STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115351	A. Building B. Wing	02/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muscogee Manor & Rehabilitation Ctr	7150 Manor Road Columbus, GA 31907

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, record review, and review of the facility's policy titled Self-administered Medication, Treatments, the facility failed to ensure that one resident (R) (R57) of 42 sampled residents swallowed medication before leaving the resident's room. This deficient practice had the potential to increase the risk of clinical complications. Findings include:Review of the facility policy titled Self-administered Medication, Treatments reviewed 06/20/2023, documented under Policy Statement: Self-administered medications and treatments must be carefully monitored and recorded in Medication Administration Record (MAR) and Treatment Administration Record (TAR) and Self-administration of medications or treatments by residents is permitted by a physician order that includes dosage, route, and any special instructions.A review of the clinical record for R57 revealed an admission date of 11/02/2016 with diagnoses including but not limited to unspecified bipolar disorder, current episode mixed, severe, with psychotic features ,vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, bipolar disorder, current episode mixed, moderate, tremor, unspecified, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the quarterly Minimum Data Set (MDS) for R57 dated 02/03/2026 revealed a Brief Interview for Mental Status (BIMS) score of 03 indicating severe cognitive impairment.A review of the current comprehensive care plan revised 02/19/2026, revealed there was no plan documented for self-administration of medication. A review of the electronic medical record revealed there was no evidence for completion of an assessment for self-administration of medications. During observation and interview on 02/20/2026 at 9:20 AM, R57 was sitting up in bed. There was a clear small cup with water and a blue pill floating on the water sitting on the bedside table. When asked about the cup contents, R57 stated it is a pill and kept looking at the pill in the cup with water.During observation on 02/20/2026 at 9:30 AM, the clear cup containing a blue pill and water was still sitting on the bedside table next to R57.During an interview on 02/20/2026 at 9:50 AM with Licensed Practical Nurse (LPN) (LPN DD), she stated she gave the blue pill (divalproex sodium) to R57 this morning. LPN DD stated that R57 usually swallows the medication and was not sure why she did not swallow the pill.During an interview on 02/21/2026 at 10:00 AM with Unit Manager LPN HH regarding her expectation of staff related to medication administration, LPN HH stated she expects the staff to stay in the resident's room to ensure residents swallow the medication before they leave the room. LPN HH confirmed that R57 was not assessed for self-administration of 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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, resident and staff interviews, and review of the facility's policies titled Privacy Policy, Medication Administration General Guidelines, and Electronic Medical Records, the facility failed to ensure that private, clinical information was not visible to unauthorized staff, other residents, and visitors for three of 42 sampled residents (R) (R51, R62, and R43) and one of three medication carts. This deficient practice had the potential to place R51, R62, R43, and other residents at risk for protected health information to be viewed by unauthorized individuals. Findings include: Review of the facility's policy titled Privacy Policy, revised 09/10/2023, documented under the Policy: The nursing facility industries recognize their responsibility to keep information about you secure and confidential. Review of the facility's policy titled Medication Administration General Guidelines dated 01/2025, documented under Medication Administration: . 18. Resident's health information needs to remain private. Medication Administration Records [MARs] containing resident health information must not be visible when not in direct use (Paper MAR closed, Electronic Health Record information hidden). Review of the facility's policy titled Electronic Medical Records, revised 02/21/2025, documented under Procedures: . 3. Only authorized staff will be permitted access to the electronic medical records system. 9. Our electronic medical records system has safeguards to prevent unauthorized access. 1. Review of the quarterly Minimum Data Set (MDS) assessment for R51, dated 12/02/2025, Section C (Cognitive Patterns) documented a Brief Interview for Mental Status score of 06 which indicated severe cognitive impairment and Section K (Swallowing/Nutritional Status) documented that the resident received a mechanically altered diet at the time of the assessment. Review of the care plan for R51, revised 03/04/2025, documented a plan for the resident being at risk for altered nutrition. Review of the physician's orders for R51 revealed an order dated 08/07/2025, renal (dialysis) diet, minced & moist (5) texture, regular/thin consistency, with a 1500 milliliter fluid restriction and no dairy products. Review of the electronic medical record (EMR) for R51 revealed diagnoses including, but not limited to, end-stage renal disease and type 2 diabetes. Review of the progress notes for R51 revealed no evidence that the signage in the resident's room was requested by the resident or the representative. Observations on 02/20/2026 at 09:54 AM and 2:25 PM, and 02/21/2026 at 8:08 AM and 2:30 PM, revealed R51 lying in bed. Observations of the room revealed a sign on the wall above the head of the bed stating that the resident was to have no milk products or pudding. Another sign had instructions for aspiration precautions. In attempted interviews, R51 was unable to answer questions about the signage. 2. Review of the quarterly MDS assessment for R62, dated 12/30/2025, revealed that Section C (Cognitive Patterns) documented a BIMS score of 99 which indicated severe cognitive impairment and Section H (Bladder and Bowel) documented that the resident had an ostomy. Review of the care plan for R62 revised 01/16/2026, documented the resident had a colostomy. Interventions included changing the colostomy per protocol and checking the colostomy bag at least two times per shift. (continued on next page)

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	115351	A. Building B. Wing	02/22/2026

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders for R62 revealed an order dated 12/23/2025 for colostomy care per facility protocol, every shift, including checking the stoma area and reporting redness or irritation. Review of the EMR revealed diagnoses including, but not limited to colostomy status, cognitive communication deficit, and unspecified intellectual disabilities. Review of the progress notes for R62 revealed no evidence that the signage in the resident's room was requested by the resident or the representative. Observations on 02/20/2026 at 08:25 AM, 2:25 PM, and 02/21/2026 at 8:15 AM and 2:28 PM revealed R62 in a wheelchair in his room. Observations revealed a sign posted on the wall next to the bed stating the resident has a colostomy bag and to make sure to change it when the bag is full. Another sign was posted on the wall indicating a turning schedule. In attempted interviews, R62 was unable to answer questions about the signage. 3. Review of the quarterly MDS assessment for R43, dated 11/18/2025, revealed that Section C (Cognitive Patterns) documented that BIMS was not conducted because the resident was rarely/never understood and Section K (Swallowing and Nutritional Status) documented that the resident had a feeding tube at the time of the assessment. Review of the physician's orders for R43 revealed an order dated 03/24/2023, for enteral feed in the evening. Review of the EMR revealed diagnoses including, but not limited to, mild protein-calorie malnutrition. Review of the progress notes for R43 revealed no evidence that the signage in the resident's room was requested by the resident or the representative. Observations on 02/20/2026 at 09:15 AM and 02:55 PM, and 02/21/2026 at 8:22 AM, 12:20 PM, and 2:20 PM revealed R43 in bed with head of the bed (HOB) elevated. Observation of R43's room revealed a sign posted on the wall behind the head of the bed stating that the resident was a tube feeder, with instructions to elevate the head of the bed at all times. In attempted interviews, R43 was unable to answer questions about the signage. In an interview on 02/21/2026 at 2:45 PM, Certified Nurse Aide (CNA) JJ stated that the wall signage in resident rooms was placed to inform staff of residents' care needs. She stated she relied on the signs to inform her of the care required. In concurrent observations and an interview on 02/21/2026 at 2:55 PM, Licensed Practical Nurse (LPN) KK confirmed the signage in R51, R62, and R43's rooms. She stated she was unsure who placed the signs and that they had been on the wall for more than a few months. She stated that CNAs ask nurses when they have questions or concerns about resident care, and that nursing staff hold huddles to discuss resident care as needed. In an interview on 02/21/2026 at 3:05 PM, LPN/Unit Manager (UM) FF stated that the nursing and care plan team determined which residents needed medical instructional signage posted in their rooms. She stated the signs were placed to ensure the resident's care needs were communicated. LPN FF stated that nursing staff had huddle meetings to discuss resident care needs. In an interview on 02/21/2026 at 3:15 PM, LPN BB stated that medical instructional signage was (continued on next page)

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	115351	A. Building B. Wing	02/22/2026

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed in resident rooms to provide staff with instructions on resident care needs. She stated the signage contained medical information and should not be placed in the view of visitors. In a concurrent interview on 02/21/2026 at 3:30 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) stated that the Interdisciplinary Team (IDT) discussed and decided on the placement of medical information signage in resident rooms. They stated the signs were used to provide staff with information about the residents' care needs. The ADON stated there were no concerns with the signage being on the residents' walls. 4. Observation and interview on 2/21/2026 at 9:03 AM revealed Registered Nurse Supervisor (RNS) CC left the laptop screen open on the medication cart and walked away from the medication cart to go to the nurses' station on the East Hall. Information was visible on the screen, and a member of staff passed the medication cart while RNS CC was away from the cart. RNS CC confirmed she did not lock the screen on the laptop, and it should have been locked. She stated she was looking for the button earlier to lock the screen, but she was not familiar with that laptop and was not able to lock the screen. RNS CC stated that if the screen was not locked and the resident's information was visible on the screen, anybody could see the resident's information and that would be a breach of the resident's privacy and information. Interview on 02/21/2026 at 4:55 PM with the Assistant Director of Nursing (ADON) revealed that she stated the laptop screens should be locked when not in use to protect the resident's privacy. Interview on 02/21/2026 at 5:00 PM with the Director of Nursing (DON) revealed, she stated her expectations were for the nurses to lock the laptop screens when not in use. She stated that if the nurses stepped away from the laptops, the screens were to be locked because a resident could see information about another resident and it would be a HIPAA (Health Insurance Portability and Accountability Act) violation.

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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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility's policy titled Care Plan Policy, the facility failed to develop and/or implement a comprehensive care plan related to oxygen and medication parameters for two residents (R) (R62 and R70) from a sample of 42 residents. The deficient practice had the potential to increase the risk of clinical complications for R62 and R70. Findings include: Review of the facility's policy titled Care Plan Policy reviewed September 2025, documented under Procedure: 6. It is the responsibility of the Care Plan Coordinator to review timely a resident's status and any change in needs following a hospital stay or any other unexpected event as deemed appropriate. It is also the responsibility of the Care Plan Coordinator to ensure concerns/changes for a resident's care plan is updated. 7. It is the responsibility to review timely a resident's status and any change in needs following a hospital stay or any other unexpected event as deemed appropriate. 1. Review of the Electronic Medical Records (EMR) documented R62 was re-admitted to the facility on [DATE] with diagnosis included but not limited to hypertension. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview for Mental Status (BIMS) score of 09 which indicated R51 had severe cognitive impairment and Section I (Active Diagnosis) indicated R62 had hypertension at the time of the assessment. Review of the comprehensive care plan revised 01/16/2026, revealed there was no documented evidence that R62 had a care plan for hypertension. Review of Physician's Orders for R62 dated12/23/2025, documented including but not limited to metoprolol tartrate 50 milligrams (mg) give 1 tablet orally two times a day for hypertension. Observation and interview on 02/21/2026 at 8:50 AM during medication administration revealed, Licensed Practical Nurse (LPN) BB administered metoprolol 50 mg tablet to R62 and there was no parameter for the metoprolol medication. LPN BB confirmed there were no parameters for the metoprolol and the resident's heart rate was last checked on 02/19/2026. She stated metoprolol was not to be administered if the resident's heart rate was less than 60. She further stated that R62 had heart rate readings of less than 60 beats per minute (bpm) on a few occasions. LPN BB stated the nurses were responsible to find out from the doctor if there should be parameters before administering the blood pressure medications and to ensure metoprolol was not administered if R62's heart rate was less than 60 bpm. Record review of R62's EMR vital signs monitoring revealed R62 had heart rates below 60 beats per minute (bpm) on: 02/11/2026 58 bpm 02/02/2026 57 bpm 01/28/2026 54 bpm (continued on next page)

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	115351	A. Building B. Wing	02/22/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/28/2026 59 bpm 01/16/2026 58 bpm 01/12/2026 59 bpm Record review of R62's EMR vital signs monitoring revealed the last set of vital signs were done on 2/19/2026. Interview on 02/22/2026 at 7:47 AM with Nurse Manager (NM) FF revealed, she confirmed there was no care plan for hypertension for R62. She stated the nurses and NM were responsible for ensuring the care areas for the residents were included in the care plans. NM FF stated that hypertension should be on the care plan because the resident was admitted with hypertension. She further stated that R62 had a history of CVA and there was no care plan for hypertension and monitoring. Interview on 02/21/2026 at 7:53 AM with the MDS Coordinator GG revealed, she confirmed there was no care plan for hypertension regarding R62. She stated if a resident was admitted and was treated for hypertension, there should be a written care plan addressing the hypertension. She stated R62 was admitted with, treated for and received medication for hypertension. The MDS Coordinator stated that the care area for hypertension should be on the care plan because it was pertinent to the resident and it was an indicator to be care planned. Interview on 02/21/2026 at 7:53 AM with the Director of Nursing (DON) revealed, she stated her expectations were for the care areas for the residents to be care planned by the nurse managers and MDS Coordinator. The DON further stated that the care plan outlines the care of the residents and a negative outcome could result. Cross reference F755 2. Record review of the facility policy titled Oxygen Therapy Guidelines, revised 12/05/2025 documented, The following guidelines will be adhered to in all oxygen therapy patients at all times for any resident receiving oxygen therapy, and those orders will be followed. Water bottles, or humidifiers may be used in conjunction with oxygen concentrators up to 6 liters of flow via nasal cannula. It is not required that these devices be used if the liter flow is 2 LPM {liters per minute} or less unless the patients request it or there are visible signs of drying out of the nasal passages (blood -tinged nasal discharge or congestion). Any time the liter flow rate is above 2 LPM via nasal cannula, humidification may be added to the oxygen concentrator. These should be checked daily and changed when empty. Review of the electronic health record (EHR) for R70 revealed a diagnosis of but not limited to emphysema, asthma, and acute respiratory distress. Record review of R70's Annual Minimum Data Set (MDS) dated [DATE], revealed under Section O: (Special Treatment, Programs, and Procedures) that R70 was receiving oxygen. Section C: (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of 07, which indicated little to no cognitive impairment. Record review of the physician orders documented an order dated 02/03/2025, that R70 should receive oxygen 4 lpm {four liters per minute} via nasal cannula every day and night shift for dx: {diagnosis} emphysema and asthma. In addition, an order dated 02/03/2025 documented Oxygen: (continued on next page)

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	115351	A. Building B. Wing	02/22/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tubing and humidifier change every day shift every Monday. Record review of R70's care plan revised 02/05/2025, documented a focus area for oxygen therapy which stated She {R70} is currently on 02 @ 4 lpm NC {oxygen at four liters per minute nasal cannula}. The intervention listed documented, Administer oxygen and monitor O2 sat as ordered. An observation on 02/20/2026 at 9:35 AM, 12:01 PM, and 3:37 PM revealed R70 lying in bed receiving oxygen from an oxygen concentrator by nasal cannula at a flow rate of 3.5 LPM per minute instead of the physician ordered 4 LPM. In addition, there was no humidifier bottle attached to the oxygen concentrator per physician orders. An observation on 02/21/2026 at 9:36 AM, revealed R70 lying in bed receiving oxygen from a concentrator by nasal cannula at a flow rate of 4 LPM without a humidifier bottle attached and in use on the oxygen concentrator. An observation and interview on 02/21/2026 at 1:59 PM with Licensed Practical Nurse (LPN) CC confirmed R70 lying in bed receiving oxygen from an oxygen concentrator by nasal cannula at a flow rate of 4 LPM which is the correct rate compared to observation on 02/20/20/2026. However, LPN CC confirmed there was no humidifier bottle attached and in use on the oxygen concentrator per physician orders and should be used with R70. Interview on 02/22/2026 at 11:49 AM with the Director of Nursing (DON) and Administrator both confirmed it is the expectation for staff to ensure the resident is receiving oxygen at the correct flow rate and with a humidifier bottle according to the physician orders. Interview with the MDS Nurse on 02/22/2026 at 11:58 AM stated that her expectation is for staff to follow the care plan. Cross reference F695

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	115351	A. Building B. Wing	02/22/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interviews, and the facility policy titled Medication Administration Subcutaneous Insulin, the facility failed to follow physician ordered protocol for finger stick blood sugar results and failed to accurately administer insulin from a pen device for two residents (R) (R83 and R51) from a sample of 25 residents receiving insulin. The deficient practice increased the risk of poor clinical outcomes. Findings include:1. Review of the facility protocol titled Dr. (name) Insulin Protocol dated 08/08/2024, documented under Monitoring: 3) Call MD {Medical Doctor} for FSBS that are <50 mg/dl.Review of the electronic medical record (EMR) revealed R83 was admitted to the facility on [DATE]. The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed R83 had a Brief Interview for Mental Status (BIMS) score of 99 indicating severe cognitive impairment. The resident had a diagnosis of but not limited to Diabetes Mellitus (DM) and was receiving insulin.Review of a Physician Order dated 01/15/2026, documented, Insulin Protocol: Call MD For FSBS {finger stick blood sugar} that Are <50mg/dl {50 milligrams per deciliter is a unit to measure blood sugar levels in blood} as needed for DM.Review of the Medication Administration Record (MAR) documented a blood sugar result on 01/25/2026 of 46 and on 02/15/2026 a result of 43. Review of the MAR and EMR revealed no evidence that the physician was notified of the blood sugar results of less than 50. Interview with Licensed Practical Nurse (LPN) II on 02/22/2026 at 10:50 AM revealed she is agency and stated she was not sure about the blood sugar or insulin protocol and thinks it is specific to each resident. LPN II stated each resident will have physician orders on the protocol like giving glucose gel or juice and when to notify the physician of low blood sugar. Interview with the Assistant Director of Nursing (ADON) on 02/22/2026 at 12:25 PM revealed she spoke with the two nurses on the dates the blood sugar results were below 50. The ADON stated the two nurses gave the resident a juice and rechecked the blood sugar but failed to document the results of the recheck. The ADON confirmed they did not call the physician as ordered and they should have for the blood sugars of 43 and 46.2. Review of the facility's policy titled Medication Administration Subcutaneous Insulin dated 01/2023, documented Subcutaneous insulin, Policy: To administer subcutaneous insulin as ordered and in a safe, accurate and effective manner. Page 6. C. Keep the injection button pressed all the way in. Slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose will be delivered. Review of the Electronic Medical Records (EMR) documented R51 was admitted to the facility on [DATE] with diagnosis included but not limited to Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview for Mental Status (BIMS) score of 06 which indicated R51 had severe cognitive impairment, Section I (Active Diagnosis) R51 had Diabetes Mellitus, and Section N (Medication) R51 received insulin.Review of the care plan dated 12/01/2025, documented for R51 Focus: The resident has Diabetes Mellitus. Goal: The resident will be free from any signs and symptoms (s/sx) of hypoglycemia through the review date. Intervention: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.Review of Physician's Orders dated 06/10/2025, documented medication included but not limited to Lantus Solostar subcutaneous solution pen-injector 100 unit/ml (insulin glargine) inject 15 unit subcutaneously every morning and at bedtime related to type 2 diabetes mellitus with hyperglycemia. Observation and interview on 02/21/2026 at 8:17 AM during medication administration revealed that Licensed Practical Nurse (LPN) AA did not leave the insulin pen in place for at least 10 seconds after pushing the button on the insulin pen during insulin pen administration. LPN AA confirmed she did not hold the insulin pen in place long enough after injecting the insulin and she removed it too quickly. She stated if the insulin pen was not held in place when the insulin was injected, some of the insulin may spill out when the pen was removed and the resident would not receive the correct amount of insulin.Interview on 02/21/2026 at 4:55 PM with the Assistant Director of Nursing (ADON) confirmed insulin pen needles should be held in place for at least 10 seconds for all (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the insulin to be administered to the resident. The ADON stated the insulin pen should not be removed immediately because the insulin could leak out from the site and the resident would not receive all the medication.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled Oxygen Therapy Guidelines, the facility failed to ensure that one of 11 residents (R) (R70) receiving oxygen was administered oxygen therapy in accordance with the physician orders. This deficient practice had the potential to place R70 at risk for respiratory complications and a diminished quality life.Findings include:Record review of the facility policy titled Oxygen Therapy Guidelines, revised 12/05/2025 documented, The following guidelines will be adhered to in all oxygen therapy patients at all times for any resident receiving oxygen therapy, and those orders will be followed. Water bottles, or humidifiers may be used in conjunction with oxygen concentrators up to 6 liters of flow via nasal cannula. It is not required that these devices be used if the liter flow is 2 LPM {liters per minute} or less unless the patients request it or there are visible signs of drying out of the nasal passages (blood -tinged nasal discharge or congestion). Any time the liter flow rate is above 2 LPM via nasal cannula, humidification may be added to the oxygen concentrator. These should be checked daily and changed when empty.Review of the electronic health record (EHR) for R70 revealed a diagnosis of but not limited to emphysema, asthma, and acute respiratory distress.Record review of R70's Annual Minimum Data Set (MDS) dated [DATE], revealed under Section O: (Special Treatment, Programs, and Procedures) that R70 was receiving oxygen. Section C: (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of 07, which indicated little to no cognitive impairment.Record review of the physician orders documented an order dated 02/03/2025, that R70 should receive oxygen 4 lpm {four liters per minute} via nasal cannula every day and night shift for dx: {diagnosis} emphysema and asthma. In addition, an order dated 02/03/2025 documented Oxygen: tubing and humidifier change every day shift every Monday.Record review of R70's care plan revised 02/05/2025, documented a focus area for oxygen therapy which stated She {R70} is currently on 02 @ 4 lpm NC {oxygen at four liters per minute nasal cannula}. The intervention listed documented, Administer oxygen and monitor O2 sat as ordered.An observation on 02/20/2026 at 9:35 AM, 12:01 PM, and 3:37 PM revealed R70 lying in bed receiving oxygen from an oxygen concentrator by nasal cannula at a flow rate of 3.5 LPM per minute instead of the physician ordered 4 LPM. In addition, there was no humidifier bottle attached to the oxygen concentrator per physician orders.An observation on 02/21/2026 at 9:36 AM, revealed R70 lying in bed receiving oxygen from a concentrator by nasal cannula at a flow rate of 4 LPM without a humidifier bottle attached and in use on the oxygen concentrator. An observation and interview on 02/21/2026 at 1:59 PM with Licensed Practical Nurse (LPN) CC confirmed R70 lying in bed receiving oxygen from an oxygen concentrator by nasal cannula at a flow rate of 4 LPM which is the correct rate compared to observation on 02/20/20/2026. However, LPN CC confirmed there was no humidifier bottle attached and in use on the oxygen concentrator per physician orders and should be used with R70. Interview on 02/22/2026 at 11:49 AM with the Director of Nursing (DON) and Administrator both confirmed it is the expectation for staff to ensure the resident is receiving oxygen at the correct flow rate and with a humidifier bottle according to the physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115351	A. Building B. Wing	02/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muscogee Manor & Rehabilitation Ctr	7150 Manor Road Columbus, GA 31907

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review and review of the facility's policy titled Medication Administration General Guidelines, the facility failed to follow acceptable standards of practice when administering medications for one resident (R) (R62) from a sample of 42 residents. The deficient practice had the potential to increase the risk of poor clinical outcomes. Findings include:Review of the facility's policy titled Medication Administration General Guidelines, dated 01/2025, documented Medication Administration 2. Obtain and record any vital signs as necessary prior to medication administration. In addition, 20. The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR (medication administration record), and action taken as appropriate.Review of the Electronic Medical Records (EMR) documented R62 was re-admitted to the facility on [DATE] with diagnosis included but not limited to hypertension.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview for Mental Status (BIMS) score of nine which indicated R51 had moderate cognitive impairment and Section I (Active Diagnosis) hypertension.Review of the comprehensive care plan revised 09/23/2025, revealed there was no written care plan addressing hypertension and/or associated medications.Review of Physician's Orders dated 12/23/2025, documented and order for metoprolol tartrate 50 milligrams (mg) give 1 tablet orally two times a day for hypertension.Observation and interview on 02/21/2026 at 8:50 AM during medication administration, Licensed Practical Nurse (LPN) BB administered metoprolol 50 mg tablet to R62 without checking a pulse or blood pressure prior to administering the metoprolol medication. LPN BB confirmed there were no parameters ordered or checked for the use of metoprolol. She stated metoprolol was not to be administered if the resident's heart rate was less than 60 beats per minute (bpm). LPN BB further stated that R62 had heart rate readings of less than 60 bpm on a few occasions based on his vital signs record. LPN BB stated the nurses were responsible to find out from the doctor if there should be parameters before administering the blood pressure medications and to ensure metoprolol was not administered if R62's heart rate was less than 60 bpm.Record review of R62's EMR vital signs monitoring revealed R62 had heart rates below 60 beats per minute (bpm) on:02/11/2026 58 bpm02/02/2026 57 bpm01/28/2026 54 bpm01/28/2026 59 bpm01/16/2026 58 bpm01/12/2026 59 bpmInterview on 02/21/2026 at 4:55 PM, the Assistant Director of Nursing (ADON) stated the nurses should call the doctor for parameters on certain medications such as metoprolol. She confirmed if there were no parameters assessed; the resident's heart rate could drop when they take metoprolol.Interview on 02/21/2026 at 5:00 PM, the Director of Nursing (DON) stated the nurses should recognize if there was a need for metoprolol to have parameters and to call the doctor for parameter orders. The DON confirmed the resident's heart rate could fall when they take metoprolol and the nurses should reach out to the doctor for advice on getting parameters when administering the medication.Interview on 02/21/2026 at 10:56 AM, the Pharmacist stated the resident should be monitored for drop in blood pressure and drop in heart rate when receiving metoprolol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115351	A. Building B. Wing	02/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Muscogee Manor & Rehabilitation Ctr	7150 Manor Road Columbus, GA 31907

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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. Based on observations, staff interviews and record review, the facility failed to place open dates on two bottles of glucose test strips in two of four medication carts. This deficient practice had the potential to cause abnormal blood sugar readings and worsening of the residents' medical conditions.Findings include:Review of the facility's documents demonstrated a policy was requested from the facility for blood sugar strips however no policy was provided.Observation and interview on 02/21/2026 at 1:27 PM during review of the medication cart 1 on the [NAME] Wing revealed one bottle of blood sugar test strips was in the cart with no open dates. Licensed Practical Nurse (LPN) DD was present during the review and confirmed the bottle of blood sugar test strips had no open date.Observation and interview on 02/21/2026 at 1:43 PM during review of the medication cart 2 on the [NAME] Wing revealed one bottle of blood sugar test strips were in the cart with no open dates. LPN EE was present during the review and confirmed the bottle of blood sugar test strips had no open date. Record review of the facility's Checklist for Blood Sugar documented number 60. Blood Glucose monitoring solution/strips dated. (Expires 3 months after first use).Interview on 02/22/2026 at 8:52 AM with the Assistant Director of Nursing (ADON) confirmed the opening date should be placed on the glucose strip bottle when they are first opened. She stated the nurses would not know when the days are up since the strips would be effective for only a certain time period after opening.Interview on 02/22/2026 at 8:55 AM with the Director of Nursing (DON) revealed it is her expectation for open dates to be placed on the bottles of glucometer strips upon opening. She stated after the bottle is opened there was a certain time period within which they should be used. The DON stated that if the strips had no open date and the time period passed within which they should be used, the efficacy of the strips may not be what they should be, and the resident may have inaccurate blood sugar readings.