STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115498	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hospital Authority of Brooks County, Georgia, The	1901 West Screven Street Quitman, GA 31643

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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 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 interviews, and review of the facility's policy titled Food Receiving and Storage, the facility failed to discard expired foods and to ensure food items were properly labeled and dated in the dry pantry and in the refrigerator/freezers to prevent foodborne illness. The deficient practice had the potential to affect 133 out of 140 residents receiving an oral diet.Findings include:Review of the facility's undated policy titled, Food Receiving and Storage revealed under Dry Food Storage: 4. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). Such foods are rotated during a first in-first out system. Under Refrigerated/Frozen Storage: 7. Refrigerated foods are labeled, dated and monitored so they are used by their use by date, frozen, or discarded.During a tour of the kitchen on 8/26/2025 at 9:00 am with the Assistant Director of Food Service, revealed, the following concerns:1. Observation of the dry pantry revealed four one gallon of red cooking wine with an expiration date of 8/4/2025.2. Observation of the walk-in cooler revealed a green plastic container labeled tomatoes with a use by date of 8/22/2025; a blue plastic container labeled lettuce with a use by date of 8/23/2025; a red plastic container labeled tomatoes with a use by date of 8/24/2025 and a foam container wrapped in plastic wrap, labeled EL, dated 6/26/2025.3. Observation of Unit A refrigerator contained a sandwich covered in plastic wrap not labeled or dated.4. Observation of Unit B refrigerator/freezer revealed one gallon of chocolate ice cream with an expiration date of 3/29/2025 and two plastic containers unlabeled or dated.Interview and rounding on 8/26/2025 at 9:00 am with the Assistant Director of Food Service confirmed the identified concerns. She revealed there should not have been any expired food, or any items not labeled or dated in the dry storage area, walk in cooler, or any of the hall refrigerators/freezers. She revealed all staff was responsible for ensuring expired items were discarded and to ensure all items were labeled and dated.Interview on 8/26/2025 at 10:00 am with Assistant Director of Nursing (ADON) revealed the kitchen staff was responsible for ensuring expired food items were removed and that food items were labeled and dated on all Unit refrigerators/freezers.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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, resident and staff interviews, record review, and review of the facility's policy titled, Self-Administration of Medications by Patients/Residents, the facility failed to ensure two Residents (R) (R96 and R125) did not have unauthorized, unsecured medications at bedside. In addition, the facility failed to ensure authorized medications for self-administration was securely stored at bedside for R129. This deficient practice had the potential to allow unauthorized access of medications to other residents and visitors in the facility. The sample size was 56 residents.Finding include:Review of the undated facility's policy titled Self-Administration of Medications by Patients under the Intent statement revealed, Each patients who desires to self-administer medication is permitted to do so if the nursing centers' interdisciplinary team has determined that the practice would be safe for the patient and other patients of the nursing center and that the patient is able to accurately self-administer. Ability to appropriately self-administer medications should be documented in the documented in the patient's care plan. This evaluation of the patient 's ability to correctly and safely self-administer medications is subject to periodic re-evaluations based on changes in the patient's status.1. Review of clinical records for R96 revealed the following diagnoses but not limited to personal history of other disease related to respiratory system, lymphocytic colitis, and cognitive communication deficit.Review of the Significant Change Minimum Data Set (MDS) Assessment for R96 dated 5/22/2025 revealed, Section C (Cognitive Patterns) a Brief Interview for Mental Status Score (BIMS) score of 15 which indicated little to no cognitive impairmentObservation on 8/26/2025 at 11:29 pm of R96's room revealed prescription medication (a tube of zinc oxide paste topical ointment) labeled with the resident's name lying on the dresser. At the time of observation, R96 reported that an unidentified nurse administered (applied) the medication to his body parts and left the medication in his room.Review of clinical records for R96 revealed an omission of a completed assessment to determine whether or not the resident was capable of Self-Administration of Medications.Review of the Physician Order Form and Medication Administration Record (MAR) both dated August 2025 for R96 revealed that the resident had an order in place for the prescription.During an observation and interview on 8/26/2025 at 2:18 pm of R96's room with Registered Nurse (RN) AA, she confirmed the medications at the resident's bedside. RN AA also confirmed that R96 had not been assessed to self-administer medications independently. She reported being unsure of how the medications was left in the resident possession. RN AA then proceeded to remove the medications from the room and gave the medication to Charge Nurse Licensed Practical Nurse (LPN) BB (the assigned floor nurse).During an interview on 8/26/2025 at 4:22 pm with LPN BB, she confirmed that resident was not assessed to self-administer medications. She reported being unaware of medication being left in the resident room.Interview conducted on 8/28/2025 at 10:39 am with the Director of Nursing (DON) revealed that she was unaware of R96 having medicated cream within his possession. She stated that her expectation was that the nurses should not leave the cream in the resident room. She further stated that applying the cream for treatment requires the expertise of a nurse. 2. Review of clinical records for R125 revealed the following diagnoses but not limited to pleural effusion in other conditions classified elsewhere, hypoosmolality/hyponatremia, myocardial infarction, and cognitive communication deficit.Review of the Quarterly MDS Assessment for R125 dated 7/5/2025 revealed, Section C (Cognitive Patterns), a BIMS score of 13 which indicated little to no cognitive impairmentObservation on 8/26/2025 at 11:29 pm of R125's room revealed a bottle of cold medicine and a bottle of tums over-the-counter medication on resident's bedside table. During an observation on 8/26/2025 at 4:31 pm, RN AA confirmed that medications was in the room. She also confirmed that R125 had not been assessed to administer medications per her knowledge. RN AA then proceeded to remove the medications out of room and gave the medicine to LPN BB (assigned floor nurse).During an interview on 8/27/2025 at 10:41 am, the DON revealed that she was unaware R125 had (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unauthorized medications in her room. She further revealed that R125 was not approved to self-administer medications at the time of the survey findings. She reported that after the deficient practice was identified by the Survey Team and brought to the facility's attention, her Assistant Director of Nursing(ADON) completed a self-administer medications assessment that same day (8/26/2025) to allow the resident to self-administer medications. 3. Review of clinical records for R129 revealed the following diagnoses but not limited to diastolic congestive heart failure.Review of the Significant Change MDS assessment dated [DATE] for R129 revealed, Section C (Cognitive Patterns), a BIMS score of 15 which indicated little to no cognitive impairments.Observation and interview on 8/26/2025 at 10:15 am of R129's bathroom revealed two tubes of prescription medicated creams hanging on the handle bar. R129 revealed that she uses the cream to apply on her bottom for rash. She reported that nurses were aware. She reported that she independently used the cream daily as a treatment for a rash.During an observation of R129's bathroom on 8/26/2025 at 4:20 pm with RN AA, she confirmed that the medication was openly hanging on the handle bar in the bathroom and was not properly stored in the bedside drawer. She reported that per her knowledge R129's was not assessed to administer the cream. RN AA then proceed to remove the cream out of the bathroom and gave it to LPN BB (assigned floor nurse).Review of clinical records for R129 revealed an assessment for Self-Administration for medications dated 6/20/2025 and application for medicated cream.During an interview with the DON on 8/27/2025 at 9:30 am, she confirmed that R129 was approved to self-administer medicated creams however, the medicated cream should not have been stored in the bathroom and should have been in the resident's bedside drawer. Cross Refer F656

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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's policy titled Environmental Services Policy-cleanliness and homelike environment, the facility failed to ensure vents were free from dust and grime build up in eight residents rooms on two of six halls, A and B (Rooms 37, 38, 39, 40, 68, 66, 70, 71). Findings include: Review of the facility's undated policy titled Environmental Services Policy-cleanliness and homelike environment revealed, .3. Inspection and Oversight: Routine inspections of resident rooms and common areas will be conducted to ensure compliance with cleanliness and homelike standards. Environmental services supervisors will complete weekly rounds and document findings. Concerns identified during nursing or administrative rounds will be communicated and addressed within 24 hours. 1. Observation on 8/26/2025 at 12:05 pm and on 8/27/2025 at 10:43 am of room [ROOM NUMBER] revealed, a dirty vent grate/grille with a black substance on the front slats. 2. Observation on 8/26/2025 at 12:06 pm and on 8/27/2025 at 10:39 am of room [ROOM NUMBER] revealed, a dirty vent grate/grille with a black substance on the front slats. 3. Observation on 8/26/2025 at 12:07 pm and on 8/27/2025 at 10:37 am of room [ROOM NUMBER] revealed, a dirty vent grate/grille with a black substance on the front slats. 4. Observation on 8/26/2025 at 12:08 pm and on 8/27/2025 at 10:34 am of room [ROOM NUMBER] revealed, a dirty vent grate/grille with a black substance on the front slats. 5. Observations on 8/26/2025 at 10:53 am revealed the air vent and slats covered in a black substance along with dust build up in room [ROOM NUMBER]. 6. Observations on 8/26/2025 at 10:54 am revealed the air vent and slats covered in a black substance along with dust build up in room [ROOM NUMBER]. 7. Observations on 8/26/2025 at 11:08 am revealed the air vent and slats covered in a black substance along with dust build up in room [ROOM NUMBER]. 8. Observations on 8/26/2025 at 11:18 am revealed the air vent and slats covered in a black substance along with dust build up in room [ROOM NUMBER]. Interview on 8/27/2025 at 2:47 pm with Maintenance II revealed that vents in the resident's rooms were possibly cleaned in May of 2025 but he was unsure. Interview on 8/27/2025 at 2:48 pm with Lead Engineering Assistant JJ revealed he and staff clean the vent grates/slats about every six months. Interview on 8/27/2025 at 2:50 pm with the Maintenance Supervisor revealed they clean the vents about every two months. He was unsure when the vents were last cleaned. He said summer months were worse but admitted he didn't increase cleaning or the monitoring of the vents. He confirmed the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vents were covered in dust and grime. He admitted that he and his crew started cleaning the vents on the A hall on the night of 8/26/2025 due to him receiving a text and picture from an employee that this surveyor was taking pictures of the vents in resident's rooms. He revealed the facility dropped the ball. When asked if he thought it was good for residents to breathe the dust/black substance, he said no, we should have ensured the vents were clean. Observation and interview on 8/28/2025 at 10:00 am during a walk-through with the Environmental Supervisor confirmed that all of the identified vents were dirty.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policies titled, Care plans, Comprehensive Person-Centered, and Self-Administration of Medications by Patients, the facility failed to develop and implement a person-centered, comprehensive care plan for three of 18 Residents (R) (R59, R101, and R129). Specifically, they failed to implement the care plan for oxygen (O2) therapy related to not administering O2 per the physician order for R59; failed to develop a care plan for O2 use, water humidification, and posting signage for R101; and failed to develop a care plan for self-administration of medication for R129. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs, and a diminished quality of life.Findings include: Review of the facility's policy titled, Care plans, Comprehensive Person-Centered revised March 2022 revealed, Policy Statement, A comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Under Policy Interpretation and Implementation, 1. The Comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or significant Change in Status), and no more than 21 days after admission . 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan includes measurable objectives and timeframes .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Assessments of resident's are ongoing and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan .at least quarterly . Review of the facility's undated policy titled, Self-Administration of Medications By Patients revealed, .Ability to appropriately self-administer medications should be documented in the patient care plan. 2. The results of the interdisciplinary team assessment are recorded in the Patient Care Plan, which is placed in the patient 's medical record. 1. Review of clinical records for R59 revealed diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease (COPD), and chronic respiratory failure with hypoxia. Review of physician orders dated 4/16/2025 revealed orders for oxygen at two (2) liters per minute (LPM) via nasal canula, continuous. Review of care plan dated 1/30/2024 and revised on 7/22/2025 for R59 revealed a diagnosis of COPD and chronic respiratory failure with hypoxia. Interventions included but not limited to: Administer oxygen as prescribed or per standing order. Observations on 8/26/2025 at 10:25 am and 4:10 pm revealed R59's oxygen setting at one (1) LPM. Observation on 8/27/2025 at 10:34 am revealed R59's oxygen setting at 1-1.5 LPM. Observation on 8/27/2025 at 10:37 am with Assistant Director of Nursing (ADON) EE confirmed the R59's oxygen order was for 2 LPM by looking in the electronic health record. She then confirmed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R59's oxygen was set on 1 to 1.5 and not at 2 LPM. She revealed her expectations were for nurses to check the oxygen settings during medication pass. Interview on 8/27/2025 at 1:00 pm with the Minimum Data Set (MDS) Coordinator revealed she develops and enters care plans along with other members of the interdisciplinary team and that all staff were aware of care plans and updates through clinical meetings. She revealed that all staff were expected to follow care plans and interventions including oxygen setting rates set on their prescribed rate. She confirmed the physician orders for R59 was for 2 LPM. Interview on 8/27/2025 at 1:00 pm with the Assistant Director of Nursing (ADON) EE confirmed the facility failed to follow the care plan for R59 related to oxygen. She revealed she expects her nurses to check the rates during medication pass and rounds and to provide care per the physician orders and care plans. 2. Review of clinical records for R101 revealed, diagnoses that included but not limited to, Alzheimer's disease, dementia, psychotic disorder with delusions, major depressive disorder, and anxiety disorder. Review of physician's order dated 8/27/2025 revealed O2 at 2-4 liters per minute (LPM) via nasal cannula (NC) to keep sats >90% (saturation above 90%); order dated 4/30/2024, change the oxygen tubing and humidifier bottle every Sunday. Continued review revealed an order dated 4/16/2024 for O2 at 2-4L per NC every 8 hours as needed for low O2 sat apply if o2 sats fall below 90%-discontinued 8/27/2025. Review of the care plan dated 10/2/2024, last revised on 4/9/2025 for R101 revealed, there was no care plan problem, goal, or interventions for O2 use. Observation on 8/26/2025 at 12:05 pm and on 8/27/2025 at 10:43 am of R101 lying in bed receiving O2 running at 2 LPM via NC from the O2 concentrator at bedside. There was no sign posted on the door or inside room [ROOM NUMBER] that indicated O2 was in use. During an observation and interview on 8/28/2025 at 12:00 pm, the DON (Director of Nursing) confirmed R101 was receiving O2, confirmed the flow rate was not set at 2 LPM and confirmed there was no sign posted that indicated oxygen was in use. The DON revealed her expectation for a resident on O2 therapy, that they should have an order, have a specific flow rate number, the order must be followed, and be care planned for O2 use including water humidification and signage posted. 3. Review of clinical records for R129 revealed the following diagnoses but not limited to diastolic congestive heart failure. Review of the Significant Change MDS assessment dated [DATE] for R129 revealed, Section C (Cognitive Patterns), a BIMS score of 15 which indicated little to no cognitive impairments. Observation and interview on 8/26/2025 at 10:15 am of R129's bathroom revealed two tubes of prescription medicated creams hanging on the handle bar. R129 revealed that she uses the cream to apply on her bottom for rash. She reported that nurses were aware. She reported that she independently used the cream daily as a treatment for a rash. During an observation of R129's bathroom on 8/26/2025 at 4:20 pm with RN AA, she confirmed that the medication was openly hanging on the handle bar in the bathroom and was not properly stored in (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the bedside drawer. She reported that per her knowledge R129's was not assessed to administer the cream. RN AA then proceed to remove the cream out of the bathroom and gave it to LPN BB (assigned floor nurse). Review of clinical records for R129 revealed an assessment for Self-Administration for medications dated 6/20/2025 and application for medicated cream. Review of the care plans for R129 revealed that there was no focus area to self -administer medications. Interview on 8/27/2025 at 9:30 am, the DON confirmed R129 did not have care plan to self-administer medication and that her ADON created a care plan after it had been identified during the survey on 8/26/2025. Interview on 8/27/2025 at 10:30 am with the MDS Coordinator confirmed that the care plan for self-administration of medications was not created until yesterday (8/26/2025). She stated that the protocol was that once a resident was approved to self-administer medication by the IDT (Interdisciplinary Treatment Team), the care plan would be initiated to communicate to staff that the resident was capable of self-administering medications. Cross Refer F695, F554

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and review of the facility's policy titled Smoking Policy, the facility failed to ensure that precautions were in place for the safety of two of four Residents (R) (R118 and R58) during smoke breaks. Specifically, the facility failed to ensure that an uncovered ash tray was not filled with trash and R58's extinguished cigar butts was not placed in a N-95 (disposable facepiece respirator) mask hanging from a rollator. This had the potential to place residents in designated smoking areas at risk for safety.Findings include:Review of the facility's policy titled Smoking Policy, with a revision date of 3/25/2023 under the Purpose statement revealed, To provide a source for evaluation of the resident's ability to safely hold, light, smoke, and extinguish their cigarette.1. Review of the Electronic Medical Record (EMR) for R118 revealed that he was admitted to the facility on [DATE] with diagnoses that included but were not limited to sequelae of cerebral infarction, hemiplegia and hemiparesis affecting right dominant side, dementia with agitation, chronic obstructive pulmonary disease (COPD), and nicotine dependence.Review of the Quarterly Minimum Data Set (MDS) for R118 dated 5/20/2025 revealed, Section C (Cognitive Patterns) a Brief Interview for Mental Status score of 12, which indicated a mild cognitive impairment; Section E (Behavior) revealed, that the resident experiences verbal symptoms directed towards others and other behavioral symptoms not directed towards others and Section GG (Functional Abilities and Goals) revealed that he had functional limitations in range of motion to upper and lower extremities with impairment to one side and required supervision for all activities of daily living.Review of the care plan for R118 dated 4/25/2025, revealed that he is a smoker with Interventions that included but not limited to: cigarettes and lighters to be kept in the medication room and dispensed by the nurse, conduct smoking safety evaluation on admission and as needed, and to educate him on the facility's tobacco/smoking policy. An observation of smoking on 8/27/2025 at 12:32 pm revealed R118 observed smoking outside in the designated smoking area, which was located outside the entrance of unit E, near the flagpole. During this observation, it was noted that there was a fire blanket, fire extinguisher, and two ash trays. R118 was noted with cigarettes and a lighter and was seated next to one of the ash trays. The uncovered ash tray was noted to have cigarette butts and trash that was overflowing. Interview on 8/27/2025 at 3:46 pm with Registered Nurse (RN) LL revealed, Unit E was the dementia unit and there were no smokers on this unit. He stated that the only smokers that the facility had were on the second floor and were allowed to come downstairs and go out to the smoking area. He stated that he was unsure who was responsible for maintaining the ash trays.Interview on 8/27/2025 at 3:51pm with RN MM revealed that there were only five smokers. She stated that the smokers needed to have a general evaluation completed and would include evaluation and any concerns noted during the assessment. She then stated that she assume that it was the responsibility of either maintenance or housekeeping to check and empty the ash trays.Interview on 8/27/2025 at 3:57 pm with the Maintenance Assistant (MA) NN revealed that he was new at the facility and was not aware whose job it was to empty and check the ash tray for the smokers but stated, he would find out.Interview on 8/27/2025 at 4:45 pm with the Director of Nursing (DON) revealed that she was unsure who was responsible for maintaining the ash tray.Interview on 8/27/2025 at 4:55 pm with the Administrator revealed that staff were just educated, and that environmental services will check the ash trays two times a day and maintenance will check it at the end of their shift from now on.2. Review of the EMR for R58 revealed that he was admitted to the facility with diagnoses that included but were not limited to Parkinson's disease with dyskinesia (abnormal, involuntary, or uncontrolled muscle movements), and dementia.Review of the Quarterly MDS for R58 dated 6/10/2025 revealed, Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment; Section GG (Functional Abilities and Goals) revealed, that he (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required supervision or touching assistance with mobility.Review of the care plan dated 4/24/2024 for R58 revealed that he is a smoker with Interventions that included but were not limited to: cigarettes and light to be kept in the medication room and dispensed by the nurse, conduct smoking safety evaluation on admission and as needed, and to educate him on the facility's tobacco/smoking policy.Review of the smoking safety assessment dated [DATE] for R58 revealed, he had balance problems while sitting and standing and follows the facility's policy on location and time of smoking.Observation and interview on 8/28/2025 at 10:53 am with R58 revealed that when he was told he could smoke, the only thing they instructed me to do was to turn in his cigars and lighter. As he was walking in, it was noted that his extinguished cigar butts were in an N-95 mask, that was hanging from his rollator.An interview was conducted on 8/28/2025 at 11:53 am with the Social Services Director (SSD) revealed that social services was responsible for completing the smoking assessments quarterly. The SSD revealed that if a resident was assessed and needed to be supervised, then the resident would need to go outside to smoke with either a nurse or a Certified Nursing Assistant. She stated that education was provided to the residents, that includes the smoking policy. She stated that if R58 extinguished his cigars out in his mask and not in the ash tray, then he must have been nervous because he knows better. She concluded the interview and revealed that they just received education about making sure that the residents that smoke were safe, and that housekeeping was made responsible for checking the ash tray two times a day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115498	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hospital Authority of Brooks County, Georgia, The	1901 West Screven Street Quitman, GA 31643

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, staff interviews, and review of the facility's policy titled, Oxygen Administration, the facility failed to ensure that the physician's order for oxygen administration was followed for one Resident (R) (R59), failed to post proper signage outside of residents' rooms informing that oxygen was in use for three residents (R101, R145 and R11), failed to have an oxygen order for one resident (R11), and failed to ensure a humidification bottle was used for one resident (R145) out of 18 residents that received oxygen therapy. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs and a diminished quality of life.Findings include: Review of the facility's undated policy titled Oxygen Administration under the section Preparation revealed, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Under the section, equipment and supplies: The following equipment and supplies will be necessary when performing this procedure. 3. Humidifier bottle 4. no smoking/oxygen in use signs. Under, steps in the procedure 2. Place an oxygen in use sign on the outside of the room entrance door. Close the door. 12. Check the mask, tank, humidifying jar, etc. to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that water level is high enough that the water bubbles as oxygen flows through. 1. Review of clinical records for R59 revealed diagnoses that included but were not limited to Chronic Obstructive Pulmonary Disease (COPD), and chronic respiratory failure with hypoxia. Review of physician orders dated 4/16/2025 revealed orders for oxygen at two (2) liters per minute (lpm) via nasal canula, continuous. Observations on 8/26/2025 at 10:25 am and 4:10 pm revealed R59's oxygen setting at one (1) liter per minute (LPM). Observation on 8/27/2025 at 10:34 am revealed R59's oxygen setting at 1-1.5 LPM. Observation on 8/27/2025 at 10:37 am with Assistant Director of Nursing (ADON) EE confirmed the R59's oxygen order was for 2 LPM by looking in the electronic health record. She then confirmed R59's oxygen was set on 1 to 1.5 and not at 2 LPM. She revealed her expectations were for nurses to check the oxygen settings during medication pass. She further revealed that she was going to provide training and education for her staff. Interview on 8/28/2025 at 12:00 pm with the Director of Nursing (DON) revealed all orders should be specific for the liter to be set at, and that the concentrator should be set as ordered. 2. Review of clinical records for R101 revealed, diagnoses that included but not limited to, Alzheimer's disease, dementia, psychotic disorder with delusions, major depressive disorder, and anxiety disorder. Review of physician's orders dated 8/27/2025 revealed, orders that included but not limited to oxygen (O2) at 2-4 liters LPM via nasal cannula (NC) to keep sats >90% (saturation above 90%), as well as an order dated 4/30/2024 to change the O2 tubing and humidifier bottle every Sunday. Continued review revealed an order dated 4/16/2024 for O2 at 2-4L per NC every 8 hours as needed for low O2 sat (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	apply if O2 sats fall below 90%-discontinued 8/27/2025. Observation on 8/26/2025 at 12:05 pm and on 8/27/2025 at 10:43 am of R101 lying in bed receiving O2 running at 2 LPM via NC from the O2 concentrator at bedside. There was no sign posted on the door or inside room [ROOM NUMBER] that indicated O2 was in use. Observation on 8/28/2025 at 10:20 am of R101 sitting up in bed receiving O2 running at 2 LPM via NC from the O2 concentrator at bedside. There was no sign posted on the door or inside room [ROOM NUMBER] that indicated O2 was in use. 3. Review of clinical records for R145 revealed diagnoses that included but were not limited to chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen, and interstitial pulmonary disease. Review of the physician orders for R145 revealed that she was to receive oxygen at three (3) liters per minute via nasal cannula, and staff to change oxygen tubing and humidifier every night shift on Sundays. An observation and interview with R145 on 8/26/2025 at 10:49 am revealed that she was receiving oxygen at 3 LPM via nasal cannula. During that observation it was noted that there was no humidification for the oxygen and that there was no oxygen in use signage on the door. R145 revealed that she was supposed to be on three or four liters of oxygen and that she thought she was receiving humidified air. Observation on 8/27/2025 at 12:40 pm revealed that R145 was observed receiving oxygen at 3 liters via nasal cannula with no humidification with no oxygen in use signage on the door. Interview on 8/28/2025 at 10:15 am with Licensed Practical Nurse (LPN) KK revealed that she was educated by the O2 supplier that in the state of Georgia, residents did not need humidification. She also confirmed that she did not post signage of oxygen in use until yesterday afternoon for R145. During an observation and interview on 8/28/2025 at 12:00 pm, the DON (Director of Nursing) confirmed R101 was receiving O2, confirmed the flow rate was not set at 2 LPM and confirmed there was no sign posted that indicated oxygen was in use. During the walk-through the DON also confirmed that R145 was on O2, did not have water humidification, or signage that indicated O2 use. The DON revealed they had magnetic and paper signs at the nurses' station, and nurses were responsible for posting the sign when O2 was in use. The DON stated her expectations were that the nurses should never put oxygen on a resident without a physician's order, all orders should have a specific flow rate and not a range, the oxygen should be set at the flow rate ordered and staff must not adjust the flow rate without an order, water humidification should be used if the O2 setting was set at two or above, and there should always be a sign posted notifying that oxygen was in use inside the room. The DON also stated that if an order was unclear, or if there was not an order to increase the flow rate if needed, the nurse must always notify the physician for clarification or a new order before adjusting the O2. 4. Review of clinical records for R11 revealed the following diagnoses that included but were not limited to heart failure and morbid obesity. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for R11 revealed, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section C (Cognitive Pattern) a Brief Interview for Mental Status (BIMS) score of four which indicated severe cognitive impairment; Section O (Special Treatments and Programs) was not assessed for oxygen therapy. Observation on 8/26/2025 at 11:16 am revealed R11 was receiving oxygen at one (1) LPM via NC from the concentrator. Continued observation of R11's room revealed there was no oxygen sign posted on the inside or outside of the resident's room or door. During an observation on 8/26/2025 at 4:16 pm with Registered Nurse (RN) AA, she confirmed that R11 oxygen flow rate was set at 1 liter. RN AA revealed she was unsure of the clarity of physician order and proceeded to adjust the flow rate to two (2) liters. During a follow up observation on 8/27/2025 at 10:00 am and 8/28/2025 at 10:00 am , R11 was observed lying in bed receiving oxygen at a flow rate of 1 liters via NC from the concentrator. Review of the Physician Order Form (POF) dated August 2025 for R11 revealed there was no order for oxygen use. Review of care plans dated 7/9/2025 for R11 revealed, a focus area for oxygen use and intervention that included but not limited to Provide oxygen as indicated by Resident condition and /or provider order. Interview on 8/27/2025 at 11:11 am with MDS Coordinator RN CC and RN DD confirmed that the resident did not have an order for oxygen therapy. Both staff confirmed that the care plan for oxygen therapy was created in error and confirmed the order for oxygen should have been followed up prior to creating a care plan for oxygen usage. Interview on 8/28/2025 at 12:10 pm with the DON confirmed that R11 did not have oxygen signage on the door that indicated oxygen use. She confirmed that resident did not have supporting diagnoses or orders for oxygen. She stated that her expectation were for the nurses to follow up with the physician to ensure the resident have an order prior to administering oxygen. Cross Refer F656