

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Spalding Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Airport Road Griffin, GA 30224	

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 - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review and review of the facility's policies titled Handwashing/Hand Hygiene, and Infection Prevention and Control Program, the facility failed to implement infection control protocol for two residents (R) (R34 and R82) of 14 residents observed for infection control. Specifically, nurse did not sanitize hands between glove change and nurse placed a tablet in her bare hand. The deficient practice increased the risk of cross contamination and the spread of infection to residents and staff. Findings include: Review of the facility's policy titled Handwashing/Hand Hygiene undated, documented Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; m. After removing gloves. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Review of the facility's policy titled Infection Prevention and Control Program reviewed 03/02/2025, documented Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. 1. Review of the facility's electronic medical records (EMR) documented R82 was admitted to the facility 01/29/2024 with diagnosis included but not limited to diabetes mellitus. Review of the Quarterly Minimum Data Set (MDS) dated [DATE], documented Section C (Cognition) Brief Interview for Mental Status (BIMS) score of 03 which indicated R82 had severe cognitive impairment, and Section I (Active Diagnosis) documented R82 had diabetes mellitus. Review of the care plan dated 03/02/2026, documented R82 has Diabetes Mellitus type 2. Goal: will have no complications related to diabetes through the review date. Intervention: Diabetes medication as ordered by doctor. Review of the Physician's orders dated 10/23/2024, documented metformin oral Tablet 500 milligrams (MG), give 2 tablets by mouth two times a day for Diabetes. Observation on 03/18/2026 at 9:06 AM during medication administration revealed Licensed Practical Nurse (LPN) FF used her bare hands to place a metformin tablet in the pill cutter to cut it in half to administer both halves to R82. 2. Review of the facility's electronic medical records (EMR) documented R34 was admitted to the facility 06/02/2025 with diagnosis included but not limited to dysphasia. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview for Mental Status (BIMS) documented R34 was rarely or never understood, Section K (Swallowing/Nutritional Status) documented R34 had feeding tube. Review of the care plan dated 03/09/2026 documented R34 requires BOLUS PEG tube feeding with interventions to monitor/document/report as needed (PRN) any signs and symptoms (s/sx) of: Aspiration- fever, shortness of breath (SOB), tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormality. Review of the Physician's orders dated 10/23/2024 (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Spalding Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Airport Road Griffin, GA 30224	

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 - Many</p>	<p>documented Cleanse G tube site with sterile saline, pat dry with dry, sterile dressing (DSD). Apply skin protectant to skin, then cover with split gauze and secure with tape. Observation on 03/19/2026 at 10:07 AM, revealed LPN EE did not sanitize her hands between glove change during R34's GT care. Interview on 03/18/2026 at 9:07 AM with LPN FF revealed she confirmed she used her bare hands to place a metformin 1000 mg tablet in the pill cutter to cut it in half to administer to R82. She stated R82 was ordered two 500 mg tablets but since the pharmacist sent 1000 mg tablets R82 preferred the tablet cut in half because it was a large tablet and she would take the two halves rather than one large tablet. LPN FF stated she should not have used her bare hands to hold the tablet because it caused cross contamination. and the R82 would get an infection. Interview on 03/18/2026 at 9:07 AM with the Director of Nursing (DON) revealed it is her expectations for the nurses not to handle medications with their bare hands. She stated that bare hands could contaminate the pills and if the residents get these medications, the residents could get whatever contamination was on the pills, possibly infection. Interview on 03/19/2026 at 10:15 AM with LPN EE confirmed and validated that she did not sanitize nor wash her hands between glove the change during GT care. She stated the hand sanitizer station in the room was empty and she did not have any hand sanitizer to use. She stated she should have washed her hands if there was no hand sanitizer. LPN EE further stated when she did not sanitize her hands nor wash her hands between glove change R34 could get an infection. Interview on 03/19/2026 at 2:01 PM with Nurse Manager (NM) CC confirmed that anytime gloves were removed, hands were to be washed or sanitized. She stated hands were to be washed or sanitized between glove changes and whenever this was not done, it was an infection control issue. The NM further stated that the residents could get infections such as Healthcare-Associated Infections (HAIs - infections patients contract while receiving treatment in healthcare settings, such as hospitals or nursing homes.) Interview on 03/19/2026 at 2:48 PM with the Director of Nursing (DON) revealed it is her expectation that staff sanitize their hands between glove changes. The DON stated that when the staff removed gloves they were to wash or sanitize their hands before putting on another pair of gloves because if they did not, it would cause spread of infection to the residents.</p>