STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115343	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berrien Oaks Nursing and Rehab Center	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)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations and staff interviews, the facility failed to ensure pureed meals were prepared according to standardized recipes and appropriate consistency requirements for eight of eight residents who received a pureed diet. Specifically, pureed meals were not consistently prepared or served in a manner that maintained appropriate texture, appearance, palatability, and safety for residents with swallowing difficulties. This deficient practice had the potential to affect all residents receiving pureed diets by placing them at risk for choking, aspiration, poor nutritional intake, and decreased quality of life.Findings include:Observation on 05/11/2026 at 11:00 AM of puree preparation revealed that a recipe was not followed. The cook put some chicken salad in the blender, then she added water (did not measure the amount) she then put some chicken bouillon seasoning in a small Styrofoam cup and added it to the blender, she then blended the mixture, then checked it, and it appeared to be to have too much liquid in it because she then got another small Styrofoam cup and dipped some thickener out of a container, and then added it to the mixture, she then blended some more at which time she added more water. Nothing was measured during the process.Interview on 05/11/2026 at 11:15 AM with the [NAME] confirmed that she had been at the facility for eight years, and in those eight years, she had never used a recipe. She stated that she went by the consistency, and since she had been doing this so long, she knew what it should look like. Interview on 05/11/2026 at 11:30 AM with the Dietary Manager confirmed that they did not use recipes when preparing the puree meals.

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 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, and review of the facility policy titled, Food Storage: Cold Food Items, the facility failed to ensure that food was properly labeled and dated and in sanitary conditions to prevent foodborne illness. The deficient practice had the potential to affect 94 residents of 95 who received meals from the kitchen.Findings include:Review of the facility policy titled Food Storage: Cold Food Items revealed under Procedure: . 5. Cold foods are to be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross-contamination.A tour on 05/11/2026 at 9:45 AM with the Dietary Manager revealed the following concerns: Observation of the walk-in refrigerator revealed a bag of finely diced cabbage with carrots, a package of cooked ham, a piece of open ham, an open pack of what appeared to be sliced turkey, and a block of cheese, all with no label or date.Observation of the walk-in freezer showed a bag of zucchini, a bag of grilled cheese, and a package of green vegetables, all with no label or date.Observation of the dry food storage revealed expired cornmeal and flour in large containers. Interview on 05/11/2026 at 9:45 AM during the tour of the kitchen with the Dietary Manager confirmed all identified concerns. He immediately labeled and dated all items that were not labeled or dated. He confirmed that he was responsible for ensuring all food was labeled with open dates/ expired dates to ensure the safety of residents. Interview on 05/11/2026 at 10:30 AM with the [NAME] revealed that they all staff were responsible for making sure the food was labeled and dated when it came off the truck.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to ensure an indwelling Foley catheter drainage bag was covered to maintain dignity for one of three residents (R) (R57) reviewed for catheter care and dignity. This deficient practice had the potential to compromise the personal dignity of R57 by exposing clinical urinary waste to public view.Findings include:A review of the facility's electronic medical record (EMR) revealed R57's most recent admission to the facility was on 05/01/2026 with diagnoses including, but not limited to, retention of urine and presence of urogenital implants.A review of the admission Minimum Data Set (MDS) assessment dated [DATE] for R57 revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive decline. Section C (Cognitive Patterns) indicated severe cognitive impairment; a status of dependent for personal hygiene, Section GG (Functional Status), no indicators for rejection of care, Section E (Behavior), presence of an indwelling catheter.A review of the care plan for R57 dated 05/08/2026 revealed a focus area stating, I am incontinent of bowel and have a Foley Catheter. The goals with a target date of 08/06/2026 stated that R57 will not have complications from use of catheter such as pain, infection, or obstruction through next review. The interventions stated that staff should anchor catheter tubing to leg, avoid excessive tugging on catheter during delivery of care/transfers, utilize a catheter bag cover, complete catheter care every shift and as needed, check catheter tubing for proper drainage and positioning, and keep the drainage bag below level of the bladder at all times and off the floor.A review of physician orders revealed multiple active urinary retention and precaution orders, including but not limited to: Change 18fr (French) foley catheter with 10ml (milliliter) bulb to BSD (bedside drainage) bag starting on the 15th and ending on the 15th every month for urinary retention; Change foley catheter as needed for pain, blockage; Ensure catheter care completed every shift for urinary retention; Ensure foley catheter privacy bag in place every shift for urinary retention; and Enhanced Barrier Precaution (EBP) every shift for foley catheter.Observation on 05/11/2026 at 11:45 AM revealed R57 lying in bed. The resident's Foley catheter drainage bag was uncovered, leaving urine fully exposed to public view.Observation on 05/12/2026 at 09:45 AM revealed R57 lying in bed. The resident's Foley catheter drainage bag remained uncovered with the urine waste visibly exposed.Observation on 05/13/2026 at 11:05 AM revealed R57 in bed with the covers pulled over his head. The resident's Foley catheter drainage bag remained completely uncovered and visible to anyone entering the room.Observation and interview on 05/13/2026 at 11:23 AM with the Infection Preventionist (IP) revealed upon witnessing the exposed catheter drainage bag, the IP stated it was her expectation that Foley bags must be maintained in privacy bags at all times to preserve resident dignity.Interview on 05/13/2026 at 12:13 PM with the Director of Nursing (DON) revealed it was her direct expectation that catheter bags must be covered for dignity purposes.Interview on 05/14/2026 at 1:30 PM with the Administrator revealed a review of the above findings. The Administrator stated that these findings confirmed deficient practice, confirming that catheter drainage bags should not be left uncovered.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility policy titled, Medication Storage, the facility failed to assess for and obtain a physician order for the ability to self-administer medications for one of 58 sampled residents (R) (R3). The deficient practice had the potential for residents and visitors to access medications and experience adverse effects.Findings include:A Review of the facility's Medication Storage policy dated 12/08/2023 indicated under Policy: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. A review of the facility's electronic medical record (EMR) revealed R3's most recent readmission to the facility was on 03/09/2026 with diagnoses including, but not limited to, pressure ulcer of left heel (unstageable), pressure ulcer of the right heel (stage 4), type 2 diabetes mellitus, history of cardiovascular accident (CVA) with functional quadriplegia, and benign prostatic hyperplasia with lower urinary tract symptoms including ESBL (extended-spectrum beta-lactamase) positive Klebsiella/E. coli.A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for R3 revealed a Brief Interview for Mental Status (BIMS) score of 15 in Section C (Cognitive Patterns), indicating intact cognition; a status of dependent for all Activities of Daily Living (ADLs) in Section GG (Functional Status); the presence of an indwelling catheter in Section H (Bowel and Bladder); and the presence of active treatment for pressure ulcers in Section M (Skin Conditions).A review of the care plan for R3 dated 11/02/2022 and revised on 03/17/2026 revealed no documentation or assessment for self-administration of medications.A review of physician orders revealed no orders for self-administration of medications for R3.Observation on 05/11/2026 at 11:51 AM revealed R3 lying in bed with several topical medications left unsecured and unattended on the overbed table, the bedside dresser and at the sink. These findings included triple antibiotic ointment, hydrophilic wound dressing, antifungal cream, and Nystatin powder. Dermal wound cleanser was further observed on the overbed table immediately adjacent to the resident's breakfast tray.Observation on 05/12/2026 at 11:23 AM, immediately upon entering the room for wound care, revealed that all wound care medications remained unsecured on the bedside dresser and at the sink. During concurrent interviews, the Infection Preventionist (IP) and Wound Care Nurse acknowledged the safety risk of these findings, prompting the IP to immediately confiscate and discard the unsecured topical medications.Interview on 05/13/2026 at 12:13 PM with the Director of Nursing (DON) stated it was her expectation that all wound care supplies and medications remain secured on the medication and treatment carts. She further noted that leaving them at the bedside deviated from both the medication storage policy and her expectations for staff compliance.On 05/14/2026 at 1:30 PM, an interview with the Administrator stated that these findings were unacceptable practices, confirming that medications should not be accessible to residents or visitors as it constitutes an accident hazard.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and family interviews, and review of the facility's policy titled, Elopement and Wandering Policy, the facility failed to ensure safety for one of 48 sampled residents (R106). Specifically, the facility failed to provide adequate supervision and monitoring for R106 related to wandering and elopement. This deficient practice had the potential to place R106 at risk for safety concerns including but not limited to physical and/or mental distress.Findings include:Review of the facility's policy titled Elopement and Wandering Policy with an effective date of 07/09/2018 documented under Policy:This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Under Policy Explanation and Compliance Guidelines revealed: . 2. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. 3. The facility is equipped with door locks/alarms to help avoid elopements. 5. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 6. a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. d. Adequate supervision will be provided to help prevent accidents or elopements. 7. d. DON (Director of Nursing) or designee shall notify the physician and family member or legal representative. f. Once the resident is located all parties will be notified of the outcome. g. Appropriate reporting requirements to the State Agency shall be conducted. 8. Staff may be educated on the reasons for elopement and possible strategies for avoiding such behavior. f. When repeated elopement attempts occur, after the facility has exhausted possible care approaches, the resident may be referred for alternate placement in an appropriate facility. g. Documentation, physician/family notification, care plan discussions, and consultant notes as applicable. Tips for Prevention of Elopements: Consider use of a Chain of Custody for High Risk Residents; develop a schedule for periodic checks on the resident; never assume everyone knows the resident is a wanderer; make it clear to dining room aides, new staff and whoever is involved in the resident's care even for a short period of time. R106 was admitted to the facility on [DATE] with diagnoses that include, but not limited to, Alzheimer's disease and unspecified dementia, unspecified severity, with other behavioral disturbance.Review of the 04/20/2025 Comprehensive Minimum Data set (MDS) assessment for R106 revealed a Brief Interview for Mental Status (BIMS) score of 3. indicating severe cognitive impairment. Section GG, Functional Abilities and Goals revealed: Has not exhibited the behavior of wandering. Walking not attempted due to medical condition or safety concerns. Section H, Bladder and Bowel revealed: Occasional urinary incontinence (7 episodes of incontinence) and occasionally incontinent of bowel (one episode of bowel incontinence). Section N, Medications revealed: Takes an antipsychotic, antidepressant, and a diuretic 7 out of 7 days. Section P, Restraints revealed: No physical or electronic alarm devices used to monitor the movement of R106. Care Area Assessment (CAA) results include, but not limited to, cognitive loss/dementia, visual function, communication, urinary incontinence, and falls. No behavioral symptoms assessed. Review of the care plan for R106 initiated 07/05/2023 and revised 05/14/2025 revealed a focus that R106 has the potential for altered thought process, impaired cognition, and/or altered psychosocial well-being related to Alzheimer's disease, psychotic disorder, depression, and dementia as evidenced by confusion at times, impaired (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decision making, memory problems, disorganized thinking, wandering, delusions, will frequently remove hard cervical collar or decline to wear it. Goal is R106 will have optimal quality of life by socializing with others, attending activities, and involvement with care with a target date of 1/13/2026. Interventions include, but is not limited to, if R106 is wandering, ask if you can help her find something, observe for and document behavioral disturbances, observe ability to follow directions and assist with decision making as needed.There was no specific care plan in place for wandering / elopement for R106Review of physician orders for R106 revealed an order dated 06/27/2023 to chart observed behavior: 0. None, 1. Continuous crying/yelling, 2. Continuous pacing, 3. Hitting, 4. Kicking, 5. Head banging, 6. Scratching, 7. Biting, 8. Hallucination, 9. Paranoia, 10. Delusions, 11. Other.Review of the electronic medical record (EMR) for R109 revealed a progress note dated 10/13/2025 that stated, At approximately 00:15 am (12:15 AM) CNA (Certified Nursing Assistant) came to this nurse & (and) stated that she went in to check on resident & that she could not find her. This nurse, another floor nurse & (and) all CNAs looked all throughout building trying to locate resident (R106). Several staff members went outside in front & behind building to look for resident. Hospital security guard helped look also. 911 was called. This nurse notified DON (Director of Nursing). As police arrived, a CNA came up to front door & stated resident had been found. Resident was located in a bathroom that had light burned out, lying on back in bathtub. Resident was assessed for injuries; no injuries notified. Several staff members assisted resident from bathtub to W/C (wheelchair). Resident further assessed for injuries; none noted. Resident took to her room & assisted to bed. Resident kept stating that her husband had left her for another woman. V/S (Vital Signs) Temperature 97.5, pulse 78, respirations 18, BP (Blood Pressure) 130/72, O2 (Oxygen) saturation 98% on room air.Review of a progress note dated 10/05/2025 stated, Nurse from east wing noticed that someone passed by door near room [ROOM NUMBER]-160 and told her CNA someone was outside. She sent CNA down to look. This writer was down hallway at room [ROOM NUMBER] when resident came walking up sidewalk ramp pushing her wheelchair to come into the door. Resident never left the sidewalk from going around the buliding [sic]. Resident was brought back into the building and assessed. Resident had only been outside approximately 10 minutes because she was beside this writers [sic] medication cart when I was down by room [ROOM NUMBER] checking blood sugars and she was sitting there with me. She had just returned to the facility from spending the day with her family.Review of a progress note dated 09/10/2025 stated, Local hospital housekeeping staff notified this nurse that a resident was wandering the halls at the hospital in a w/c. Immediately went over to hospital and found resident propelling self down hallway with c-collar (cervical collar) in lap. C-collar reapplied and resident brought back to facility via w/c. Assessed locked doorway to and doorway locks without difficulty. Spouse, notified of incident. No s/s (signs and symptoms) of injury noted.Further review of the EMR revealed that R106 had no assessments completed for risk of elopement and unsafe wandering since admission to the facility on [DATE].Review of the Facility Reported Incidents (FRIs) since the last standard survey on 04/17/2025 revealed no FRIs related to R106's elopement on 10/05/2025.Review of care plan meetings for R106 revealed the last documented care plan meeting for the year 2025 was dated 01/07/2025 and there was no documentation in the notes for the meeting that related to concerns of wandering and elopement. Further review of the medical record revealed invites to the care plan meetings for the Resident Representative (RP) dated 01/08/2025, 03/27/2025, and 11/13/2025, but there were no documented notes for these meetings in the medical record.During a telephone interview on 05/11/2026 at 2:45 PM with a family member of R106, they confirmed being notified back in September 2025 when R106 went missing and was found in the hospital that attached to the facility. R106's family member stated that the facility notified them when R106 had a fall but was never made aware of any other time that she was missing from the facility or that she had gotten outside the building.During an interview on 05/12/2026 at 10:33 AM with Nurse Supervisor, she reviewed the medical record of R106 and confirmed there were no wandering or elopement assessments completed for R106. She confirmed there were invites to the care plan (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meetings for the Resident Representative (RP) dated 01/08/2025, 03/27/2025, and 11/13/2025, but there were no documented notes for these meetings in the medical record for R106.During an interview on 05/12/2026 at 11:00 AM with the Administrator, he confirmed there were no wandering or elopement assessments done for R106. He stated that he knew the nurse who documented the note about the resident who was outside the building but that he had a document written by a staff member about the incident that showed staff had their eyes on the resident the whole time and that the note in the chart was incorrect. Administrator stated that he did not report the elopement to the State Agency because staff had their eyes on the resident the whole time. He stated he would find the documentation and provide it to the survey team. The Administrator stated that the staff involved no longer worked in the facility.During an interview on 05/12/2026 at 2:00 PM with the Administrator, he stated that he was unable to locate additional documentation related to the elopement of R106 on 10/05/2025.During a telephone interview on 05/11/2026 at 3:49 PM with the Director of Nursing (DON) of the local hospital, she stated that one of her nurses worked PRN (as needed) at the nursing home adjacent to the hospital and was familiar with the residents there. She stated that the nurse identified R106 as she was near the entrance to the facility. The DON stated that the resident came through the door connecting the nursing home and the hospital and added that she (R106) was propelling in a wheelchair and it would have taken her at least 10 to 15 minutes to get to where she was located by staff in the hospital from the nursing home side of the building.During an interview on 05/13/2026 at 12:13 PM with the DON for the facility, she stated that they do not do hourly checks on residents who wander but ii was something that should be put into place and should be documented in the medical record of the resident who wanders.During an interview on 05/13/2026 at 3:45 PM with the Administrator, he stated that the facility no longer had alarms on the doors because they could be considered restraints. He stated they could not put belts on residents in wheelchairs as that was also a restraint. The Administrator stated that residents had the right to fall and he did not have enough staff to do one on one.