STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115483	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dawson Health and Rehabilitation	1159 Georgia Ave. S.E. Dawson, GA 39842

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility policy titled, Housekeeping, the facility failed to ensure that it was maintained in a safe, clean, comfortable environment for one of five bathrooms (Shared with room [ROOM NUMBER]-room [ROOM NUMBER]) on C Hall. Findings include:Review of the facility policy titled Housekeeping with a review date of 12/27/2025 revealed under Intent: it is the intent of this center to maintain a clean and sanitary center that is free from odor and other environmental factors that may affect the quality of life of our patients.Observations on 03/3/2026 at 9:45 AM, 03/4/2026 at 9:40 AM, and 03/5/2026 at 11:55 AM in the bathroom shared between room [ROOM NUMBER] and room [ROOM NUMBER] revealed the following:The ceiling vent was covered in a brownish gray substance. The bathroom linoleum floor on each day had a pool of clear liquid substance that resembled water (moisture). The linoleum was placed approximately 3.5 inches up the wall where baseboards would normally be located and were detached from the wall.Interview on 03/5/2026 at 11:55 AM with the Administrator and the Maintenance Director confirmed the bathroom floor shared between room [ROOM NUMBER] and room [ROOM NUMBER] was pooling water. The Maintenance Director confirmed the ceiling vent was covered in dirt and dust.

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled, Best Practices for PASSR, the facility failed to submit a Preadmission Screening and Resident Review (PASARR) Level II for one of two residents (R) (R3) reviewed for PASARR. This deficient practice had the potential to affect the appropriate level of care and services provided for R3. Review of policy titled, Best Practices for PASRR, revealed, . There are two areas a person can be a PASSR patient: SMI (Significant Mental Illness or ID/DD Intellectual Disability/Developmental Disability. Review of the Electronic Health Record (EHR) under the Diagnosis tab revealed, that R3 was admitted to the facility on [DATE]. Diagnosis included, but not limited to, an onset psychosis in April 2021.Review of R3's quarterly Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment; Section I (Active Diagnosis) revealed depression, anxiety, and psychotic disorder; Section N (Medications) revealed R3 received antipsychotic and antidepressant medications during look back period of assessment.Review of R3's EHR under the Orders tab revealed physician orders dated 11/06/2025 that the resident was currently receiving Risperdal oral tablet .25 milligrams (mg) give .25 mg by mouth at bedtime related to hallucinations, a result of psychosis. Interview on 01/29/26 at 2:30 PM with Business Development Specialist DD confirmed R3 did not have a PASRR II. She confirmed the resident had qualifying diagnoses to qualify for a PASRR II but since the resident had not had any increase in behaviors, she had not submitted a PASRR II. She revealed if the resident had an increase in behaviors, she would make a submission for a PASRR II.

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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, Controlled Substance Medication Accountability, the facility failed to ensure the Controlled Drug Record was signed after narcotic administration for three of 33 sampled residents (R) (R47, R4, and R30) during review of three of five medication carts. This deficient practice had the potential to cause incorrect narcotic counts, missed or overdose of narcotic medication for residents. Findings include: Review of the facility's policy titled Controlled Substance Medication Accountability dated 12/31/2025 documented under Intent: To establish a method of accountability and reconciliation of controlled medications. Administration, reordering, and release of controlled medication at discharge or for leave of absence: When a routine controlled medication is administered, the licensed nurse administering the medication will promptly enter the following information on the Medication Administration Record (MAR) and the Controlled Drug Record Sheet (count sheet sent from the pharmacy): Date and time of administration. Amount administered. Initials of the nurse administering the dose.Review of the facility's electronic medical records (EMR) revealed R47 was admitted to the facility on [DATE] with diagnosis that included but not limited to stage 4 pressure ulcer of sacral region.Review of the Quarterly Minimum Data Set (MDS) assessmernt dated 12/18/2025 documented in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 15, which indicated R47 had intact cognition, Section J (Health Conditions) R47 received scheduled pain medication regimen, had pain almost constantly.Review of a care plan dated 01/08/2026 documented R47 had pain related to: Pressure ulcers. Patient will report relief of pain following interventions every day through the review period. Administer pain medications as ordered.Review of the Physician's Orders dated 08/01/2025 documentation included but was not limited to oxycodone-acetaminophen 5 milligrams (mg)-325 mg tablet, 1 tablet by mouth every 6 hours. Diagnosis (Dx): Pressure ulcer of sacral region, stage 4.Observation on 03/04/2026 at 3:00 PM during review of the Hall A/C nurses' medication cart revealed one blister pack of oxycodone - APAP (acetaminophen) 5-325 had 35 tablets remaining for R47.Review of the Controlled Drug Record on the Hall A/C nurses' medication cart revealed the Controlled Drug Record had oxycodone -APAP 5-325 had 36 tablets remaining for R47.Review of the facility's EMR revealed R4 was admitted to the facility on [DATE] with a diagnosis that included but not limited to artificial knee joint.Review of the Annual MDS assessment for R4 dated 02/04/2026 documented in Section C a BIMS score stating resident is rarely/never understood, Section J (Health Conditions) R4 received scheduled pain medication regimen. Review of a care plan dated 02/12/2026 documented R4 had pain related to history of arthritis. Patient will demonstrate decrease in signs of pain during the review period. Administer pain medications as ordered.Review of the Physician's Orders dated 11/13/2023 documentation included but was not limited to hydrocodone 5 mg-acetaminophen 325 mg tablet (hydrocodone bitartrate/acetaminophen) 1 tablet G-tube (gastrostomy-stomach tube) every 8 hours, diagnosis (Dx): Pain in left leg.Observation on 03/04/2026 at 3:00 PM during review of the Hall A/C nurses' medication cart revealed one blister pack of Hydrocodone/APAP 5-325 had 21 tablets remaining for R4.Review of the Controlled Drug Record on the Hall A/C medication cart revealed the Controlled Drug Record had Hydrocodone/APAP 5-325 had 22 tablets remaining for R4.Review of the facility's EMR revealed R30 was admitted to the facility with a diagnosis that included but not limited to disorders of bone density and structure.Review of the Quarterly MDS dated [DATE] documented in Section C a BIMS score of 5, which indicated R30 had severely impaired cognition, Section J documented R30 received scheduled pain medication regimen and had continuous pain.Review of a care plan dated 02/12/2026 documented R30 had pain. Patient will report relief of pain following interventions every day through the review period. Administer pain medications as ordered.Review of the Physician's Orders dated 02/24/2026 revealed documentation (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included but was not limited to Oxycodone 10 mg tablet 1 tablet G-tube 3 times per day. Diagnosis (Dx): Other chronic pain.Observation on 03/4/2026 at 3:00 PM during review of the Hall A/C nurses' medication cart revealed one blister pack of Oxycodone HCL 10 mg tablets with 39 tablets remaining for R30.Review of the Controlled Drug Record on the Hall A/C nurses' medication cart revealed the Controlled Drug Record had Oxycodone HCL 10 mg tablets with 40 tablets remaining for R30.Interview on 3/4/2026 at 3:27 PM with Registered Nurse Supervisor RNS (RNS) CC revealed she verified and confirmed that one blister pack of oxycodone -APAP 5-325 had 35 tablets remaining and the Controlled Drug Record had 36 tablets remaining for R47, there was one blister pack of Hydrocodone/APAP 5-325 had 21 tablets remaining and the Controlled Drug Record had 22 tablets remaining for R4 and one blister pack of Oxycodone HCL 10 mg tablets had 39 tablets remaining and the Controlled Drug Record had 40 tablets remaining for R30. RNS CC stated that there were two nurses' medication carts and they were the only carts with narcotics. All the narcotics were checked on both carts for the review with three missing signatures found. RNS CC stated that the last administration time was over one hour ago and the Controlled Drug Record should have been signed after it was administered. Interview on 03/04/2026 at 3:29 PM with Licensed Practical Nurse (LPN) BB revealed she confirmed the Controlled Drug Record was not signed after she administered the narcotics to the residents R47 and R4. LPN BB stated the controlled sheet should be signed as soon after administering the narcotics and if it was not signed, the narcotic count would be off. LPN BB stated that the resident could get another dose of the narcotic because another nurse would not know when the narcotic was given.Interview on 03/04/2026 at 4:00 PM with the Director of Nursing (DON) revealed her expectations were for the nurses to sign the Controlled Drug Record after administration of the narcotics. She stated signing the Controlled Drug Record showed consistency and keeps account of the narcotics when they are taken out of the packets.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review and review of the facility's policy titled Hand Hygiene, the facility failed to practice proper infection control protocol by not sanitizing hands between glove change for one of three sampled residents (R) R47 with foley catheter. This deficient practice had the potential to cause infection to R47. Findings include: Review of the facility's policy titled Hand Hygiene dated 12/27/2025, documented under INTENT: It is the intent of this facility to promote and facilitate appropriate hand washing as set forth by the guidelines of CDC. Under PURPOSE: Hand Hygiene is the single most important means of preventing the spread of infection. The use of gloves does not replace hand washing. Under 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, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves.Review of the facility's electronic medical records (EMR) revealed R47 was admitted to the facility with a diagnosis that included but not limited to stage 4 pressure ulcer of sacral region.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented in Section C (Cognition) a Brief Interview for Mental Status (BIMS) score of 15, which indicated R47 had intact cognition, Section H (Bowel and Bladder) R47 had Indwelling catheter.Review of a care plan dated 11/25/2025 documented R47 has urinary catheter related to: Stage 3-4 wound. Evidence by: Indwelling catheter. Patient will be free of complications of indwelling catheter through the review period. Care/changing of urinary catheter as ordered. Monitor and clean skin under and around the external catheter check for redness/skin breakdown.Review of the Physician's Orders dated 08/01/2025 included but not limited to Indwelling urinary catheter to bedside drainage. Change urethral catheter every month on specific date(s). Night Shift French (Fr) Size: 16; Balloon Size:10 milliliters (ml). Diagnosis (Dx): Pressure ulcer of sacral region, stage 4.Observation on 03/04/2026 at 9:35 AM during catheter care revealed Certified Nursing Assistant (CNA) AA did not hand sanitize between glove change.Interview on 03/04/2026 at 9:42 AM with CNA AA confirmed she did not sanitize her hands between glove change during catheter care. She stated she should have washed her hands or sanitized her hands after removing gloves and before putting on clean gloves.Interview on 03/04/2026 at 3:58 PM with Licensed Practical Nurse (LPN) DD stated that hands should be washed or sanitized between glove change. She stated that if hands were not washed or sanitized between glove change, the resident would get infections.Interview on 03/04/2026 at 4:00 PM with the Director of Nursing (DON) revealed her expectations were for the staff to follow protocol for sanitizing between glove change. She stated that a possible negative outcome when the staff did not wash nor sanitize their hands would be transmission of infectious organisms to the residents which could worsen the residents' medical conditions.