STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115358	A. Building B. Wing	03/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treutlen County Health and Rehabilitation	2249 College Street, North Soperton, GA 30457

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility policies Hand Hygiene and Infection Control at a Glance, the facility failed to follow infection control practices by not covering clean linen during transport and distribution, creating a risk of crossˆcontamination for the census of 50 residents. In addition, the facility failed to perform hand hygiene during wound care for one of two sampled residents (R9).Findings include: 1.Review of the facility's policy titled Infection Control at a Glance undated, documented Goal: To have a comprehensive program that addresses detection, prevention, and control of infections among patients and associates. Purpose: Decrease the risk of infection to patients and associates. Monitor for occurrence of infection and implement appropriate prevention measures. Identify and correct problems relating to infection prevention practices. Monitor compliance with state and federal regulations relating to infection prevention. Review of the facility's policy titled Hand Hygiene reviewed 12/27/2025 documented INTENT: It is the intent of this facility to promote and facilitate appropriate hand washing as set forth by the guidelines of CDC. PURPOSE: Hand Hygiene is the single most important means of preventing the spread of infection. The use of gloves does not replace hand washing. GUIDELINE: Associates should use alcohol based hand rub or wash hands with soap and water for the following indications: Immediately after glove removal. Glove use: Gloves should not be used as a substitute for hand hygiene.If your task requires gloves, perform hand hygiene prior to donning gloves, .Perform hand hygiene immediately after removing gloves. Review of the facility's Electronic Medical Records (EMR) revealed R9 was admitted to the facility on [DATE] with diagnosis included but not limited to encounter for attention to gastrostomy. Review of the Significant Change Minimum Data Set (MDS) revealed Section C (Cognition) Brief Interview for Mental Status (BIMS) of 01 which indicated R9 had severe cognitive impairment, Section K (Swallowing/Nutritional Status) documented R1 had feeding tube. Review of Care plan dated 03/03/2026 documented included but not limited to tube feeding related to swallowing difficulties and intervention to: Assess feeding tube placement, patency, and residual every shift and before and after administration of any fluids or medications. Review of Physician's Order dated 03/10/2026 documented included but not limited to Nutren 1.5 Oral Liquid 25 Milliliter / Hour PEG Tube every 24 hours. Observations on 03/21/2026 at 11:31 PM during gastrostomy tube (GT) medication administration revealed Registered Nurse (RN) CC changed gloves without sanitizing her hands on two occasions. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/21/2026 at 11: 43 PM with RN CC revealed she confirmed she did not sanitize her hands between glove change. She stated she should have sanitized her hands when she removed her gloves and before she put on a new pair of gloves because germs may be on her hands and it may transfer to the new pair of gloves. She stated the resident would get sick or get an infection when she did not hand sanitize between glove change. Interview on 03/21/2026 at 5:10 PM with the Infection Preventionist revealed she stated her expectations were for the staff to sanitize their hands between glove change. She stated when gloves were removed, hands were to be sanitized or washed before another pair of gloves were put on. The IP stated when hands were not washed or sanitized between glove change a negative outcome would be the residents would be at risk for infection. Interview on 03/22/2026 at 11:11 AM with the Director of Nursing (DON) revealed she stated her expectations were for the staff to sanitize or wash their hands between glove change. She stated the staff were expected to sanitize their hands after removing gloves and before putting on a new pair of gloves. 2. Observations on 03/20/2026 at 11:00 AM and 03/21/2026 at 11:30 AM revealed a laundry aide transporting resident clothing from room to room without the laundry being covered, exposing the clean laundry/linens to residents, staff, and visitors ambulating throughout the hallway, making the laundry susceptible to airborne pathogens. Interview on 03/20/2026 at 11:50 AM with Laundry Aide DD revealed she usually covered the bottom of the cart where the clothes were folded but did not cover the hanging items. Interview on 03/20/2026 at 12:00 PM with the Director of Nursing (DON) and the Administrator revealed that per the facility's policy, clean laundry did not need to be covered for protection when transporting clean clothing/linens to resident rooms.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record reviews, and review of the facility's policy titled Medication Administration - General, the facility failed to follow accepted standards of practice for one of 20 sampled residents (R44). This deficient practice created a risk of infection and the potential to negatively affect R44's medical condition. Findings include:Review of the facility's policy titled Medication Administration - General, reviewed 04/15/2025, documented: INTENT: To facilitate that medications are administered as prescribed, in accordance with good nursing principles. Review of the facility's Electronic Medical Records (EMR) revealed R44 was admitted to the facility on [DATE] with diagnoses including, but not limited to, hypertensive heart disease, chronic kidney disease with heart failure, chronic kidney disease, and essential tremors. Review of the admission Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview of Mental Status (BIMS) score of 15, which indicated R44 had intact cognition. Section I (Active Diagnoses) documented R44 had hypertension. Review of the care plan dated 01/27/2026 documented a focus area for diuretic use related to spironolactone, with interventions to monitor for hypotension and signs and symptoms (s/s) of dehydration. Review of the Physician's Orders dated 01/13/2026 documented orders including, but not limited to, spironolactone 25 milligram (mg) tablet, 1 tablet by mouth 2 times per day *** BEST IF TAKEN WITH FOOD *** and primidone 50 mg tablet (PRIMIDONE) 1 tablet by mouth 2 times per day. Observation on 03/21/2026 at 11:11 AM revealed that during review of the B Hall medication cart, Licensed Practical Nurse (LPN) BB was present. Two tablets were on the bare surface of one drawer. LPN BB used her bare hands to remove the two tablets and placed them in the open packet among R44's other medications. The open packet was attached to the original packets of medications from the pharmacy. LPN BB looked at each tablet and compared them to the pharmacy packet to confirm the tablets were from R44's medication packets. She secured the packet of tablets with tape, including the two loose tablets from the surface of the medication cart drawer, folded the packets together, and placed the packet in the drawer among R44's other medications. LPN BB stood beside the medication cart and waited to proceed with the review of the cart. Interview on 03/21/2026 at 11:13 AM with LPN BB revealed she confirmed and validated that she removed the two tablets with her bare hands and placed them in the open packet with R44's other medications. She confirmed she taped the packet, folded it, and placed it among R44's other medications. LPN BB stated the tablets were spironolactone 25 mg and primidone 50 mg. LPN BB stated she could have administered the medications to R44 later in the shift if R44 was scheduled to receive them. She further stated that because she placed the loose tablets from the drawer into the packet with the other medications, secured them with tape, and folded the packets together in the medication cart among R44's other medications, another nurse could also administer the medications to R44. LPN BB further stated that if R44 received the tablets that had been on the surface of the drawer, R44 could get sick and develop an infection. Interview on 03/21/2026 at 5:10 PM with the Infection Preventionist (IP) revealed she stated that tablets must not be placed in bare hands because this would cause contamination of the tablets and create a potential risk for residents to develop infections. The IP further stated the medication drawer was not considered a clean surface, so medications from the surface of the drawer must not be placed in packets and secured to be given to residents. She stated that if residents received such medications, they could develop infections. Interview on 03/22/2026 at 8:56 AM with Registered Nurse (RN) CC revealed she stated that when tablets were on the surface of the medication cart drawer, they were not to be placed back in the residents' medication packets or placed in the drawer where other medications were kept. She stated the medication cart drawers were not clean and that this was an infection control issue. RN CC further stated the residents could get sick or develop infections if they were given such medications. Interview on 03/22/2026 at 11:11 AM with the Director of Nursing (DON) revealed she stated her (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectations were for nurses to follow correct protocol regarding loose medications found in the medication carts and to ensure they were not placed back into circulation.