

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2025
NAME OF PROVIDER OR SUPPLIER Altamaha Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 West Cherry Street Jesup, GA 31545	

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Based on observation, interview, record review, and review of the facility's policies titled Safe Smoking Standard and Fall Management, the facility failed to ensure an environment free from accident hazards for two of 42 sampled residents (R) (R51 and R6). Harm was identified to have occurred on 7/30/2025, when Certified Nursing Assistant (CNA)12 was independently providing a bed bath for R51, and the resident fell from the bed. It was determined that R51 required two-person assistance for bed mobility (turning from left to right in the bed). Findings included:A review of the facility's policy titled Fall Management, dated January 2025, indicated, The facility strives to reduce the risk of falls and injuries by promoting the implementation of the Risk Reduction: Falls and Injuries Program. Residents are assessed for the fall risk factors. The interdisciplinary team works with the residents and family to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. A review of the facility's policy titled Safe Smoking Standard, revised December 2022, indicated, No staff member, visitor, or resident is permitted to smoke inside the building at any time, this includes e-cigarettes and smokeless products such as chewing tobacco. The policy specified, Oxygen use is prohibited in the smoking area.1. A review of R51's admission Record revealed the facility admitted R51 on 7/3/2025. According to the admission Record, the resident had a medical history that included diagnoses of generalized muscle weakness and a need for assistance with personal care. A review of R51's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 7/9/2025, revealed R51 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was dependent on the staff for bathing. A review of R51's Care Plan Report included a focus area initiated 7/28/2025 that indicated the resident required assistance with activities of daily living (ADL) care related to activity intolerance, confusion, fatigue, impaired balance, and limited mobility. Interventions directed the staff to provide the resident with extensive assistance from one staff member with bathing/showering per schedule and as necessary, and that the resident required extensive assistance of two staff members to turn and reposition in bed as necessary. A review of R51's progress note dated 7/30/2025, during the provision of a bed bath by CNA12, when the resident was rolled, the resident's leg went off the side of the bed, which caused the resident to roll off the bed onto the floor. Per the progress note, the resident hit their head, which caused a laceration. The progress note indicated the resident was assessed by the Nurse Practitioner and subsequently transferred to the emergency room for further evaluation and treatment. A review of R51's hospital Visit Record dated 7/30/2025, indicated the resident fell out of the bed and hit their head while getting a bed bath. The record indicated the resident had a laceration to the scalp, a four-centimeter (cm) linear which was closed with skin glue and an adhesive. During an interview on 8/8/2025 at 2:49 pm, CNA12 stated she was told in the report when she started her shift for work about the needs of the residents, such as whether they needed one or two people for assistance. CNA12 stated she took care of R51 on 7/26/2025 before the fall, and the resident did not require two-person assistance, so she thought it was okay to give the resident a bed bath by herself. She stated the resident turned over onto their right side and just kept going. CNA12 stated that when the resident's leg went off the side of the bed, the resident slid off the bed. She stated the Director of Nursing (DON) and Administrator educated her to use two people with R51. CNA12 stated she did not mean for it to happen. During an interview on 8/8/2025 at 9:39 am, the Licensed Practical Nurse Unit Manager (LPN UM) stated that two people should be used for a bed bath if the resident required two people for bed mobility. The LPN UM stated that on 7/30/2025, when she entered R51's room, the resident was wrapped up in the covers and lying on the floor with the covers draped off the bed. The LPN UM stated the resident had a bleeding laceration to their forehead. During an interview on 8/8/2025 at 11:03 am, the DON stated the CNA should have two people for a bed bath if two people were needed for bed mobility. The DON stated the CNA was giving R51 a bath, unassisted, and when she turned the resident over, the resident just kept going off the side of the bed. She stated the resident got a laceration on their forehead, first aid was rendered, and the resident was transferred to the emergency room for further evaluation and treatment. According to the DON, CNA12 was in-serviced one-to-one to make sure she used two people when giving care. During an interview on 8/8/2025 at 11:30 am, the Administrator stated the staff should use two people for a bed bath if the resident required two persons to assist with bed mobility. The Administrator stated she was told the CNA was giving R51 a bed bath, and the resident rolled and fell out of the bed that was in a high position. She stated the CNA worked as needed, and she did not look for or ask</p>		