STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115419	A. Building B. Wing	02/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks - Athens Skilled Nursing, The	490 Kathwood Dr Athens, GA 30607

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 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 interview, and review of the facility policy titled, Labeling, Dating, and Storage, the facility dietary staff failed to ensure prepared food items were properly labeled and dated. Dietary staff also failed to ensure nutrition supplements were properly dated to indicate when to use by. The deficient practice affected all 136 facility residents who were all receiving an oral diet Findings include:Review of the facility policy titled Labeling, Dating, and Storage revised 11/11/2022 revealed under Procedure: 1. Food and beverage items will have an identifying label as well as a received dated and opened date, as applicable; for items prepare onsite, a use by date will also be indicated.Observation on 02/20/2026 at 9:15 AM of the 600 hall kitchenette revealed the kitchen had refrigerated pull out drawers that contained three rectangle shaped steam table pans. Two pans contained two-ounce containers of pre-portioned salad dressings, and one pan contained four-ounce cartons of nutrition supplements. Continued observation revealed that there were no labels or dates on the individual containers of pre-portioned salad dressing or on the pan. The pan with the nutritional supplements had no date to indicate when the supplements were defrosted and placed in the pan.During an interview on 02/20/2026 at 9:15 AM, the Dietary Manager (DM) confirmed that the salad dressing containers and the nutrition supplements were not properly labeled or dated. The DM stated that the dietary aides portion out the salad dressings in the small containers in the main kitchen and place them in a pan and the aides are responsible and expected to date the pan before bringing them to each kitchenette. The DM revealed that dietary staff were expected to date the pan when the nutritional supplements were taken from the freezer and placed in the pans. The DM stated the nutritional supplements were to be used within 14 days after they were thawed.Observation on 02/20/2026 at 9:20 AM of the 500, 700, and 800 hall, the kitchenette revealed the kitchen also had refrigerated pull out drawers that contained three rectangle shaped steam table pans. Two pans contained two-ounce containers of pre-portioned salad dressings, and one pan contained four-ounce cartons of nutrition supplements. Continued observation revealed that there were no labels or dates on the individual containers of pre-portioned salad dressing or on the pan. The pan with the nutritional supplements had no date to indicate when the supplements were defrosted and placed in the pan.During an interview on 02/20/2026 at 9:20 AM, the DM confirmed that the salad dressing containers and the nutrition supplements were not properly labeled or dated. The DM stated that the dietary aide was responsible for labeling and dating the pans prior to bringing them to the kitchenette.Observation on 02/20/2026 at 9:28 AM of the 100, 200, 300, and 400 hall kitchenette revealed the kitchen also had refrigerated pull out drawers that contained three rectangle shaped steam table pans. Two pans contained two-ounce containers of pre-portioned salad dressings, and one pan contained four-ounce cartons of nutrition supplements. Continued observation revealed that there were no labels or dates on the individual containers of pre-portioned salad dressing or on the pan. The pan with the nutritional supplements had no date to indicate when the supplements were defrosted and placed in the pan.During an interview on 02/20/2026 at 9:29 AM, the DM confirmed that the salad dressings containers or pan did not have any labels or dates. The DM also confirmed that the pan with the nutrition supplement had no label to indicate the 14-day use by date. The DM stated that the dietary aides typically date these pans and was unsure why they were missing.

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations, staff interviews, and review of the facility policy titled, Cleaning Procedures: Major Equipment, the facility's dietary staff failed to ensure two of three kitchenette freezers were free from frost build-up which could lead to food contamination. Findings include:Review of the facility policy titled Cleaning Procedures: Major Equipment reviewed 10/23/2025 revealed under Procedure: under Walk in Refrigerator and Walk in Freezer, Daily:1. Keep freezer elements free of frost and ice build-up.Observation on 02/20/2026 at 9:20 AM of the kitchenette for the 500, 700, and 800 halls revealed a small freezer sitting on the countertop. The freezer had three shelves, and the middle shelf was fully covered with frost that was an inch thick. Continued observation revealed ice cream cups were sitting within the frost.During an interview on 02/20/2026 at 9:20 AM, the Dietary Manager (DM) confirmed that there was frost build-up on the middle shelf of the small freezer and confirmed the ice cream cups were within the frost build-up. The DM stated that the freezer was cleaned and defrosted as needed, generally when they visibly saw frost, there was no set schedule.Observation on 02/20/2026 at 9:28 AM of the kitchenette for the 100, 200, 300, and 400 halls revealed a small freezer sitting on the countertop. The freezer had three shelves, and the middle shelf was fully covered with a thick layer of frost and ice cream cups sitting within the frost.During an interview on 02/20/2026 at 9:28 AM, the DM confirmed the small freezer had a layer of frost and confirmed there were ice cream cups stored on the frost. The DM stated that the freezer was cleaned and defrosted when there was visible frost.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility's policy titled, Resident Independent Self-Administration and Medication Assistance of Medications, the facility failed to assess one of 46 sampled residents (R) (R13) for self-administration of medication. This deficient practice created the potential for accidental ingestion, improper dosing, allergic reaction, or misuse of medication.Findings Include:Review of the facility policy titled Resident Independent Self-Administration and Medication Assistance of Medications, reviewed 02/16/2026, revealed under section titled Policy Statement, Residents who have the cognitive and functional capacity to safely engage in the self-administration of medications with or without staff assistance or supervision shall be allowed to store their own medications securely and self-administer medications if they so desire. As stated under section titled, Procedure, self-administering of medications by a resident is permitted only upon the specific written orders of the physician or other authorized healthcare provider, obtained on a semi-annual basis. All medications shall be stored under lock and key at all times whether kept by a resident or kept by the assisted living center, except when required to be kept by a resident on his/her person due to need for frequent or emergency use, as determined by the resident's physician. Observation on 02/20/2026 at 10:22 AM in R13's room revealed a prescription bottle labeled Magic Mouthwash (medicated mouthwash) sitting on the resident's windowsill. The prescription label directed: Swish and spit 5 mL (milliliters) by mouth every 3 hours as needed for mouth/throat pain. The medication was accessible at bedside and not secured.Review of the electronic medical record (EMR) revealed R13 was with diagnoses including unspecified dementia with anxiety, delirium, cognitive communication deficit, dysphagia (oral phase), restlessness and agitation, depression, fracture of left wrist, sacral fracture, and generalized muscle weakness. Review of the quarterly MDS dated [DATE] for R13 revealed a Brief Interview for Mental Status (BIMS) score of (0 - No (resident is rarely/never understood). Section GG (Functional Abilities and Goals) revealed the residents required substantial to maximal assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. Section N (Medications) indicated the resident received antipsychotic, antidepressant, antibiotic, opioid, and antiplatelet medications. Review of the EMR revealed no documentation indicating that R13 had been assessed or authorized to self-administer medications.Review of physician orders revealed Magic Mouthwash was not listed as a self-administration medication and there was no order authorizing bedside storage or resident self-administration. Review of the R113'S care plan revealed the resident has dementia with cognitive communication deficit and is unable to make daily decisions without cues and supervision due to short- and long-term memory impairment. Interventions include redirection when potential injury is evident and supervision with ADL care. R113 also receives psychotropic medications, including quetiapine (antipsychotic) and sertraline (antidepressant), for delirium and depression, with monitoring for side effects. The care plan reflects impaired cognition, impaired decision-making, need for supervision, and behavioral symptoms. The care plan did not reflect interventions supporting resident self-administration of medications.Interview on 02/21/2026 at 12:21 PM with Registered Nurse (RN) BB stated residents were not allowed to self-administer medications unless assessed and authorized. She stated medications brought from the hospital or outside sources must be secured in the medication cart for safety and to prevent double dosing. When shown the medication, she stated the resident should not have had the medication in her room. She identified potential negative outcomes including double dosing and ingestion by a cognitively impaired resident.Interview on 02/21/2026 at 12:27 PM with Licensed Practical Nurse (LPN) CC stated residents were not allowed to self-administer medications unless assessed and based on cognitive status. She stated she was aware the R13's daughter had brought the Magic Mouthwash into the room and that the daughter had used it while present. She stated the medication should not be kept at bedside. She identified (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potential negative outcomes including the resident ingesting the medication improperly, becoming ill, or another resident accessing the medication and experiencing an allergic reaction.Interview on 02/21/2026 at 12:36 PM with the Director of Nursing (DON) revealed if a resident wishes to self-administer medications, there must be a physician order, cognitive assessment, and care plan in place. She stated, to her knowledge, no residents in the facility were authorized to self-administer medications. She confirmed the resident should not have had the medication in her room.Interview on 02/21/2026 at 12:53 PM with the Administrator confirmed medications should not be stored in resident rooms unless properly authorized. She stated potential negative outcomes include accidental ingestion, allergic reaction, or misuse of medication.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and a review of the facility policy titled Medication Storages in Healthcare Centers the facility failed to properly lock and secure two of six medication carts (medication cart 600 hall and medication cart 800 hall).Findings Include: Review of the facility policy titled Medication Storage in Healthcare Centers revised 11/11/2025 revealed under the Policy Statement that medications and biologicals are stored securely and properly in accordance with manufacturer recommendations or supplier guidance. Under the Procedure section, the policy states: Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. Observation on 02/17/2026 at 11:10 AM revealed Licensed Practical Nurse (LPN) AA entered resident room [ROOM NUMBER] (on 800 hall) while his medication cart remained unattended in the hallway. The medication cart was observed unlocked with no licensed staff present at the cart. When asked about the unlocked cart, LPN AA stated he realized he had left the medication cart unattended and acknowledged he was not supposed to leave the cart unlocked. During an observation and interview on 02/22/2026 at 06:37 AM with Licensed Practical Nurse (LPN) FF on 600 hall revealed the medication cart was unlocked and unattended. It was observed LPN FF was at the nurse station on 600 hall cleaning and whipping down the area while the medication cart remained unlocked. Continued observation and interview revealed LPN FF approached the cart and stated she was cleaning her area to begin her shift and as long as she's in the area, the medication cart does not have to be locked unless she was going into a resident's room. Interview on 02/17/2026 at 12:40 PM with the Director of Nursing (DON) revealed she was made aware of the incident. The DON stated medication carts should not be left unlocked and confirmed that carts must be secured when not directly attended by licensed staff. The DON stated a potential negative outcome would include unauthorized individuals accessing the medication cart. Interview on 02/17/2026 at 12:53 PM with the Administrator revealed medication carts should not be left open unless directly attended by licensed nursing staff. The Administrator stated a potential negative outcome includes residents or unlicensed staff gaining access to medications, creating risk for medication diversion, misuse, or resident harm.