STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115534	A. Building B. Wing	03/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azalealand Nursing Home	2040 Colonial Drive Savannah, GA 31406

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 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 and Storage, the facility failed to ensure food items were properly stored, sealed, and labeled. In addition, the facility failed to maintain sanitary conditions for one of three ice machines. The facility had 66 residents who received oral nutrition and were therefore affected by these deficient practices.Findings include:A record review of the facility policy Food Storage stated: Sufficient storage facilities are provided to keep food safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination.A brief observation of the kitchen dated 02/27/2026 at 8:00 AM revealed the following:The following open food items were not dated or labeled: two packs of fish sticks, chicken breast, diced ham, hush puppies, hamburger patties, onion rings, pound cake, a slice of cake, sliced tomatoes, grits, cream of wheat, unidentifiable frostˆbitten meat, and shredded cheese.The following food items were found in the dry pantry closet with no expiration date: two packs of spaghetti noodles wrapped in saran wrap, two open bags of macaroni noodles, an open bag of wide noodles, and an opened bag of rice. In addition, the ice machine in the kitchen was observed to have a dirty substance on both the outside and the inside.Observation/interview on 02/27/2026 at 8:00 AM with the Certified Dietary Manager (CDM) revealed and confirmed that the items listed above were not dated or labeled, and that the ice machine was dirty on the inside and outside.Interview on 02/27/2026 at 9:30 AM with the Dietary Supervisor (DS) confirmed that the above items should have been labeled and dated with open and expiration dates.DS also confirmed he would have the ice machine serviced by the professional company that maintained it. He further confirmed that all unlabeled and undated food would be discarded.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, resident and staff interviews, and record review, the facility failed to ensure resident privacy during incontinent care and transfer for two of 29 sampled residents (R) (R22) (R59). This deficient practice had the potential to place both residents at risk of a diminished quality of life and cause emotional distress and lack of trust.Findings include:Record review of the electronic health record (EHR) for R22 revealed diagnoses including, but not limited to, dementia and fracture of an unspecified part of the neck of the right femur, subsequent encounter for closed fracture with routine healing.Record review of the Quarterly Minimum Data Set (MDS) for R22, dated 01/16/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of nine (indicating mild cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident was dependent for Activities of Daily Living (ADLs), with transfers requiring the use of a mechanical device.Observation on 02/27/2026 at 9:48 AM revealed Certified Nursing Assistants (CNA) DD and CNA BB providing a transfer to a shower bed using a Hoyer lift for R22 with the room door wide open. R22's body was observed extended in the air, allowing public view exposure from the waist down, exposing her brief and the disfigurement of her legs from the contracture.Interview on 02/27/2026 at 10:30 AM with CNA DD and CNA BB, both staff confirmed they forgot to close the room door. Both CNAs reported that the Hoyer lift and the shower bed could fit in the room with the door closed. They confirmed that this was a dignity issue.Interview on 02/29/2026 at 10:01 AM with the Director of Nursing (DON) revealed the DON reviewed the photographs with the surveyor. She confirmed that the transfer was a deficient practice and was a dignity issue. She reported that certified nursing assistants had enough space in the resident's room to position the shower bed in R22's room and close the door to ensure privacy.Interview on 02/29/2026 at 5:30 PM with the Administrator revealed the Administrator reviewed the photographic evidence. He reported being unaware of the incident until it was brought to his attention by the surveyor. He reported that he planned to address the issues.Record review of the electronic health record (EHR) for R59 revealed diagnoses including, but not limited to, paroxysmal atrial fibrillation, type 2 diabetes mellitus with diabetic neuropathy, cognitive communication deficit, and presence of a cardiac pacemaker.2. Record review of the Quarterly Minimum Data Set (MDS) for R59, dated 01/2/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident required substantial/maximal assistance for toileting and was essentially dependent for most Activities of Daily Living (ADLs).Observation on 02/29/2026 at 9:48 AM revealed CNA CC providing incontinent care to R59. Continued observation revealed that the window blinds were open and the privacy curtain did not completely encircle the bed for R59, and R59 was observed with no covering on her bare body below the waist. This allowed exposure of R59 to other people entering her room and open view to the public outside. The resident's window faced the public street and the front lawn walkway.Interview on 02/28/2026 at 12:11 PM with R59 revealed and confirmed the curtain was open and reported that CNAs never closed the window blinds. R59 reported that her preference was for CNAs to ensure her privacy by closing the window.Interview on 02/28/2026 at 12:14 PM with CNA CC confirmed forgetting to ensure the privacy curtains encircled the bed and to close the window blinds. CNA CC confirmed receiving training on closing the blinds.Interview on 02/28/2026 at 12:31 PM with the DON revealed that her expectations were for staff to pull privacy curtains during patient care. She reported that this incident with R59 would be classified as a dignity issue.

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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 Medication Storage in the Facility, the facility failed to ensure four of 29 sampled residents (R) (R53, R37, R38, and R59) did not have unauthorized and unsecured medications at the bedside. This failure had the potential to result in medication errors, improper use, and adverse drug events for the residents.Findings include: Review of the facility's policy titled, Medication Storage in the Facility with effective date of May 1, 2020, under the Policy section revealed, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supple is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Under the Procedures section revealed, .B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications permitted to access. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. 1. Review of R53's Electronic Health Records (EHR) revealed diagnoses that included, but were not limited to, hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side, ophthalmoplegic migraine, not intractable, hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side. Review of R53's Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Section C (Cognitive Patterns) revealed, a Brief Interview of Mental Status (BIMS) score of six which indicated severe cognitive impairment, and Section GG (Functional Abilities and Goals) revealed, impairment on one side to the upper and lower extremities, required substantial/maximal assistance with activities of daily living (ADL). Review of R53's Physician's Orders revealed there were no active orders for eye drops or nasal sprays. Further review of the physician orders revealed that there were no physicians' orders authorizing the resident to self-administer medications. Review of R53's EHR revealed there was no evidence that a self-administration of medications assessment had been completed to determine if the resident could not self-administer medications. Observation on 02/27/2026 at 9:05 AM revealed, R53 lying in bed with [Name] lubricant eye drops and ipratropium bromide nasal spray was sitting on the bedside table. During a concurrent observation and interview on 02/27/2026 at 2:24 PM, the Director of Nursing (DON) and Certified Medication Aide (CMA) AA both confirmed that the [Name] lubricant eye drops and ipratropium bromide nasal spray was sitting on top of the bedside table inside R53's room. Interview with the Director of Nursing (DON) revealed that she was unsure if R53 had been assessed to self-administer medications or if an order was in place for R53 to self-administer medications but would check and ask CMA AA to remove the medications from the room. She revealed her expectation was for the nurses to remove medications and not to leave them in the room unattended. Interview on 02/27/2026 at 2:35 PM with the ADON and DON, R53, R37, R38, and R59 records were reviewed. The Assistant Director of Nursing (ADON) confirmed the residents did not have a (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order to self-administer medications nor had an assessment been completed for R53, R37, R38, and R59. Further review of the records revealed that R53 did not have an order for eye drops or nasal spray. ADON revealed that R53's had to have brought the medications from home because they do not carry that brand of eyedrops and there were no orders for either of them. The DON revealed she would plan to provide education to the residents' family not to bring medication from home and leave them in the resident's room and for staff to remove medications not authorized from the room. The DON confirmed that the residents (R53, R37, R38, and R59) could not self-administer their own medications. Findings include 2. Review of R37's Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of twelve, which indicated cognitive awareness with little to no cognitive impairment. Section GG (Functional Abilities and Goals) revealed impairment on one side of the upper and lower extremities and that the resident required substantial/maximal assistance with Activities of Daily Living (ADLs). Review of R37's Physician's Orders revealed an active order for eye drops dated 04/25/2024. The order stated: Refresh Tears Ophthalmic Solution 0.5% (Carboxymethylcellulose Sodium Ophth) instill 1 drop in both eyes three times a day for dry eyes. Further review revealed no physician orders authorizing the resident to self^administer medications. Review of R37's EHR revealed no evidence that a self^administration of medications assessment had been completed to determine whether the resident could self^administer medications. Observation on 02/27/2026 at 9:05 AM revealed R37 lying in bed with [Name] lubricant eye drops sitting on the bedside table. 3. Review of R38's Electronic Health Record (EHR) revealed diagnoses that included, but were not limited to, Parkinson's disease without dyskinesia and without mention of fluctuations, unspecified dementia (moderate) without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, hypertension, squamous blepharitis of the right upper eyelid, squamous blepharitis of the left upper eyelid, and prediabetes. Review of R38's admission Minimum Data Set (MDS) assessment dated [DATE] for Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated little to no cognitive impairment. Section GG (Functional Abilities and Goals) revealed no impairment of the upper or lower extremities and that the resident required partial/moderate assistance with Activities of Daily Living (ADLs). Review of R38's Physician's Orders revealed no active orders for eye drops. Further review revealed no physician orders authorizing the resident to self^administer medications. Review of R38's EHR revealed no evidence that a self^administration of medications assessment had been completed to determine whether the resident could self^administer medications. Observation on 02/27/2026 at 9:05 AM revealed R38 lying in bed with [Name] lubricant eye drops sitting on the bedside table. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of R59's Electronic Health Record (EHR) revealed diagnoses that included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy (unspecified), paroxysmal atrial fibrillation, cognitive communication deficit, and presence of a cardiac pacemaker. Review of R59's Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated little to no cognitive impairment. Section GG (Functional Abilities and Goals) revealed no impairment of the upper or lower extremities and that the resident required partial/moderate assistance with Activities of Daily Living (ADLs). Review of R59's Physician's Orders revealed an active order for eye drops (start date 11/12/2024). The order stated: Artificial Tears Ophthalmic Solution (Artificial Tear Solution) instill 1 drop in both eyes three times a day for dry eyes. Further review revealed no physician orders authorizing the resident to self^administer medications. Review of R59's EHR revealed no evidence that a self^administration of medications assessment had been completed to determine whether the resident could self^administer medications. Observation on 02/27/2026 at 10:01 AM revealed R59 lying in bed with [Name] lubricant eye drops sitting on the bedside table. Interview on 02/27/2025 at 4:35 PM with the Director of Nursing revealed she confirmed the medications at the bedside for R37, R38, and R59. She reported that none of the above^mentioned residents were authorized to self^administer medications. She stated that if any of the residents had prescription medications, the medications should remain on the medication cart. She confirmed that the medications appeared to be over^the^counter products brought in by family. She reported that her expectation was for nursing staff to monitor medications at the resident's bedside.