <p>Review of the quarterly MDS for R40 dated 12/27/2024 assessed a BIMS score of 10, which indicates moderate cognitive impairment.</p> <p>Observations on 4/14/2025 at 12:42 pm and 3:30 pm, 4/15/2025 at 10:01 am and 3:10 pm, and 4/16/2025 at 2:20 pm, revealed R40 lying in bed A (room door opened) with an attached catheter and drainage bag. Continued observation revealed the dignity bag was flipped to the opposite clear side and allowed open visual exposure to urine.</p> <p>During an interview on 4/16/2025 at 3:10 pm with RN FF, she verified that Certified Nursing Assistant (CNA) staff failed to reposition the dignity bag on the correct side facing the door to prevent the urine from being exposed to the doorway. She further stated that CNAs were trained on dignity. She could not pinpoint which CNA was working with on the dayshift. RN FF returned to the resident room and provided a different dignity bag that provided full coverage on each side.</p> <p>Interview with the Director of Nursing (DON) on 4/17/2025 at 3:55 pm, the DON reported that she just did an in-service and CNAs should be pulling privacy curtains during resident care services. She reported being unaware that this was happening. She further stated that her expectation was that any resident with a catheter should have a dignity bag.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>39786</p> <p>Based on observations, resident and staff interviews, and review of the facility's policy titled, Physical Environment-Room Repairs, the facility failed to ensure that resident's rooms were clean and in good repair in two of five halls, in rooms (Rm) Rm 130, Rm 134, Rm 135, Rm 136, and Rm 143, and in the kitchen and laundry.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Physical Environment-Room Repairs effective date 9/26/2023 stated under Policy: The center will ensure the residents have a safe, homelike, environment free from physical hazards. Under Procedure: 1. To ensure a safe, homelike environment. Findings from these rounds will be prioritized and the repairs made as indicated. 2. Apart from completing room rounds, a Maintenance Care App (application) for any repairs staff find need completed throughout the day. Any repairs requiring immediate attention are to be reported directly to the Maintenance Director or Administrator.</p> <p>1. Observation on 4/14/2025 at 1:16 pm, on 4/15/2025 at 9:30 am and 3:05 pm, on 4/16/2025 at 12:16 pm, and on 4/17/2025 at 8:59 am inside resident Rm 136 revealed behind the head of bed B and to the side of bed B next to the window, the green painted wall was gouged or scrapped.</p> <p>Observation on 4/14/2025 at 1:25 pm, on 4/15/2025 at 3:10 pm, on 4/16/2025 at 8:10 am and 12:20 pm, and on 4/17/2025 at 9:06 am inside resident Rm 130 revealed broken sheetrock on the side and head of bed A.</p> <p>Observation on 4/14/2025 at 1:36 pm inside resident Rm 134 revealed a heavily coated dusty and broken air filter in the unit under the window.</p> <p>Observation on 4/15/2025 at 1:21 pm and 3:15 pm and on 4/16/2025 at 12:25 pm inside resident Rm 134 revealed the air filter had been cleaned but the filter was still broken and would not go all the way back down in the slot. R14 and her daughter who was visiting revealed the maintenance guy said that it needed repair.</p> <p>Observation on 4/17/2025 at 9:10 am inside resident Rm 134 revealed the broken air filter had been removed from the unit under the window. R14 was in bed B and her daughter was visiting and both stated the maintenance guy had removed the filter a few minutes ago to replace it.</p> <p>Observation on 4/14/2025 at 12:45 pm and on 4/17/2025 at 8:56 am inside resident Rm 135 revealed the top hinge to the bathroom door needed repair and the door leaned to one side causing it to rub and making it difficult to open and close the door. There was also broken sheetrock and broken tiles in the shower.</p> <p>Observation on 4/17/2025 at 1:25 pm inside Rm 143 revealed broken sheetrock at the side of bed A, bed height, and on the side of bed B above the baseboard under the window.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 4/17/2025 starting at 1:10 pm with the Administrator during walking rounds confirmed the following identified concerns needed cleaning, maintenance, or repair:</p> <p>Observation on 4/17/2025 at 1:24 pm inside Rm 143 of busted sheetrock at the side of bed A, bed height, and on the side of bed B above the baseboard under the window, confirmed by the Administrator who revealed it was from the bed being pushed against the wall and when they let the bed up and/or down it messed up the wall. He also confirmed the broken sheetrock by bed B below the window.</p> <p>Observation on 4/17/2025 at 1:26 pm in Rm 136 revealed a gouged wall at the head of bed B and to the side of the window. The Administrator confirmed it was scratched up and revealed it was the plastic (protective) wallboard and stated the white wallboard was showing/coming through the green paint from where it had been scratched/scuffed/gouged.</p> <p>Observation on 4/17/2025 at 1:28 pm in Rm 135 revealed the bathroom door top hinge needed repair, and broken tiles in the bathroom, confirmed by the Administrator.</p> <p>Observation on 4/17/2025 at 1:29 pm in Rm 134 revealed the broken air filter had been cleaned and removed by maintenance to replace it.</p> <p>Observation on 4/17/2025 at 1:30 pm in Rm 130 revealed broken sheetrock on two different walls, confirmed by the Administrator.</p> <p>36377</p> <p>2. Observation of the kitchen began on 4/14/2025 at 10:45 am and ended at 11:30 am. The following repairs needed were noted with the Dietary Manager (DM).</p> <p>Observation of walls on 4/14/2024 at 10:46 am of the dishwasher room revealed dirty floor tiles built up with dirt and grease, debris, and dirty walls, specially underneath the three-compartment sink and below the drying rack counter.</p> <p>Observation of the dishwasher door revealed a thick coating of rust.</p> <p>Observation of the chemical storage area on 4/14/2025 at 10:48 am revealed a dirty floor, large holes in the wall, and dark brown spots on the ceiling area.</p> <p>Observation of the kitchen exit door on 4/14/2025 at 10:50 am revealed the door failed to have a secure tight shut.</p> <p>Observation of the deep fryer on 4/14/2025 at 11:01 am revealed grease build up and a thick coating of rust on the side frame panel. Continued observation revealed a small hole which resulted in oil leaking from the fryer to the floor.</p> <p>Observation of the air conditioner unit duct on 4/14/2025 at 11:02 am revealed peeling aluminum.</p> <p>Observation of the door frame and wall corner edges on 4/14/2025 at 11:15 am revealed rugged edges and missing a wall seal and door frame seal.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 4/16/2025 at 2:02 pm with the Maintenance Supervisor confirmed the holes in the walls in the chemical area. He reported that he had already started repairs in the kitchen.</p> <p>Interview on 4/17/2025 at 11:05 am with the Administrator, he described the missing tiles and dark greyish tile color in the kitchen dishwash area as actually a thin layer of the cement. The Administrator confirmed all needed repairs in the kitchen and reported that his maintenance staff had been very active in completing most of the repairs this week.</p> <p>50941</p> <p>3. Observation of the kitchen began on 4/14/2025 at 10:45 am and ended at 11:30 am. The following repairs needed were noted with the Dietary Manager (DM).</p> <p>Observation of walls on 4/14/2024 at 10:46 am of the dishwasher room revealed dirty floor tiles built up with dirt and grease, debris, and dirty walls, specially underneath the three-compartment sink and below the drying rack counter.</p> <p>Observation of the dishwasher door revealed a thick coating of rust.</p> <p>Observation of the chemical storage area on 4/14/2025 at 10:48 am revealed a dirty floor, large holes in the wall, and dark brown spots on the ceiling area.</p> <p>Observation of the kitchen exit door on 4/14/2025 at 10:50 am revealed the door failed to have a secure tight shut.</p> <p>Observation of the deep fryer on 4/14/2025 at 11:01 am revealed grease build up and a thick coating of rust on the side frame panel. Continued observation revealed a small hole which resulted in oil leaking from the fryer to the floor.</p> <p>Observation of the air conditioner unit duct on 4/14/2025 at 11:02 am revealed peeling aluminum.</p> <p>Observation of the door frame and wall corner edges on 4/14/2025 at 11:15 am revealed rugged edges and missing a wall seal and door frame seal.</p> <p>Interview on 4/16/2025 at 2:02 pm with the Maintenance Supervisor confirmed the holes in the walls in the chemical area. He reported that he had already started repairs in the kitchen.</p> <p>Interview on 4/17/2025 at 11:05 am with the Administrator, he described the missing tiles and dark greyish tile color in the kitchen dishwash area as actually a thin layer of the cement. The Administrator confirmed all needed repairs in the kitchen and reported that his maintenance staff had been very active in completing most of the repairs this week.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377</p> <p>Based on staff interviews, record review, and review of the facility policy titled, Care Plan, the facility failed to ensure care plan development for one of 48 sampled residents (R) (R40) related to a foley catheter. The deficient practice had the potential for R40's needs and services to go unmet.</p> <p>Findings include:</p> <p>Review of the facility policy titled Care Plan with an effective date of 9/1/2022 stated under Policy: Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.</p> <p>1. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed in Section H (Bowel and Bladder) an assessment for catheter usage and oxygen therapy.</p> <p>Review of R40's physician orders revealed an order for a foley catheter.</p> <p>Review of R40's care plan revealed no plan of care for a foley catheter.</p> <p>Interview with the MDS Coordinator and Director of Nursing (DON) on 04/17/2025 at 3:50 pm, the MDS Coordinator verified that a care plan for the foley catheter was not created. The MDS Coordinator reported that the care plan was created on day four of the survey (which was 4/17/2025). The MDS and DON reported that any nurse could have created a care plan. The DON reported creating a care plan was important because it guided the patient care of the residents.</p> <p>Review of R40's Physician Order dated 8/16/202 stated O2 (oxygen) at 2 lpm (liters per minute) via NC (nasal cannula) as needed (PRN) for SOB (shortness of breath), low oxygen saturation (sat).</p> <p>Interview on 4/17/2025 at 3:50 pm, the MDS Coordinator reported that her expectation was that staff follow the care plan for oxygen therapy.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52213</p> <p>Based on observations, record review, staff interview, and review of the facility's policy titled, Oxygen Administration, the facility failed to properly administer oxygen (O₂) and properly maintain the oxygen concentrator for three of 14 residents (R) (R59, R53, and R40) currently using oxygen. The deficient practice had the potential of decreased blood oxygen levels, an increased risk of infection for the residents, and the danger of not knowing oxygen was in use.</p> <p>Findings include:</p> <p>A review of the facility's undated policy titled Oxygen Administration under Compliance Guidelines, number 5, Section a: Follow manufacturer recommendations for the frequency of cleaning equipment filters. The policy also states, 6. Oxygen warning signs must be placed on the door of the resident's room where oxygen is in use. 7. Cleaning and care of equipment shall be in accordance with the facility's Oxygen Safety Policy. The Oxygen Safety policy was requested, but the Director of Nursing (DON) stated that the facility had no such policy.</p> <p>1. Review of the electronic medical record (EMR) revealed that R59 was admitted to the facility with diagnoses of but not limited to chronic obstructive pulmonary disease (COPD), atrial fibrillation, and dependence on supplemental oxygen.</p> <p>Review of the Physician's Orders dated 10/4/2025 revealed and order for oxygen at 2 liters per minute (LPM) via nasal cannula (NC) as well as an order to change the oxygen tubing and humidifier bottle every Wednesday on night shift.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating little to no cognitive impairment. Section O (Special Treatments, Procedures, and Programs) revealed oxygen therapy.</p> <p>Review of the care plan, reviewed 1/28/2025, documented the problems/needs related to oxygen dependence included, risk for respiratory complications to include respiratory distress and infection. Interventions: Administer oxygen as needed per order; observe oxygen saturation and/or oxygen as ordered/indicated.</p> <p>Observation on 4/14/2025 at 1:11 pm of R59 revealed resident sitting up in bed with NC in their nose, O₂ running at 2 LPM. The O₂ tubing was noted to be crimped where the O₂ tubing exited the humidification bottle, not allowing O₂ to reach the resident. The filter was also noted to be caked with a thick layer of fluffy, white/gray substance resembling dust. The humidifier bottle was dated 4/9/25 [sic]. The resident denied shortness of breath (SOB).</p> <p>Observation on 4/14/2025 at 1:46 pm revealed the O₂ tubing was still crimped. R59's nurse, Registered Nurse (RN) JJ was notified. RN JJ immediately checked and verified R59's tubing was crimped and she uncrimped it. Nurse JJ stated at that time that tubing should not be crimped.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 4/15/2025 at 8:40 am, R59's O2 was checked. The tubing had been changed. R59's O2 was flowing freely, with no crimps noted in the tubing. The filter was still caked with a thick coating of fluffy, white/gray dusty substance.</p> <p>Observation on 4/17/2025 at 9:05 am, R59's O2 concentrator filter still noted to be dirty.</p> <p>Observation and interview on 4/17/2025 at 1:26 pm with the Administrator confirmed the dirty filter and he revealed that it should not be dirty and needed to be cleaned. The DON was also with the Administrator during the walking rounds and confirmed that the air filter to the O2 concentrator was dusty/dirty. The DON revealed that it was her expectation that the nurse on night shift (11:00 pm to 7:00 am) was to replace the O2 tubing and clean the air filter for the O2 concentrator weekly on Wednesday night. The facility had no smoking/no vaping signs outside of every resident room in the facility. There was no specific signage outside resident rooms indicating that O2 was in use. The Administrator stated, The no smoking or vaping signs should cover the Oxygen in Use sign rule. That was why we bought those stickers for every room.</p> <p>50171</p> <p>2. Review of R53's Face Sheet revealed diagnoses that included but not limited to urinary tract infection, site not specified, chronic obstructive pulmonary disease (COPD), unspecified.</p> <p>Review of R53's Quarterly MDS dated [DATE] revealed in Section C (Cognition) a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment; Section GG (Functional Status), resident requires minimal assistance with all Activities of Daily Living (ADL's); Section M (Skin), resident is at risk for pressure ulcers. Section O (Special Treatments, Procedures, Programs), resident receives Oxygen therapy.</p> <p>Review of R53's Physician's orders included but was not limited to NovoLOG FlexPen Solution Pen-injector 100 UNIT/ML (milliliter) (Insulin Aspart) Inject as per sliding scale: if 0 - 149 = 0 units, Insulin Degludec FlexTouch Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Degludec) Inject 15 unit subcutaneously at bedtime, Oxygen 2L (liters).</p> <p>Review of R53's care plans revealed a plan in place that have interventions that include administer medications as ordered, and administer oxygen as needed per order; observe oxygen saturations (sats) on room air and/or oxygen as ordered/indicated.</p> <p>An observation of R53 on 4/14/2025 at 1:45 pm revealed R53 lying in bed receiving O2 via NC, the oxygen was observed to be on 3.5 LPM.</p> <p>An observation of R53 on 4/14/2025 at 9:20 am revealed R53 was asleep in her bed receiving O2 via NC, the O2 was observed to be on 3.5 LPM.</p> <p>An observation of R53 on 4/16/2025 at 11:05 am revealed R53 was up in her wheelchair watching television. She was receiving O2 via NC, the O2 was observed to be set on 3.5 LPM.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 4/16/2025 at 11:50 am with the DON confirmed that R53's O2 should be set on 2 LPM and any resident on O2 should have an order for O2 and the orders should indicate the flow. A physician was the only person that could say if the resident should be on O2 and what the flow should be set on. The DON revealed that she expected the nurse to check the resident's O2, make sure they were not in distress, and if they felt that the residents needed more O2, they should call the physician. The DON stated that she was not sure why it wasn't on two, because all of the residents O2 was checked at the beginning of each shift to make sure it was correct.</p> <p>36377</p> <p>3. Review of R40's EMR revealed diagnoses of but not limited to Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and dependence on supplemental oxygen.</p> <p>Review of the MDS assessment revealed a BIMS score, of 10 which indicates moderate cognitive impairment. Section O (Special Treatments, Procedures, and Programs) resident was assessed for oxygen therapy usage.</p> <p>R40's care plan dated 7/23/2024 identified problem: My respiratory status is impaired due to Congestive Heart Failure, COPD, Obstructive Sleep Apnea; dependence on supplemental oxygen and listed an intervention to Administer oxygen as needed per order; observe oxygen saturations on room air and/or oxygen as ordered/indicated.</p> <p>Record review of R40's Physician Order and Medication Administration Record (MAR) dated April 2024 revealed an order dated 8/16/2023 that read O2 at 2lpm (liters per minute) via NC as needed for SOB, low oxygen saturation.</p> <p>Observation on 4/15/2025 at 2:00 pm to 3:37 pm. revealed R40 lying in bed receiving O2 by NC from her setting on 4 LPM. Signage posted on the doorway did not indicate O2 therapy was in use.</p> <p>During an observation at the time of an interview of R40 on 4/15/02025 at 3:37 pm, RN FF confirmed that R40's O2 setting was set on the wrong liter flow. She reported that R40 went out for a medical appointment and the O2 got set on the wrong liter flow. Signage posted on the doorway did not indicate O2 therapy was in use.</p> <p>Observation at the time of interview on 4/16/2025 at 1:20 pm of R40 with Licensed Practical Nurse (LPN) GG revealed resident lying in bed receiving O2 by O2 concentrator via NC on 3 LPM. LPN GG verified that R40 's O2 level was set on 3 LPM instead of 2 LPM. LPN GG adjusted the flow rate. Signage posted on the doorway did not indicate O2 therapy was in use.</p> <p>Interview on 4/17/2025 at 4:00 pm, The DON reported that her expectation was that nurses should have been making multiple rounds to monitor the resident 's O2 flow rate. She stated that prior to R40's fall, R40 had a history of adjusting her O2 flow rate. Since the fall, R40 was non-ambulatory and unable to get out of bed and adjust her O2 flow rate.</p>		