STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115576	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak View Home, Inc	119 Oakview Street Waverly Hall, GA 31831

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 observation, staff interview, and review of the facility policies titled Storage Areas and Cleaning and Sanitizing, the facility failed to ensure food items were discarded on or before the discard or expiration date. In addition, the facility failed to maintain sanitary conditions for dishware and utensils. The deficient practices had the potential to place the 80 residents receiving nutrition and hydration from the kitchen at increased risk of foodborne illness. Findings include: Review of the facility policy titled Storage Areas, reviewed 12/27/2024, revealed the Guideline section included, First in first out (FIFO) should be followed.Review of facility policy titled Cleaning and Sanitizing, reviewed 12/27/2024, revealed the Intent section included, It is the intent of this center to clean and sanitize utensils, dishware, pots and pans, workspace, and equipment to minimize the risk of food-borne illnesses.Observations during a tour of the kitchen on 9/16/2025 at 7:42 am, with [NAME] CC, revealed: The dry storage area contained one opened, unlabeled 21-oz. (ounce) taco seasoning with an expiration date of 7/27/2025. The reach-in refrigerator contained three 46-oz. containers of opened thickener, unlabeled and undated.Further observations during the tour revealed that the vegetable preparation sink was rusty and the ventilation above the sink had a buildup of fuzzy material. Continued observation revealed food substance on cups that had been washed and were dry. In an interview on 9/16/2025 at 9:31 am, Dietary Aide (DA) AA stated that her responsibilities included washing dishware and utensils using the high-temperature dishwasher. She stated she occasionally scraped food off of the dishware, but she typically rinsed it off. In an interview on 9/16/2025 at 9:37 am, DA BB stated that her responsibilities consisted of utilizing the high-temperature dishwasher and storing the dry dishware. DA BB acknowledged the presence of food substances on the cups and stated that she did not inspect the dishware. She stated she was aware that this oversight could pose a risk of illness to residents.In an interview on 9/18/2025 at 11:39 am, the Certified Dietary Manager (CDM) stated that both the CDM and all staff members were responsible for checking the labels and expiration dates on every food item, and discarding the item on or before the discard date and expiration date. The CDM confirmed the food substances on the cups and stated that the dietary staff responsible for dishwashing will undergo training.

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 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. Based on observations, staff interviews, record review, and review of the facility's policy titled Use of Oxygen Therapy, the facility failed to ensure that one of 13 residents (R) (R3) with oxygen orders was administered oxygen therapy in accordance with the physician's orders. This deficient practice had the potential to place R3 at increased risk of respiratory complications. Findings include:Review of the facility's policy titled Use of Oxygen Therapy, reviewed 12/27/2024, revealed the Guideline section included, Physician's order for oxygen should be obtained and include: Oxygen with liter flow as ordered.Review of the Face Sheet for R3 revealed diagnoses including, but not limited to, chest pain, shortness of breath, chronic bronchitis, and chronic respiratory failure with hypoxia.Review of the Annual Minimum Data Set (MDS) for R3, dated 7/21/2025, revealed Section O (Special Treatments, Procedures, and Programs) documented that the resident received oxygen. Review of the care plan for R3 revealed a care area of respiratory difficulties. Interventions included administering oxygen as ordered. Review of the physician's order for R3 revealed an order dated 1/5/2025 for oxygen via a nasal cannula (NC) at 2 liters per minute (LPM) every 24 hours, every eight hours. Observation on 9/16/2025 at 12:18 pm revealed R3 receiving oxygen via NC via an oxygen concentrator with the flow meter set on 3.5 LPM. Observation on 9/16/2025 at 3:05 pm revealed R3 receiving oxygen via NC via an oxygen concentrator with the flow meter set on 3.5 LPM.Observation on 9/17/2025 at 8:46 am revealed R3 receiving oxygen via NC via an oxygen concentrator with the flow meter set on 3.5 LPM.In an interview on 9/17/2025 at 8:50 am, Licensed Practical Nurse (LPN) CC confirmed that R3's physician orders included an order for oxygen at 2 LPM via a NC. LPN CC verified the flow meter was set to 3.5 LPM on R3's oxygen concentrator. LPN CC stated it could have been unintentionally altered by someone who was unaware of the proper settings. LPN CC further stated that R3 required oxygen therapy for shortness of breath, but staff should ensure the oxygen was administered as ordered. In an interview on 9/18/2025 at 11:20 am, the Assistant Director of Nursing (ADON) confirmed that R3's physician's order was for oxygen at 2 LPM via a NC. The ADON stated the nurses were responsible for checking daily to ensure the flow rate was accurate.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, staff interviews, review of the manufacturer's package insert, and review of the facility's policies titled Pharmacy Services Medication Administration-General, Pharmacy Services Medication Orders, and Pharmacy Services Insulin Administration, the facility failed to ensure a medication error rate below five percent. There were two errors with 28 opportunities for two of 19 residents (R) (R4 and R71) observed, for a medication error rate of 7.14 percent. This deficient practice had the potential to result in medication not being given in accordance with the physician's orders and adversely affect R6 and R11's clinical condition. Findings Include:Review of the facility's policy titled Pharmacy Services Medication Administration-General, revised 4/15/2025, revealed the Intent section stated, To facilitate that medications are administered as prescribed, in accordance with good nursing principles.Review of the facility's policy titled Pharmacy Services Medication Orders, revised 12/31/2024, revealed the Types of Medication Orders section included, Hold Orders: Hold orders and signed and held orders are not permitted, with the exception of 'hold until medication available from the pharmacy' orders as specified in the guideline Medication Unavailable for Administration. Orders to hold a medication will be treated as an order to discontinue, and a new order must be written to resume.Review of the facility's policy titled Pharmacy Services Insulin Administration, revised 12/31/2024, revealed the Insulin Pen section included, . 5. Prime the pen and clear air from needle: a.) Turn the dose knob at end of the pen to 1 or 2 units. b.) Hold the pen with needle pointing upward. c.) Press dose knob while watching for insulin drop or stream to appear. d.) Repeat, if needed, until insulin is seen at the tip. 11. Inject the insulin by quickly inserting the needle straight in . 12. Use your thumb to press down on the dose knob until it stops (the dose window will be back at zero). 13. Needle should remain in subcutaneous tissue for 10 seconds to allow all of the medication to be administered properly.Review of the Novolog (insulin aspart) injection package insert revealed the Instructions for Use section included, Before each injection, small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units . press the punch-button all the way in . A drop of insulin should appear at the needle tip . check and make sure that the dose selector is set at 0. Turn the dose selector the number of units you need to inject. Inject the dose by pressing the punch-button all the way in until the 0 lines up with the pointer. Keep the needle in the skin for at least 6 seconds and the punch-button pressed all the way in . 1. Review of the physician orders for R4 revealed an order dated 7/25/2025 for insulin aspart [a medication used to treat high blood sugar] 100 units/milliliter (ml) (3ml) subcutaneous pen per sliding scale subcutaneous before meals and at bedtime. Observation on 9/17/2025 at 11:20 am, on the B-Hall medication cart with Registered Nurse (RN) GG, revealed the resident's fingerstick blood sugar reading was 232, indicating the resident should receive 4 units of insulin. Observation revealed RN GG prepared and administered the insulin without priming the needle after she attached it to the insulin pen. RN GG stated that the insulin pen was only primed upon initial use and did not require priming before each subsequent dose. Further observation revealed that RN GG did not hold the insulin pen in place for the recommended duration following dose delivery. The pen was held in place for approximately one second or until a click sound was heard. RN GG stated that she normally held the pen in place only until a click sound was heard. In an interview on 9/17/2025 at 11:55 am, RN GG stated that she was mistaken regarding insulin pen priming. She acknowledged that the pen should be primed before each administration. RN GG stated that failure to prime the insulin pen could result in air entering the pen and potentially cause the resident to receive an incorrect dose of insulin.2. Review of the physician orders for R71 revealed an order dated 3/27/2025 for albuterol sulfate HFA (hydrofluoroalkanes) 90 micrograms (mcg) [a medication used to treat lung conditions] two puffs by mouth three times per day. Observation on 9/17/2025 at 3:08 pm, on the A-Hall medication cart with Certified Medication Aide (CMA) HH, revealed the albuterol inhaler for R71 was not available on the cart or in the emergency medication (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	kit. CMA HH confirmed the medication had not been administered because it was not available. CMA HH stated that the medication had been reordered the previous day but had not arrived from the pharmacy. She stated she placed the order on hold and submitted another reorder request to the pharmacy. She stated the facility's process was to place the medication on hold and wait for pharmacy delivery. In an interview on 9/17/2025 at 3:12 pm, CMA HH stated that when medication was not in stock, she would place the medication on hold until delivery. She also confirmed that the albuterol inhaler for R71 was not available on the medication cart or in the emergency kit and that placing it on hold was the facility's required procedure, and all that she was required to do.In an interview on 9/17/2025 at 4:42 pm, the Nurse Consultant stated that insulin pens should be primed with one to two units of insulin prior to each dose administration, and the pen should be held in place when administered per policy recommendations to ensure the full dose delivery. The Nurse Consultant stated that the failure to follow these steps may result in incomplete insulin administration.In an interview on 9/18/2025 at 12:46 pm, the Director of Nursing (DON) stated her expectation was for medications to be administered per the physician's order, and if a medication was unavailable, staff were expected to determine the reason with the pharmacy and notify the provider. The DON stated medications should only be placed on hold after consulting with the provider.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled Hand Hygiene, the facility failed to ensure that staff followed hand hygiene practices during the delivery of resident clothes on one of three units (Hall B) and during wound care for one of five residents (R) (R7) with wounds. These deficient practices had the potential to place the residents residing on Hall B and R7 at risk of infection due to cross-contamination. Findings Include:Review of the facility's policy titled Hand Hygiene, revised 12/27/2024, revealed the Guideline section included, Associates should use alcohol based hand rub or wash hands with soap and water for the following indications: Immediately before touching a patient. Before performing aseptic tasks. Before moving from a soiled body site to a clean body site. After touching a patient or the patient's immediate environment. After contact with blood or contaminated surfaces. Immediately after glove removal. Gloves should not substitute for hand hygiene, and hand hygiene must be performed before donning gloves and immediately after removing gloves.1. Observation on 9/16/2025 at 12:14 pm revealed that Laundry Aide EE delivered clean clothing to three residents' rooms on Hall B without performing hand hygiene upon entering or exiting any room.In an interview on 9/16/2025 at 12:18 pm, Laundry Aide EE acknowledged that she did not perform hand hygiene when delivering resident clothing on Hall B. She stated she just forgot. She further stated that there were signs posted throughout the facility reminding staff to perform hand hygiene.2. Review of the electronic medical record (EMR) revealed R7 was admitted to the facility on [DATE], and diagnoses included, but were not limited to, pressure ulcer of other site stage 3.Review of the Physician's Orders for R7 revealed orders dated 7/15/2025 and 8/28/2025 to apply collagen dressing on Tuesday, Thursday, and Saturday once per day. The procedure included cleaning the right lower leg with normal saline, patting it dry, applying collagen to the open area, applying [treatment] on top, and covering it with a border dressing, related to a stage 3 pressure ulcer.Observation on 9/17/2025 at 10:04 am revealed the Director of Nursing (DON) performed wound care for R7. During the wound care observation, the DON removed her gloves and put on a new pair without performing hand hygiene between dirty and clean dressing changes. In an interview on 9/17/2025 at 10:25 am, the DON confirmed she didn't perform hand hygiene between glove changes during wound care for R7.In an interview on 9/17/2025 at 6:19 pm, the Wound Care Consultant stated that hand hygiene was required between glove changes.