STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115492	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare FT Oglethorpe	2403 Battlefield Pkwy Fort Oglethorpe, GA 30742

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of facility policy, the facility failed to ensure residents reviewed for accuracy of medical records had active physician orders for respiratory care and current pressure ulcer status for one of one resident (Resident (R) 36) reviewed for respiratory care and one of two residents (R22) reviewed for pressure ulcers out of a total of 30 residents in the sample. The deficient practice had the potential for facility residents to not receive appropriate care and services to meet their needs for oxygen usage and wound care treatment.Findings include:Review of the facility's policy titled, Respiratory Manual, dated July 2019, revealed The purpose of delivering oxygen by nasal cannula is to.correct hypoxemia by increasing available alveolar oxygen.diminish the myocardial workload by correcting hypoxemia. Check for a complete physician order.Review of the facility's policy titled, Documentation Guidelines, dated May 2025, revealed Medications and Treatments are administered based on provider orders. Medications and Treatments are documented in the EHR (electronic health record). The nurse/medication technician administering the medication is responsible for assuring: right patient, right medication, right dose, right route, right time. Skin assessments (2) Ongoing skin assessment: All patients' skin is assessed on a weekly basis by a licensed nurse, and findings are documented in the Weekly Skin Observations.1. Review of R36's Face Sheet, located in the electronic medical record (EMR) under the Face Sheet tab, revealed R36 was admitted to the facility with diagnoses that included but not limited to malignant neoplasm of ampulla of [NAME], centrilobular emphysema, and peripheral vascular disease.Review of R36's five day Minimum Data Set assessment MDS located in the MDS tab in the EMR with an Assessment Reference Date ARD of 9/3/2025, revealed a Brief Interview for Mental Status BIMS assessment with a score of thirteen out of 15, which indicated little or no cognitive impairment. The resident was revealed to require the use of intermittent oxygen therapy.Review of R36's Physician Orders, located in the EMR under the Resident tab, revealed there was no specific physician order, nor standing physician order, to identify the required liters per minute (LPM) of oxygen required for R36.Review of R36's Care Plan, initiated on 8/28/2025 and located in the EMR under the Care Plan tab, revealed the resident was at risk for respiratory complications secondary to centrilobular emphysema, anemia and a history of smoking. The goal was to minimize the risk of respiratory complications through the next review. An approach included to administer medications as ordered.During an observation on 9/24/2025 at 3:50 PM, R36 was observed in his room with his oxygen concentrator in use at 3 LPM.During an observation on 9/25/2025 at 7:45 AM, R36 was observed in his room with his oxygen concentrator in use at 3 LPM.During a concurrent interview on 9/25/2025 at 7:50 AM, Registered Nurse (RN)1 and Nurse Practitioner (NP) stated that they had a standing order for two to four LPM for residents, that should be added to the EMR on admission. RN1 confirmed the standing physician order was not in the EMR for R36, and that it should have been added to his physician order. She stated that the nurses rely on the EMR during medication administration. During an interview on 9/26/2025 at 8:10 AM, RN3 stated that when a resident was receiving oxygen, they would refer to the physician orders in the EMR to determine the appropriate LPM for the resident.During an interview on (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/26/2025 at 8:50 AM, the Director of Nursing stated that oxygen orders showing the LPM should be in the EMR for each resident. At 10:31 AM, she confirmed that a complete and accurate EMR for a resident would ensure all physician orders were documented.2. Review of the admission Record located under the Resident tab under the Face Sheet section revealed R22 admitted with diagnoses of but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, pressure ulcer of sacral region, stage IV and pressure injury of deep tissue right heel. Review of the quarterly MDS with and ARD of 8/19/2025 indicated R22 had a BIMS of 13 of 15, indicating she was cognitively intact. Section M (Skin Condition) indicated R22 had one unhealed stage III wound that was present upon admission, one stage IV wound that was present upon admission and one unstageable wound that was present upon admission. Review of the admission Observation dated 2/26/2025 located under the Resident tab under Observations revealed R22 was admitted with a sacral pressure ulcer. Review of the admission Observation dated 6/3/2025 located under the Resident tab under Observations did not reveal R22 readmitted with any pressure wounds. Review of the Weekly Skin assessment dated [DATE] located under the Resident tab under Observations in the EMR revealed R22's pressure injury stage IV healed and R [right] heal some redness.Review of the Weekly Skin assessment dated [DATE] located under the Resident tab under Observations in the EMR did not reveal R22 had any pressure wounds. Review of the Weekly Skin assessment dated [DATE] located under the Resident tab under Observations of the EMR did not reveal R22 had any pressure wounds. Review of the Weekly Skin Observation dated 9/23/2025 indicated that R22 did not have any wounds or open areas. During an interview on 9/24/2025 at 4:07 PM, LPN4 stated R22 had a sacral wound and a wound on her right heel. During an interview and record review on 9/25/2025 at 10:30 AM, the DON stated R22 still had wounds. She stated LPN1 was a new nurse and did not completely understand how to complete the weekly skin assessments.During a phone interview on 9/25/2025 at 4:26 PM, LPN1 stated she received education regarding how to complete weekly skin assessments. These assessments include a full head to toe assessment. She stated she did not think she was supposed to document old wound data on the weekly skin assessments.During an interview on 9/26/2025 at 7:46 AM, the Assistant Director of Nursing (ADON) stated the weekly skin assessments should include documentation regarding all skin issues. She stated the nurses could make a note to reference wound management notes in the EMR/treatment in place. Her expectation was for the weekly skin assessments to reflect any current and ongoing skin issues. During an interview on 9/26/2025 at 10:28 AM, the DON stated her expectation was for the licensed nurses to document on the weekly skin assessments if there was a dressing intact, document if the resident had an existing wound and to refer to the wound management section of the EMR. She stated the dressing should only be changed if they are visibly soiled. The DON stated she expected the nurses to accurately complete the skin assessments and reference any ongoing issues with the resident's skin to ensure the record was accurate.

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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, record review, resident and staff interviews, and facility policy review, the facility failed to ensure catheter drainage bags were not in direct contact with the floor for one of one resident (Resident (R) 55) reviewed for catheters out of 32 sample residents. In addition, the facility failed to ensure staff performed adequate hand hygiene between residents during medication administration for three residents (R118, R48, and R54) reviewed for medication administration. These deficient practices had the potential to place residents at risk for the spread of infection and cross-contamination and created a risk for an increased potential for urinary tract infectionsFindings include:1. Review of the facility policy titled, MRSA (Methicillin-resistant Staphylococcus aureus) Recommendations by sited, dated February 2025 revealed, .under Patients with Urinary Catheters, indicated keep drainage bags off the floor., but below the level of the patients bladder.Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed that R55 was admitted to the facility with diagnoses that included but not limited to diabetes with neuropathy, hypertension and chronic obstructive pulmonary disease.Review of the 8/25/2025 Comprehensive Care Plan located in the Care Plan tab of the EMR revealed a problem that R55 was at risk for infections/complications due to the use of an indwelling catheter. Review of the EMR revealed that R55 had completed a course of antibiotics due to a urinary tract infection. Review of the Urinalysis, Reflex Microscopic and Culture collected on 9/13/2025 indicated an Escherichia Coli organism. Review of the Physicians Order revealed an order, dated 9/17/2025, for Macrobid 100 milligrams (mg) twice a day. Review of the Medication Administration Report for the Month of September 2025 revealed that R55 had completed a course of Macrobid (an antibiotic used to treat urinary tract infections) 100mg twice a day from 9/17/2025 - 9/23/2025. Observation on 9/25/2025 at 9:54 AM revealed R55's catheter drainage bag was lying directly on the floor. During an interview with Licensed Practical Nurse (LPN) 5, at time of observation, LPN5 confirmed that the catheter drainage bag was lying directly on the floor and should not have been lying on the floor. Interview with the Director of Nursing (DON) on 9/26/2025 at 9:03 AM revealed that the R55?s catheter drainage bag should be below the level of the resident's bladder and not lying directly on the floor. 2. Review of the facility's policy titled, Hand Hygiene Policy, dated February 2025, revealed, under Purpose To decrease the number of microorganisms, preventing cross contamination between staff and patients. And under Procedure Provide hand hygiene before and after contact with each patient.Review of the facility's policy titled, Medications Administration -General Guidelines revision date 2/25/2025, revealed under Procedures. item 2: .hand washing refers to washing hands with soap and water. or thoroughly applying an alcohol-based hand rub.The person administering medications adheres to good hand hygiene.after coming into direct contact with a resident. Item 4. Before administering a medication.Observation during medication administration on 9/25/2025 at 7:43 AM revealed Licensed Practical Nurse (LPN) 5 did not don (put on) gloves or perform hand hygiene prior to pouring and administering medications, nor did she perform hand hygiene between R 118, R 48, and R 54. Observation on 9/25/2025 at 6:44 AM revealed LPN5 did not don gloves and did not wash or sanitize her hands prior to pouring and administering R118's morning medications.Observation on 9/25/2025 at 7:19 AM revealed LPN5 did not don gloves and did not wash or sanitize her hands between R118 and (R) 48 and did not wash or sanitize her hands prior to pouring and administering (R) 48's morning medications.Observation on 9/25/2025 at 7:43 AM revealed LPN5 did not don gloves and did not wash or sanitize her hands between R48 and R54 and did not wash or sanitize her hands prior to pouring and administering R54's morning medications. Interview with LPN 5 9/25/2025 at 7:43 AM confirmed that she had not washed or sanitized her hands between residents and did she don gloves or wash and sanitize her hands prior to pouring and administering the resident's morning medications. Interview with the Director of Nursing (DON) on 9/26/2025 at 9:03 AM revealed that her expectation were staff should adhere to the facilities hand hygiene policy. The DON confirmed that facility's hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	washing policy required staff to perform hand hygiene when coming into contact with a resident and before administering medication.Review of R58's Face Sheet, located in the EMR under the Face Sheet tab, revealed R58 was readmitted to the with diagnoses that included but not limited to benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine, and overactive bladder. Review of R58's five day MDS located in the MDS tab in the EMR with an ARD of 7/10/25, revealed a BIMS assessment with a score of nine out of 15, which indicated moderate cognitive impairment. The resident was revealed to require the use of an indwelling catheter. Review of R58's Physician Orders, located in the EMR under the Resident tab, revealed, Indwelling urinary catheter.for diagnosis of benign prostatic hyperplasia with urinary retention.Review of R58's Care Plan, initiated on 7/4/2025 and located in the EMR under the Care Plan tab, revealed the resident was at risk for infection related to comorbidities and foley catheter. The goal was for complications related to infection and treatment of infection minimized through the next review. Approaches included observing increased signs and symptoms of infection.During an observation on 9/23/2025 at 10:58 AM, R58 was observed in his room seated in his wheelchair. The resident's catheter bag was observed hanging directly underneath the wheelchair, the bag and tubing touching the floor. The resident was again observed at 11:22 AM in the facility hallway going down the hallway in his wheelchair, with his catheter bag and tubing dragging on the floor.During an observation on 9/24/2025 at 7:55 AM, R58 was observed in his room seated in his wheelchair. His catheter bag was observed touching the floor underneath his wheelchair. The resident was again observed at 8:33 AM with the catheter bag still touching the floor underneath his wheelchair.During an observation and interview on 9/24/25 at 8:35 AM, R58 was again observed seated in his wheelchair with his catheter bag touching the floor. The Infection Preventionist (IP) and Licensed Practical Nurse (LPN) 2, both stood at a medication cart outside R58's room. The IP stated the catheter bag should be off the floor. LPN2 also confirmed the catheter bag should be off the floor.During an interview on 9/24/2025 at 8:39 AM, R58 stated that his catheter tubing had been caught on his wheelchair in the past, and he knew it should not be touching the floor.During an interview on 9/26/2025 at 9:02 AM, the DON stated that catheter bags and tubing should be off the floor.