

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2025
NAME OF PROVIDER OR SUPPLIER  Twin Oaks Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE  301 South Baker Street Alma, GA 31510	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32513</p> <p>Based on observation, resident and staff interviews, record review, and review of the facility policy titled, Enhanced Barrier Precautions, the facility failed to implement Enhanced Barrier Precautions (EBPs) for one resident (R) (R219) with bilateral diabetic ulcers and weeping lower leg skin tears out of four sampled residents. This failure had the potential to place R219 at risk of increased transmission of infection.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Enhanced Barrier Precautions, dated 7/3/2024, revealed, .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms .prompt recognition of need .All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions .All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions .The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities .An order for enhanced barrier precautions will be obtained for residents with any of the following .wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, surgical wounds, and chronic venous stasis ulcers .</p> <p>1. Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R219 was admitted to the facility on [DATE] with diagnoses that included heart failure, diabetes, and gout.</p> <p>Review of the Order Summary located in the Orders tab of the EMR revealed the following wound orders:</p> <p>A. Cleanse Blisters to Bilateral lower legs with NS [normal saline], apply xeroform and cover with large Tegaderm with pad daily. Dated 3/22/2025.</p> <p>B. Cleanse Diabetic ulcers to the left foot, 2nd toe with wound cleanser, apply xeroform and cover with band aids daily. Dated 3/22/2025.</p> <p>C. Cleanse diabetic wound to bottom of Right and Left foot w/NS, pat dry, apply TAO [topical antibiotic ointment], cover with band aids daily. Dated 3/23/2025.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 115513
		If continuation sheet Page 1 of 4

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D. Cleanse skin tears to the left upper and lower arm with wound cleanser, apply xeroform and cover with padded Tegaderm daily. Dated 3/22/2025.</p> <p>E. Cleanse the Diabetic Ulcer on the right foot 1st and 2nd Toes with wound cleanser, apply xeroform and cover with Band aids. Dated 3/22/2025.</p> <p>During an interview/observation on 3/26/2025 at 12:14 pm, R219 was sitting in her wheelchair. She was alert and communicative. Her bilateral legs were without bandages due to having had a shower. There were multiple wounds observed on her legs, and the skin tears were large and weeping clear fluid. R219 was asked if staff wore a protective gown when providing treatments to her legs. R219 stated, No, they don't.</p> <p>During an observation and interview on 3/26/2025 at 1:58 pm, the Treatment Nurse (TN) performed wound care to R219's lower legs. She was not observed to have worn a gown during the procedure. The TN was asked why she didn't have a gown on during the resident's wound care. She stated, I don't know why. The TN confirmed that she did not wear a gown when performing wound care and said she should have had the proper personal protective equipment (PPE) on due to the oozing wounds.</p> <p>During an interview on 3/26/2025 at 2:19 pm, the Infection Preventionist (IP) stated, I was not aware that the ulcers on her legs were diabetic ulcers. I thought they were skin tears. If they are diabetic ulcers, then definitely she should have had EBP precautions.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15879</p> <p>Based on observation, resident and staff interviews, record review, and review of the facility policy titled, Safe and Homelike Environment, the facility failed to ensure one resident (R)(R59) out of 22 sampled residents' room had an adequate working air conditioner for a comfortable temperature for the resident. This failure had the potential to cause R59 to not be comfortable in her own room.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Safe and Homelike Environment, original date of 10/22 revealed Twin Oaks Convalescent Center will provide a safe, clean, comfortable and homelike environment . comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents . housekeeping and maintenance services will be provided to maintain a sanitary, orderly and comfortable environment . the facility will maintain comfortable and safe temperature levels . any environmental issues that were unresolved should be reported to the Administrator.</p> <p>Review of R59's Admission Record Face Sheet located in the electronic medical record (EMR), under the Profile tab revealed R59 was readmitted to the facility on [DATE] with diagnoses of hemiplegia, hemiparesis, cerebral infarction (stroke), atrial fibrillation, aphasia, dysphagia, and fibromyalgia.</p> <p>Review of R59's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 3/7/2025 revealed R59 had a Brief Interview of Mental Status (BIMS) completed and it indicated R59 was unable to complete due to moderately impaired cognitive skills.</p> <p>During an observation on 3/25/2025 at 2:25 pm, R59 revealed she was in her room and was lying in bed. She was sweating, and her hair looked damp. Observation further revealed that R59 shook her head yes when Family Member (FM)1 asked her if she was hot. FM1 revealed the air conditioner in R59's room had not worked properly for almost a year, and she had reported it to staff many times. FM1 further revealed that staff would come in and use the remote to turn the air conditioner on, and it would blow out cool air for a while, but then it would get hot again in the room. FM1 further revealed maintenance had looked at it before, but the air conditioning still would quit working after maintenance looked at it.</p> <p>During an observation on 3/26/2025 at 3:50 pm revealed R59 was sweating, and she stated she was hot.</p> <p>During an interview on 3/26/2025 at 4:00 pm with the Maintenance man revealed that if there was an issue with the air conditioning not working properly, there should be a ticket in the electronic reporting system, which indicated a work ticket had been established. The Maintenance man further revealed that the E Hall, where R59 resided, had been renovated, and all the rooms had one of two air conditioning systems in their rooms. He revealed each unit had a universal remote control that the nurses or certified nursing assistants (CNAs) could use to control the temperature.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/26/2025 at 4:15 pm, the Safety Coordinator revealed if an issue had been reported, it should be on their log of work tickets. Interview further revealed that after he checked the air from the unit, the temperature of R59's room was 80 degrees Fahrenheit (F). The unit in the resident's room did not have a digital readout, so you could not tell what the temperature was set on. The Safety Coordinator confirmed the air conditioner was not blowing out cool air and it should be.</p> <p>During an observation and interview on 3/26/2025 at 4:45 pm revealed Licensed Practical Nurse (LPN) 3 got the remote from the nurse's station that staff had access to and gave it to the Safety Coordinator and when he attempted to change the temperature the remote did not work on the unit in R59's room. Observation further revealed the Safety Coordinator had to go to the hospital maintenance office to get the remote needed for the unit in R59's room. Observation further revealed that when the Safety Coordinator used the correct remote, the air conditioner kicked on and was cycling to cool the room off. LPN3 revealed to her knowledge that the remote at the nurse's station was the only one they had available. LPN3 further revealed she had been in R59's room earlier and used that remote to adjust the temperature of the room, but she did not realize it did not work for R59's room.</p> <p>During an observation on 3/26/2025 at 4:30 pm, the Maintenance man and the Safety Coordinator revealed the temperature of the room was 70 degrees F after the correct remote was utilized to set it.</p> <p>During an interview on 3/26/2025 at 4:36 pm, with the Maintenance Supervisor revealed a work ticket had been done on 3/25/2025 by the other Maintenance man but the Safety Coordinator and the Maintenance man did not look in the right place yesterday, however he did not see any other work tickets but would get back with me if he did. The Maintenance Supervisor further revealed the average room temperature should be between 70 and 80 degrees F, but that depended on the resident's preference.</p> <p>During an interview on 3/26/2025 at 4:36 pm, the Maintenance Supervisor confirmed there definitely was a lack of training on work tickets and remotes that were used to control room temperatures.</p> <p>During an interview on 3/28/2025 at 10:57 am, the Director of Nursing (DON) revealed she expected the staff to check with the residents on whether the temperature of the room was comfortable, and if it was not comfortable, then interventions should be taken to make the room comfortable for the residents.</p>		