STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115474	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynn Haven Health and Rehabilitation	747 Monticello Highway Gray, GA 31032

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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 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. Based on observations, staff interviews, and record review, the facility failed to ensure oxygen circuits were properly stored for two of 23 residents (R) (R1 and R26) on respiratory care. This deficient practice had the potential to place R1 and R26 at increased risk of respiratory infection. Findings include:1. Review of the admission Minimum Data Set (MDS) for R1, dated 8/27/2025, revealed Section I (Active Diagnoses) documented diagnoses included, but were not limited to, pneumonia. Section O (Special Treatments, Procedures, and Programs) documented that the resident received oxygen. Review of the physician's orders for R1 revealed an order dated 8/22/2025 for oxygen at two liters per minute via nasal cannula every eight hours for pneumonia. Further review revealed an order dated 8/21/2205 for albuterol sulfate 2.5 milligrams (mg)/3 milliliters (ml) solution for Observations on 9/23/2025 at 11:54 am, 9/24/2025 at 2:05 pm, and 9/25/2025 at 10:31 am in R1's room revealed an incentive spirometer on the dresser, uncovered and not in use.In an interview on 9/25/2025 at 11:42 am, Registered Nurse (RN) KK stated she had not noticed the uncovered incentive spirometer during rounds and confirmed it should have been covered. She further stated the negative outcome of leaving it exposed was the potential for bacterial buildup, which could lead to infection when used.2. Review of the Quarterly MDS for R26, dated 8/13/2025, revealed Section I (Active Diagnoses) documented diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD).Review of the physician's orders for R26 revealed an order dated 5/9/2025 for albuterol sulfate 0.63 mg/3 ml solution one vial via nebulizer every six hours as needed for shortness of breath or wheezing.Observations on 9/23/2025 at 11:14 am, 9/24/2025 at 2:08 pm, and 9/25/2025 at 10:23 am in R26's room revealed a nebulizer mouthpiece on the dresser, uncovered with visible debris present.In an interview on 9/25/2025 at 11:47 am, RN KK revealed that during her morning rounds, she checked respiratory equipment and ensured it was bagged when not in use. She confirmed the nebulizer should have been covered and acknowledged the negative outcome could be inhaling particles and increased infection risk.In an interview on 9/25/2025 at 12:00 pm, the Director of Nursing (DON) revealed that incentive spirometers and nebulizers were expected to be bagged when not in use. The DON stated that staff were expected to check respiratory equipment during rounds to ensure compliance. She stated that a negative outcome of leaving equipment uncovered was an infection risk.An interview on 9/25/2025 at 12:54 pm with the Administrator confirmed his expectation that incentive spirometers and nebulizers should be covered when not in use. He stated that a negative outcome of failure to do so could be an infection risk.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, staff interviews, record review and review of facility's policy titled, Medication Administration- General, The facility failed to ensure that three out of four residents (R) R12, R25 and R39 were free of medication error rate above 5% or greater. This failure had the potential of putting all residents in the facility at risk of receiving wrong or no medication which could potentially have life threatening consequences. The facility census was 65.Findings include:A review of the facility's policy titled, Medication Administration- General, reviewed 4/15/2025 under topic, Guideline, revealed that, Medications are administered in accordance with a valid prescriber order. If a medication order seems to be unrelated to the patient's current diagnoses or condition(s), the prescriber is contacted for clarification prior to administration of the medication. This interaction with the prescriber is documented in the nursing notes or elsewhere in the medical record as appropriate. Prior to medication administration the Nurse or Certified Medication Aid (CMA): Reads the administration directions on the MAR and verifies correct medication, dose and directions for use. During an observation of medication pass on 9/24/2025 at 8:30 am with CMA AA revealed her administering medications to R12 was administered Fluticasone/salmeterol 50 mcg one puff and Tiotropium Bromide 18mcg one puff. A record review of R12 physician orders revealed tiotropium bromide 18 mcg capsule with inhalation device (tiotropium bromide) 2 Puffs Inhalation 1 time per day. Interview on 9/24/2025 at 8:54 am with CMA AA revealed her stating that she usually puffs only once because she says it makes her shaky. CMA AA stated that she has been in the facility for 3.5 years and usually works on wing 1 but works on wing 2 on my pickup days. She confirms that R12 was to receive two inhalations of the medication. She stated that if she hadn't disposed of the used pill (powder) she would have gone back to give that second puff. CMA stated that in this situation she would go and ask the nurse what to do. During a medication pass observation on 9/24/2025 at 9:03 am with CMA BB revealed her administering medications to R39. CMA BB administered acetaminophen 325mg 2 tablets (tabs), aspirin 81mg 1tab chewable, certavite 1tab, preservision 1capsule (cap), atenolol 50mg 1tab, escitalopram 20mg 1tab and vit D3 1tab. During a review of R39 physician orders on 9/24/2025 at 9:20 am revealed that calcium carbonate 500 mg-vitamin D3 10 mcg (400 unit) chewable tablet 1 tablet by mouth 1 time per day was not administered. During an interview on 9/24/2025 at 9:30 am with CMA BB revealed her stating that the medication was administered. She stated that the medication came prepackaged along with other medications from the pharmacy and that she had discarded the package and was unable to present it when requested. During a medication pass observation on 9/24/2025 at 9:03 am with CMA BB revealed her administering medications to R25. CMA BB administered calcium 600mg 1tab, docusate sodium 100mg 1tab, loratadine 10mg 1tab, divalproex sprinkles 125mg 1cap, preservision 1tab, paroxetine 20mg 1tab, propranolol Hydrochloride (HCL) 20mg 1tab, quetiapine 25mg 1tab and liquacel 16/2.5grams 30ml in 4oz water. During a review of R25 medications on 9/24/2025 at 9:45 am revealed Systane complete 0.6 % eye drops (propylene glycol) 1 drops instill in both eyes 2 times per day and multiple vitamin-minerals tablet 1 tablet by mouth 1 time per day was not administered. Instead, CMA BB administered liquacel 16/2.5grams 30ml in 4oz water which was not listed in R25 medication orders. During an interview on 9/24/2025 at 9:50 am with CMA BB revealed her stating that Systane complete 0.6 % eye drops were not in the medication cart and she would have to inform the nurse for direction. CMA BB also stated that she administered the liquacel instead of the multiple vitamin-minerals tablet 1 tablet because R25 received her medications crushed and the liquid is easier for her to swallow. During an interview on 9/24/2025 at 11:21 am with Licensed Practical Nurse (LPN) II revealed that she will contact the pharmacy to reorder the missing medications and the Nurse Practitioner regarding all three residents. She stated that whenever the CMAs have a medication issue that they are to notify her immediately for assistance. LPN II stated that she will also contact the pharmacy for the list of prepackaged medications for R39. During an interview on 9/24/2025 at (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:40 am with Nurse Practitioner (NP) JJ revealed that she recently added calcium to R39 medications following blood work that indicated low levels of calcium. She stated that R39 was already on Vitamin D3 and therefore added calcium carbonate 500 mg-vitamin D3 10 mcg (400 unit) chewable tablet 1 tablet by mouth 1 time per day. NP JJ further stated that calcium carbonate 500 mg-vitamin D3 10 mcg (400 unit) is a different medication from the Vitamin D3 and that R39 requires both medications. During another interview on 9/24/2025 at 2:30 pm with LPN II revealed that the list of prepackaged medications sent by the pharmacy was regarding R39 and that calcium carbonate 500 mg-vitamin D3 10 mcg (400 unit) chewable tablet 1 tablet by mouth, 1 time per day was not on the list. LPN II confirmed that the medication was not a prepackaged medication and admitted to checking the list and the medication cart minutes before to verify that it was correct. She admitted that the list was correct and that the medication was instead a floor stock medication that should have been administered by CMS BB. During a telephone interview on 9/24/2025 at 2:50 pm with Certified Pharmacy Tech (CPT) HH revealed that she confirmed sending the list to the facility. CPT HH admitted to sending the list of prepackaged medications to the facility at the request of LPN II. She confirmed that the list is correct and that all prepackaged medications are delivered to the facility on Wednesdays to be used starting on Fridays and that the last package should end on Thursday night. CPT HH also stated that the facility should have an additional package of medication for R39 for tomorrow's use. She also stated that calcium carbonate 500 mg-vitamin D3 10 mcg (400 unit) chewable tablet is listed in her system as a facility floor stock medication and confirmed that it is not one of the prepackaged medications sent by the pharmacy. During an interview on 9/24/2025 with the Director of Nursing (DON) revealed that she conducts spot checks and gets on the cart with the CMA and watch them do medication pass and documents results at least every three months. DON stated that all CMAs are aware that they should report all medications issues to the charge nurse. She also stated that she conducts an annual skills training with all CMAs, and the results are documented in their records. DON stated that if the CMA fails any training, then she is re-educated. DoneDB

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and review of the facility's policies titled Hand Hygiene and Meal Service, the facility failed to ensure infection control practices were followed during a meal in the dining room. This deficient practice had the potential to place the residents at risk of infection due to cross-contamination. The census was 65. Findings include:A review of the facility's policy titled Hand Hygiene, reviewed 12/27/2024, revealed the Purpose section included, Hand hygiene is the single most important means of preventing the spread of infection. The use of gloves does not replace hand washing. The Guideline section included, Gloves should not be used as a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. A review of the facility's policy titled Meal Service, reviewed 12/27/2024, revealed the Guideline section included, Meals should be served under sanitary conditions. Associates will follow safe food handling techniques. Associates should wash hands before starting tray distribution. Associates should wash hands and change gloves between task and between patient contact. Observation on 9/23/2025 at 11:20 am of lunch in the dining area revealed Dietary Aide (DA) CC and DA FF serving meals to residents seated in the dining room. DA CC and DA FF were observed entering the kitchen, touching the kitchen counter and kitchen door before re-entering the dining room and placing meal trays on the tables in front of residents. DA CC and DA FF were not observed performing hand hygiene between tasks. Observation on 9/23/2025 at 11:35 am of lunch in the dining area revealed Certified Medication Aide (CMA) DD was observed entering the dining room and sitting at a table with two residents. She put on gloves before assisting one resident at the table with the meal, then removed her gloves and put on another pair before assisting the other resident with the meal. Observation revealed that hand hygiene was not performed between glove changes or between assisting each resident with the meal. CMA DD was then observed adjusting one resident's wheelchair at the table before returning to assist another resident with his meal without performing hand hygiene. Observation on 9/23/2025 at 11:52 am of lunch in the dining area revealed CMA EE was observed transporting a resident in a wheelchair into the dining room and placing her at a table. CMA EE was observed placing a chair between the two residents at the table, putting on gloves, and then assisting one resident with her meal. CMA EE was then observed removing her gloves, placing them in her pocket, before putting on another pair and beginning to assist the other resident at the table without performing hand hygiene at any point during the dining process. Observation on 9/23/2025 at 12:00 pm of lunch in the dining area revealed CMA GG entered the dining room, put on gloves, assisted a resident with opening a drink, placed a straw in the cup, removed her gloves, and placed them in her pocket. CMA GG was then observed putting on a new pair of gloves to assist another resident in the dining room with setting up her utensils. Observation on 9/23/2025 at 12:20 pm of lunch in the dining area revealed the Dietary Manager (DM) entering the dining room pushing a cart full of goods for the kitchen. She was observed stopping to adjust a resident's wheelchair and rubbing the resident's arm. She was then observed opening a cup and packets of condiments for another resident at the table without performing hand hygiene.In an interview on 9/23/2025 at 12:30 pm, DA CC and DA FF both confirmed that they did not perform hand hygiene at any time while assisting residents with the lunch meal. DA CC and DA FF stated that they had not received education on hand hygiene and were still learning the job. In an interview on 9/23/2025 at 12:40 pm, the DM stated she should have performed hand hygiene, and didn't realize she hadn't. The DM stated that she was aware that hand hygiene should have been performed prior to assisting the resident with her meal and was aware that the dietary staff had not performed hand hygiene during the lunch meal. In an interview on 9/23/2025 at 12:40 pm, CMA DD stated she had not performed hand hygiene at any time during the lunch meal. She stated that she was aware that she should have performed it. In an interview on 9/23/2025 at 12:45 pm, CMA EE confirmed she did not perform hand hygiene while assisting residents with the lunch (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meal, nor between glove changes. She stated she should have performed hand hygiene between glove changes, between tasks, and should have discarded the dirty gloves into a trash can. In an interview on 9/23/2025 at 1:00 pm, CMA GG confirmed she did not perform hand hygiene at any time while in the dining room assisting residents with lunch. She stated that she should have performed hand hygiene upon entering the dining room and between glove changes. She further stated that she should have discarded dirty gloves in a trash can. In an interview on 9/25/2025 at 3:15 pm, the Assistant Director of Nursing (ADON)/ Infection Preventionist (IP) stated she was aware of staff not performing hand hygiene while assisting with residents with lunch. She stated that she had provided several in-services on infection control throughout the year, and it was an ongoing issue.