STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Dublinair Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Industrial Blvd Dublin, GA 31021	

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 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 observations, staff, resident and resident representative interviews, and review of the facility's policy titled Care Plans, Comprehensive Person-Centered, the facility failed to develop a comprehensive person-centered care plan for one residents (R) (R3) related to heel boots. Additionally, the facility failed to develop a comprehensive person-centered care plan for one resident (R2) related to fall mats. This failure has the potential to place residents at risk for unmet needs and diminished quality of life. 1. Findings include: Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, revealed, that A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.8. The comprehensive, person-centered care plan will: a include measurable objectives and time frames; include the resident stated goals upon admission and desired outcomes; Include incorporate identified problem areas; Incorporate risk factors associated with identified problems; Build on the residence strengths; Aid in preventing or reducing decline in the residence functional status and/ or functional levels. Review of the Electronic Medical Record (EMR) revealed R2 was admitted into the facility on 3/5/2025 with a diagnosis that included, but not limited to, mood disorder due to a known physiological condition with depressive features, fracture of unspecified part of left clavicle, initial encounter for closed fracture. Review of the most recent Significant Change Minimum Data Set (MDS) dated [DATE] documented that R2 had a Brief Interview of Mental Status (BIMS) of 07, indicating that the resident has cognitive impairment. (Section GG) revealed that the resident is dependent for all (Activities of Daily Living) ADL care. Review of the Physicians' orders for R2 revealed an order dated 12/31/2025 for the resident's bed to be low with fall mats Review of R2's care plan dated 12/29/2025 revealed it was not updated to reflect the physician's order requiring fall mats. Goals and interventions were not developed. Observation made on 2/3/2026 at 1:00 PM of R2 in bed with no fall mats. Observation made on 2/3/2026 at 5:30 PM of R2 in bed with no fall mats. (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation made on 2/4/2026 at 12:15 PM of R2 in bed with no fall mats. Observation made on 2/5/2026 at 9:15 AM of R2 in bed with no fall mats. An interview and observation on 2/5/2026 at 9:15 AM with the Director of Nursing (DON) revealed that R2's fall mats were not placed on the side of the bed or in the resident's room. The DON revealed that she expects the staff to follow all doctors' orders and that it be placed on the care plan. 2. Review of the EMR revealed R3 was admitted into the facility on 3/8/2023 with a diagnosis that included but not limited to anxiety disorder, chronic pain syndrome, mild protein- calorie malnutrition. Review of the most recent Significant Change Minimum Data Set (MDS) dated [DATE] documented that R3 had a Brief Interview of Mental Status (BIMS) of 99 indicating that the resident had severe cognitive impairment. Review of R3's care plan dated 10/23/2025 revealed it was not updated to reflect the physician's order dated 1/16/2026 requiring the resident to wear bilateral heel boots at all times, every shift. Goals and interventions were not developed. Review of the Physicians' orders for R3 revealed an order dated 1/16/2026 for the resident to wear bilateral heel boots at all times, every shift. Observation made on 2/3/2026 at 1:13 PM of R3 in her geri chair in her room and bilateral heel boots were not worn. Observation made on 2/4/2026 at 12:46 PM of R3 in her geri chair in her room and bilateral heel boots were not worn. Observation and interview on 2/4/2026 at 5:45 PM of R3 in her room, in her geriatic chair revealed bilateral boots were not being worn. Interview with oldest daughter revealed that bilateral boots are worn only on occasions, although the family has expressed concerns to the staff. An interview with Director of Nursing (DON) on 2/5/2026 at 1:52 PM revealed that her expectations if for staff to follow MD orders as written and that the care plan be updated as significant changes occur.

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	115356	A. Building B. Wing	02/05/2026

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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 0689 Level of Harm - 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 staff and family interviews, record reviews, and a review of the facility's policy titled, Accidents and Incidents - Investigating and Reporting, the facility failed to provide an environment free from accident hazards for one of one Residents (R) (R3) related to a fall. On 12/12/2025, actual harm occurred when Licensed Practical Nurse (LPN) FF blew an air horn on C hall (R3 was ambulating at the time of the air horn activation), which startled R3 and increased ambulation, resulting in a fall. R3 sustained an acute comminuted intertrochanteric fracture of the right femur. R3 was hospitalized on [DATE] and underwent an operative fixation (a surgical repair for broken bones) as a result of the fall. Findings include:Review of the Electronic Medical Records (EMR) for R3 revealed resident was admitted into the facility on 3/8/2023 with a diagnosis that included: dementia in other diseases classified elsewhere, Alzheimer's Disease, unspecified severity with mood disturbance, and depression.Review of the most recent Significant Change Minimum Data Set (MDS) dated [DATE] documented that R3 had a Brief Interview of Mental Status (BIMS) of 99, indicating severe cognitive impairment. Further review revealed that R3 displays signs of wandering daily, no recent behaviors, dependent for bathing, dressing and personal hygiene.Review of R3's care plan dated 10/23/2025 revealed that R3 would be free of falls through the review date of 10/14/2025 with no revision date. Interventions include refer R3 for physical therapy evaluation (PT) as needed, monitor the changes in the condition that may warrant increased supervision/assistance and notify the physician, refer to restorative nursing programs as needed, evaluate the effectiveness and side effects of psychotropic drug(s) for possible decrease in dosage/elimination of drugs, encourage the use of non-skid footwear as tolerated and low beds with fall mats.Review of R3's facility records revealed witness statements detailing the fall of R3 that occurred on 12/12/2025. Witness statement #1 received from Certified Nursing Assistant (CNA) LL revealed that she witnessed Licensed Practical Nurse (LPN) FF blowing an air horn behind R3 going down the hall. She reported it startled R3 and she was walking fast. CNA LL stated she kept telling R3 to slow down but by the time she was able to get close to her, she had fallen. LPN FF was trying to get R3 to walk but I sat her down in her Geri chair. At the end of my shift, she was still sitting in the Geri chair.Witness statement # 2 received from CNA OO revealed that at approximately 11:00 p.m., I assisted another CNA with changing R3. During care, we both noticed a bruise on her right hip. We immediately notified LPN FF. She came in and completed an assessment. Afterward, we ensured that R3's bed was in the lowest position before leaving the room.Witness statement # 3 received from LPN NN revealed on 12/12/2025, she was standing at Nurses Station 1 with the Consultant Pharmacy Representative receiving medications when an air horn was blown by LPN FF. After the air horn was blown, R3 was observed moving past the nurses' station at a fast pace. LPN NN returned to Nurses Station 2 to put the received medications away. She was not made aware of a fall until several hours into the shift and did not witness the fall.Telephone interview with LPN FF on 02/04/2026 at 3:43 PM. She stated that on the evening of the incident, R3 was ambulating from D and E Hall toward C Hall with CNA LL. LPN FF revealed that CNA LL was instructing R3 to slow down, as the resident was walking at a fast pace. LPN FF stated that she activated an air horn; however, she denied that the air horn was related to the R3's fall and stated it was intended to startle other staff members, including LPN MM. LPN FF reported that R3 was walking quickly but denied that she was running at any time. She stated that after CNA LL released the resident's hand, R3 continued down the hallway and subsequently fell over lifting equipment that was positioned in the hallway. LPN FF stated that R3 was found on the lip of the equipment, which is where staff assisted her after the fall. LPN FF stated that (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	she had been counseled by administration regarding the incident and was instructed not to bring or use an air horn at work and not to record or post videos while at work. LPN FF stated that she would not engage in these actions again.Telephone interview on 2/4/2026 at 6:04 PM with complainant revealed that on the evening of December 12th at 7:51 p.m., she received a call from LPN FF stating that R3 had taken off running, fallen, and hit her head. She asked if I wanted her sent to the emergency room. The complainant revealed that R3 has severe dementia and is unable to speak for herself, feed herself, or make decisions of any kind. The last time she was taken to the emergency room (ER), she became extremely combative and distressed. After that incident, the doctor and I agreed that, if possible, she should be monitored at the nursing home rather than sent to the ER. Because of this, I told the nursing home not to send her to the ER and to monitor her, as I was unable to get there immediately. They informed me that she seemed okay, her vital signs were good, she was acting like herself, and she had a goose egg on her head. The complainant stated at approximately 1:30 AM a family member received a phone call from the emergency room informing her that R3 was being admitted . We were told that she had a broken hip and would require surgery, and that the surgery was scheduled to take place the following morning.Review of hospital records dated 12/13/2025 R3 was seen at the local emergency room (ER) related to a fall in which R3 hit her head, resulting in a large hematoma. Initially, the family did not desire transport to the ER, however R3 was unable to bear weight on her right lower extremity and complained of pain. A right hip and femur x-ray revealed an acute comminuted intertrochanteric fracture of the right femur. R3 was also positive for an acute urinary tract infection. An orthopedic surgeon was consulted, and a surgical fixation was completed on 12/13/2025. The procedure performed was right hip cehalomedullary nail placement with a reduction. R3 will follow up in two weeks for suture removal. R3 was discharged back to the facility on [DATE].An interview was conducted with CNA II on 2/5/2026 at 12:15 PM. CNA II stated that she was aware of the foghorn-related incident; however, her shift had ended before it occurred. CNA II stated that LPN FF had been blowing the foghorn throughout the day on the date of the incident; however, CNA II stated that the foghorn was not blown at her. Interview with LPN JJ on 2/5/2026 at 12:23 PM revealed that LPN FF stated that she blew a foghorn at LPN MM to scare him, which resulted in R3's fall. LPN JJ further stated that approximately two to three days after the fall, LPN FF blew the foghorn at her to scare her. An interview with the Administrator on 2/5/2026 at 2:03 PM revealed she received a call from LPN FF regarding a fall involving R3 on 12/12/2025. The Administrator stated she does not recall whether she was informed of a possible head injury at the time of the initial call. She reported that LPN FF advised that the R3's family had been notified and declined transport to the emergency room because the family was out of town. The Administrator stated that LPN FF called back later that night to report a bruise on the R3's hip discovered while changing her. States that LPN FF advised they were transporting R3 to the ER. The Administrator further revealed that on the following Monday, 12/15/2025, while in her office, she heard a foghorn being activated by LPN FF. She exited her office and took possession of the foghorn. Day-shift staff began reporting details surrounding R3's fall and advised that LPN FF had activated the foghorn at the time of the fall. The Administrator stated that according to staff reports, R3 was walking quickly on C Hall with CNA LL when LPN FF blew the foghorn. It appeared that the sound startled R3 significantly, causing her to walk faster, lose control, and subsequently fall. The Administrator confirmed that she believed this demonstrated poor judgment on the part of LPN FF. LPN FF was presented with the disciplinary report but refused to acknowledge it by signing. The Administrator interview revealed that no formal educational or in-service training was provided to LPN FF related to this incident; however, a verbal warning was issued.