STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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. 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 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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	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 how much assistance the resident needed. The Administrator stated she filed a state report, the CNA was educated, and an in-service was done. 2. A review of R6's admission Record revealed that the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease (COPD).A review of R6's Annual MDS assessment, with an ARD of 4/1/2025, revealed R6 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident used oxygen therapy.A review of R6's Order Summary Report that contained active orders as of 8/5/2025, revealed an order dated 7/18/2024 for supplemental oxygen at three liters per minute by way of a nasal canula as tolerated every shift. A review of records revealed a Facility Incident Report Form, dated 11/19/2024, indicated residents reported today [11/19/2024] that [R6] was smoking in the smoking area with [his/her] oxygen on. Resident states that [his/her] oxygen was turned off. No one was hurt.A review of records revealed an Employee Interview Form, signed by the Activities Director (AD) and dated 11/19/2024, indicated, On smoke break today at 11:00 am the smokers reported to me that [R6] was outside on last night's smoke break with [his/her] oxygen on smoking. A review of records revealed a Witness Statement Form, signed by R6 and dated 11/19/2024, indicated the resident admitted they had one cigarette, they turned their supplemental oxygen off, CNA15 lit their cigarette, and once they finished their cigarette, they turned their supplemental oxygen back on. A review of records revealed, CNA15's Witness Statement Form, dated11/19/2024, indicated, I took [R6] out to smoke and forgot to leave the [his/her O2 [oxygen] tank inside, even still I turned it off, asked my nurse what should have been the best thing to do the next day and he said I should have left it by the door my mistake.A review of records revealed that CNA15's Separation Notice, signed by the Administrator and dated 11/21/2024, indicated CNA15's employment with the facility was terminated on 11/22/2024 for a violation of company policy. Per the Separation Notice, CNA15 placed residents in danger by allowing a resident to smoke with a supplemental oxygen tank. During an interview on 8/7/2025 at 2:15 pm, R6 stated they went out one time to smoke with their supplemental oxygen, and the CNA who let them go out lost their job. R6 stated that after that incident, they began to vape. Review of R6's progress note dated 5/20/2025 revealed that the CNAs approached R6 in the DON's office and informed nursing that a vape was found in the resident's room. Per the progress note, staff saw smoke in the resident's room and walked in and saw the vape. A review of R6's social service progress note dated 5/21/2025, indicated a vape device was found in the resident's possession after the resident was reportedly caught smoking. During an interview on 8/7/2025 at 9:10 am, the AD stated CNA15 let R6 go out during a smoke break with a supplemental oxygen tank on the back of the resident's wheelchair. During an interview on 8/7/2025 at 10:33 am, the DON stated she believed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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	staff knew it was not okay to have supplemental oxygen outside for a smoke break. During a follow-up interview on 8/7/2025 at 3:57 pm, the DON stated that 5/20/2025 was the first time R6 was found with a vape in their room. The DON stated the vape was removed, and the resident was caught again with a vape on 5/24/2025 in their room. The DON stated that the risk of vaping in a resident's room was that it could potentially start a fire. During an interview on 8/7/2025 at 4:13 pm, the Administrator stated she thought she had heard a while ago that R6 was vaping in their room. She did not recall what was done after the incident and did not know how many times the resident was caught with a vape. The Administrator stated the resident was not allowed to vape in their room because the resident was on supplemental oxygen, and it was flammable. During a telephone interview on 8/9/2025 at 9:18 am, the former DON stated she was the DON at the time when CNA15 allowed R6 to go outside with a supplemental oxygen tank to smoke. According to the former DON, R6 wanted to go outside with the group, and CNA15 told the resident it was okay to go outside with the supplemental oxygen tank because he had turned it off. The former DON stated it scared the other residents, and they reported it the next day. Per the former DON, CNA15 admitted he made a mistake. During a telephone interview on 8/9/2025 at 10:18 am, the former Administrator stated he was the Administrator when CNA15 allowed R6 to go outside with a supplemental oxygen tank to smoke. The former Administrator stated that CNA15 was suspended, and then their employment was terminated. During an interview on 8/9/2025 at 1:54 pm, the DON stated her expectation was that all smoking materials were to be kept with the staff and no residents could have smoking materials in their room. The DON stated that staff were expected to report any found smoking materials to anyone in charge. During an interview on 8/9/2025 at 2:44 pm, the Administrator stated her expectation for vapes in a resident's room was that they were not allowed, and she expected them to be stored with cigarettes. The Administrator stated she expected staff to report to her, the DON, or a nurse if they found a resident with a vape. During an interview on 8/9/2025 at 2:46 pm, the Administrator stated her expectation was that there were to be no supplemental oxygen tanks outside while residents were smoking.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on staff interviews and review of the facility's policy titled Grievance Policy, the facility failed to develop a grievance policy that met all regulatory requirements. This failure had the potential to affect all 56 residents who resided in the facility.Findings included:A review of the facility's policy titled, Grievance Policy, dated January 2025, revealed the policy did not include procedures to notify the resident of their right to file a grievance in writing or orally, the right to file a grievance anonymously, the reasonable timeframe the resident could expect a completed review of the grievance, the right to obtain the review in writing, the required contact information of the grievance official, and the contact information of outside entities with whom grievances could also be filed. The policy did not identify the grievance official and did not include steps to prevent any further potential violation of any resident's rights during the grievance review. Furthermore, the policy did not describe how the facility supported the resident's right to voice any grievance without discrimination, reprisal, or the fear of discrimination or reprisal, made prompt efforts to resolve the resident's grievance, or made information on how to file a grievance or complaint available to the residents.During an interview on 8/7/2025 at 9:35 am with the Administrator and the Regional Nurse Consultant (RNC), the Administrator stated that the grievance policy was the policy that the facility had and that she was not aware of any other policy. After review of the policy, the RNC stated the grievance policy did not meet any of the regulatory requirements. The RNC stated that some of the grievance policy requirements were met under resident rights, but were not reflected in the grievance policy.During an interview on 8/8/2025 at 7:58 am, the Administrator stated she used the policies that the company provided and ensured they were followed.During a follow-up interview on 8/8/2025 at 8:07 am, the Administrator stated her expectation regarding the grievance policy was that it covered all the areas of regulation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy titled Medication Administration, the facility failed to ensure that two of two medication carts were locked when out of the sight of a licensed nurse.Findings included:A review of the facility's policy titled Medication Administration, dated 1/2025, indicated, Medication carts are to be kept locked at all times and under the visual supervision of the licensed nurse.During an observation on 8/4/2025 at 11:22 am, the medication cart in the 300 Hall was unlocked, and the nurse was in a room down the hall.During a concurrent observation and interview on 8/6/2025 at 8:45 pm, a medication cart located by room [ROOM NUMBER] was unlocked, and there were three bottles of medications on top of the cart: iron, melatonin, and docusate sodium. Licensed Practical Nurse (LPN)1 walked down the hall after coming out of room [ROOM NUMBER] and stated the medication cart should have been locked when she walked away, but a resident needed something from her. LPN1 stated the medication cart should be locked anytime it was out of sight of the nurse. LPN1 again stated she should have locked the cart when she walked away from it.During an interview on 8/8/2025 at 9:39 am, the LPN Unit Manager stated the medication cart should be locked at all times when not in sight of the nurse to prevent anyone from getting into it.During an interview on 8/8/2025 at 11:03 am, the Director of Nursing stated the medication cart should be locked at all times when not in sight of the nurse so that no one could tamper with the cart.During an interview on 8/8/2025 at 11:30 am, the Administrator stated the medication cart should be locked at all times when the nurse is not in front of it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on resident and staff interviews and review of the facility's policy titled Resident Rights & Dignity Management, the facility failed to ensure mail was delivered to residents on Saturdays. Specifically, mail was delivered to a locked box outside the facility on Saturdays; however, no staff retrieved and delivered the mail to the residents until Monday morning. This had the potential to affect all residents who might have received mail on Saturdays.Findings included:A review of the facility's policy titled Resident Rights & Dignity Management, dated January 2025, indicated, 3. The facility will make every effort to assist each resident in exercising their right to ensure that the resident is always treated with respect, kindness, and dignity.During a Resident Council meeting on 8/5/2025 at 3:00 pm, six residents stated they did not receive mail on Saturdays. Per the residents, the Activities Director (AD) delivered the residents' weekend mail on Monday mornings.During an interview on 8/9/2025 at 10:08 am, the AD stated that mail delivery came around 11:30 am, Monday through Friday, and on Saturdays to the locked box located outside the front door of the facility. The AD stated that if she was not at work on the days that the mail was delivered by the post office, the mail stayed in the mailbox until she came in on Monday mornings. During an interview on 8/9/2025 at 11:20 am, the Director of Nursing (DON) stated that before 8/9/2025, all she knew was that she saw the mail carrier come and place mail in the box outside the facility, and she believed the AD retrieved the mail from the box and distributed the mail to the residents. Per the DON, she was unaware of what occurred with the mail on Saturdays. The DON stated she had not thought about the mail or the days of the week the mail was delivered. During an interview on 8/9/2025 at 10:19 am, the Administrator stated that mail was delivered from the post office to a locked mailbox in front of the building. The Administrator stated she did not have any expectations about mail delivery on Saturdays, as she had not thought about the weekends. She stated her expectation going forward would be that the manager on duty would check and distribute the residents' mail on Saturdays. During an interview on 8/9/2025 at 11:38 am, the Regional Operations Manager stated the facility did not have a policy related to mail delivery.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and review of the facility's policy titled Medication Administration, the facility failed to ensure the medication error rate was five percent (%) or less. There were six medication errors out of 27 opportunities, which yielded a medication error rate of 22.2% for three of five residents (R) (R5, R10, and R45) observed for medication administration.Findings included:A review of the facility's policy titled Medication Administration, dated 1/2025, indicated, Policy: To promote the health and safety of the residents we serve by ensuring safe assistance and administration of medications and treatments. The policy specified, b. The residents' MAR [medication administration record] is reviewed to determine what medications are to be administered, and then the staff removes those medications from the medication cart. c. Staff will compare the MAR with the label of each medication for the following: i. Right Person ii. Right Medication iii. Right Date iv. Right Time v. Right Route vi. Right Dose vii. Expiration Date.1. A review of the manufacturer's instructions for use for the Novolin R FlexPen revised November 2022, indicated Giving the airshot before each injection. Before each injection, small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to make sure you take the right dose of insulin: E. Turn the dose selector to select 2 units. F. Hold your Novolin R FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the Novolin R FlexPen. A small air bubble may remain at the needle tip, but it will not be injected.A review of R45's Order Summary Report, which contained active orders as of 8/9/2025, included the following orders:- an order dated 6/24/2025, for omeprazole oral capsule delayed release 20 milligrams (mg), give one capsule by mouth at bedtime for gastroesophageal reflux disease.- an order dated 7/21/2025, for quetiapine fumarate tablet 25 mg, give one tablet by mouth at bedtime, related to a psychotic disorder with hallucinations due to a known physiological condition.- an order dated 6/24/2025, for senna oral tablet 8.6 mg, give one tablet by mouth at bedtime for constipation.- an order dated 6/24/2025, for Novolin R insulin solution, inject as per sliding scale if blood glucose level is 301-350 milligrams per deciliter (mg/dL), inject 8 units per sliding scale.During a concurrent medication administration observation and interview on 8/6/2025 at 8:14 pm, Licensed Practical Nurse (LPN)2 did not administer R45's omeprazole, quetiapine, or senna. LPN2 checked R45's blood glucose level, and it was noted to be 347 mg/dL. LPN2 did not prime the insulin pen needle after he placed it on the Novolin R pen and turned the dose knob to 6 units. LPN2 administered 6 units of insulin instead of the ordered 8 units. LPN2 stated he did not know the insulin pen needle needed to be primed.During a follow-up interview on 8/7/2025 at 6:45 am, LPN2 stated he should have followed the five rights of medication administration and double checked to make sure all the medications were given. LPN2 stated he did not realize he had not given the senna or omeprazole, and he overlooked getting the quetiapine out of the emergency kit.2. A review of the Basaglar Tempo Pen Instructions for Use, revised November 2022, indicated, Priming your Pen Prime before each injection. Priming means removing the air from the Needle and Cartridge that may collect during normal use. It is important to prime your Pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with the Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat the priming steps 6 to 8, but not more than 4 times. If you still do not see insulin, change the Needle and repeat the priming steps 6 to 8. Small air bubbles are normal and will not affect your (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dose.A review of R10's Order Summary Report that contained active orders as of 8/9/2025 revealed an order dated 5/15/2025 for Basaglar Kwik Pen subcutaneous solution pen injector 100 units per milliliter, inject 30 units subcutaneously at bedtime for type 1 diabetes mellitus with diabetic neuropathy.During a concurrent medication administration observation and interview on 8/6/2025 at 9:23 pm, Licensed Practical Nurse (LPN)1 did not prime the needle after she placed it on the Basaglar Kwik Pen and turned the dose knob to 30 units. LPN1 stated she did not know the needle needed to be primed.3. A review of the Lantus Solostar Instructions for Use, revised May 2025, indicated, Step 3: Do a safety test. Always do a safety test before each injection to check your pen and the needle to make sure they are working properly. Make sure that you get the correct Lantus dose. 3A Select 2 units by turning the dose selector until the dose pointer is at the 2 mark. 3B Press the injection button all the way in. When insulin comes out of the needle tip, your pen is working correctly: If no insulin appears, you may need to repeat this step up to 3 times before seeing insulin. If no insulin comes out after the third time, the needle may be blocked. If this happens: change the needle, then repeat the safety test. Do not use your pen if there is still no insulin coming out of the needle tip. Use a new pen. Do not use a syringe to remove insulin from your pen. If you see air bubbles: You may see air bubbles of the insulin. This is normal; they will not harm you. The Instructions for Use specified, Step 5: Injecting Your Lantus Dose 5C. Place your thumb on the injection button. Then press all the way in and hold. 5D Keep the injection button held in and when you see 0 in the dose window, slowly count to 10. This will make sure you get your full dose.A review of R5's Order Summary Report that contained active orders as of 8/9/2025, revealed an order dated 11/25/2024, for Lantus Solostar subcutaneous solution pen-injector 100 units per milliliter, inject 15 units subcutaneously one time a day for diabetes.During a concurrent medication administration observation and interview on 8/7/2025 at 8:04 am, the Licensed Practical Nurse Unit Manager (LPM UM) did not prime the needle after she placed it on the Lantus pen injector and turned the dose knob to 15 units. When the LPN UM injected the insulin, she did not hold the pen in place for a count of 10. The LPN UM stated she did not know the needle needed to be primed.During an interview on 8/10/2025 at 11:03 am, the Director of Nursing stated the insulin pen needle should be primed with one to 2 units so no air is injected.During an interview on 8/8/2025 at 3:12 pm, the Nurse Practitioner stated insulin pens should be primed with two units before the dose being given to ensure the needle worked and the resident received the appropriate dose of insulin.During an interview on 8/8/2025 at 11:30 pm, the Administrator stated she deferred all medication questions to the clinical team but expected the staff to follow the manufacturer's guidelines and standards of practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview, record review, review of the Healthcare Professional Operator's Manual and review of the facility's policies titled, Glucometer Cleaning, and Respiratory Management, the facility failed to ensure that infection control practices were followed for five of five of 42 sampled residents (R) (R30, R45, R49, R24 and R47). Specifically, the nurse failed to ensure that the glucometer was cleaned and disinfected between use for R30, R45, and R49; the facility also failed to ensure that staff did not touch medication with their bare hands for R45 during medication administration; and the facility failed to ensure that respiratory equipment was cleaned and stored appropriately for R24 and R47.Findings included: A review of the facility's policy titled Glucometer Cleaning, dated January 2025, indicated, All glucometers must be cleaned/disinfected after each resident use. Per the policy, Wipe Down with Sani-cloths. The policy specified, Supplies and medications for finger stick monitoring or insulin administration should not be placed on potentially contaminated environmental surfaces.A review of the undated Healthcare Professional Operator's Manual for the EvenCare G3 Blood Glucose Monitoring System indicated, The EVENCARE G3 Meter should be cleaned and disinfected between each patient. The meter is validated to withstand a cleaning and disinfection cycle of ten times per day for an average period of three years. The manual specified, Step 4. To clean the meter, use a moist (not wet) lint-free cloth dampened with a mild detergent. Wipe all external areas of the meter, including both the front and back surfaces, until visibly clean. Avoid wetting the meter test strip port. Step 5. To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. Other EPA-registered wipes may be used for disinfecting the EVENCAR G3 system; however, these wipes have not been validated and could affect the performance of the meter. Wipe all external areas of the meter, including both front and back surfaces, until visibly wet. Avoid wetting the meter test strip port. Wipe meter dry or allow to air dry.A review of the facility's policy titled Respiratory Management, dated January 2025, indicated Continuous Positive Airway Pressure (CPAP) or Bi-Level Positive Airway Pressure (BiPAP) Policy. CPAP/BiPAP is provided to residents who have a physician's order. Per the policy, 2. Clean mask and hose with soap and water as needed and/or weekly. Cleaning for CPAP mask, frame, and headgear: -Unplug from power source -Disconnect mask and air tubing from CPAP machine-Disassemble mask into three parts -In a sink, clean mask, and headgear to remove any oils using soap and water; avoid using strong chemicals including dish detergent and they may damage the mask -Place cushion and frame on flat surface on top of a towel to dry -Disconnect air tubing from mask and CPAP machine -Rinse the inside and outside of the air tubing with mild soap and warm water, rinse again -Place tubing on flat surface on top of towel to dry -Disconnect humidifier tub from CPAP machine and rinse with mild soap and water -Place tub on flat surface on a towel to dry. The section of the policy titled Aerosolized Medication indicated, 17. Rinse the nebulizer and mouthpiece. Shake the air dry and store it in a plastic bag that is labeled with the resident's name and room number. Nebulizer and mouthpiece may also be stored in the machine if a storage shelf is available. 1. A review of R45's admission Record revealed that the resident had a medical history that included a diagnosis of type 2 diabetes mellitus with hyperglycemia (high blood sugar). A review of R45's Significant Change in Status Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 6/30/2025, revealed R45 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident received insulin injections.A review of R45's Care Plan Report included a focus area initiated 10/11/2024, which indicated the resident had insulin-dependent diabetes mellitus. Interventions instructed staff to provide diabetes medication as ordered by the doctor and observe and document for side effects and effectiveness. During a concurrent medication administration observation and interview on 8/6/2025 at 8:14 pm, Licensed Practical Nurse (LPN)2 entered R45's room and obtained the resident's fingerstick blood sugar. Afterwards, LPN2 cleaned the glucometer with an alcohol wipe and allowed it to air dry. LPN2 stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he cleaned the glucometer between each use and thought it was appropriate to use an alcohol wipe to clean it since he used alcohol to sanitize his hands. LPN2 then went back to the medication cart and popped a pill out of a medication card into his bare hand and placed the pill in a medication cup. LPN2 was stopped and admitted that he had touched the pills. LPN2 stated he should not have touched the pills and threw both pills away, and popped out new pills appropriately. 2. A review of R30's admission Record revealed that the resident had a medical history that included a diagnosis of type 2 diabetes mellitus. A review of R30's Quarterly MDS assessment, with an ARD of 7/15/2025, revealed R30 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated R30 received insulin injections.A review of R30's Care Plan Report included a focus area revised 5/25/2021, which indicated the resident had diabetes mellitus. Interventions instructed staff to provide diabetes medication as ordered by the doctor and observe and document for side effects and effectiveness. A review of R49's admission Record revealed, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus. A review of R49's Quarterly MDS, with an ARD of 5/16/2025, revealed that R49 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated R49 received insulin injections.A review of R49's Care Plan Report included a focus area revised 9/17/2024, which indicated the resident had insulin-dependent diabetes mellitus. Interventions instructed staff to provide diabetes medication as ordered by the doctor and observe and document for side effects and effectiveness. During a concurrent observation and interview on 8/6/2025 at 8:48 pm, LPN1 had a glucometer sitting on top of the medication cart. LPN1 entered R30's room to check the resident's blood sugar. After obtaining the blood sample, LPN1 set the glucometer on the resident's bed while awaiting the results. Once the results were received, LPN1 took the glucometer out to the medication cart and did not clean or disinfect it prior to checking the blood sugar for R49. After checking R49's blood sugar, LPN1 went out of the resident's room and placed the glucometer on top of the medication cart. At 9:08 pm, LPN1 was stopped prior to checking the next resident's blood sugar, and she stated she was supposed to clean the glucometer between each use with the germicidal wipes. LPN1 stated she forgot, but she should have done it. LPN1 was not able to find the germicidal wipes on the medication cart and had to get a container of germicidal wipes from the front desk. During an interview on 8/8/2025 at 9:39 am, the LPN Unit Manager (UM) stated medications should not be touched with bare hands because it was an infection control and contamination issue. The LPN UM stated the glucometer should be cleaned before starting and between each resident use before it was placed back into the medication cart. The LPN UM stated the glucometer should be cleaned with germicidal wipes for infection control and to prevent cross-contamination. During an interview on 8/8/2025 at 11:03 am, the Director of Nursing (DON) stated the nurse should not touch medications with their bare hand, and if they did, the medication should be thrown away. The DON stated the glucometer should be cleaned after each resident's use with the germicidal wipes to prevent cross-contamination. During an interview on 8/8/2025 at 11:30 pm, the Administrator stated she deferred all questions to the clinical team but expected the staff to follow the facility policy, manufacturer's guidelines, and standards of practice. 3. A review of R47's admission Record revealed that the resident had a medical history that included a diagnosis of shortness of breath.A review of R47's Quarterly MDS, with an ARD of 5/12/2025, revealed R47 had a BIMS score of 15, which indicated the resident had intact cognition. A review of R47's Order Summary Report that contained active orders as of 8/6/2025, revealed an order dated 5/23/2025, for albuterol sulfate nebulization solution 0.083% three milliliters (ml) inhaled orally by way of nebulizer every six hours as needed for shortness of breath. A review of R47's Medication Administration Record for the timeframe 8/1/2025 through 8/31/2025 revealed the resident received an albuterol nebulizer treatment on 8/3/2025 at 12:22 pm. During a concurrent observation and interview on 8/4/2025 at 3:56 pm, the surveyor noted a nebulizer machine on R47's nightstand with the tubing attached to the machine and the mask with a medication cannister lying on top of the machine. R47 stated that the tubing, mask, and medication cannister were new, but they had never (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	seen the staff clean the equipment before. During a concurrent observation and interview on 8/6/2025 at 8:30 am, the surveyor noted a nebulizer mask and a medication canister with a small amount of fluid were sitting on top of R47's nightstand next to the nebulizer machine. R47 stated the staff did not rinse it out. During a concurrent observation and interview on 8/6/2025 at 9:58 pm, LPN2 stated nebulizer equipment should be rinsed out and placed on a paper towel to air dry, then placed in the plastic bag. LPN2 entered R47's room and noted the resident's nebulizer mask and medication canister were lying on top of the nightstand on top of a plastic bag, and there was a small amount of fluid in the canister. LPN2 stated there should not be any fluid in the canister, and it should be stored in the bag, not on top of it. During an interview on 8/8/2025 at 9:39 am, the LPN Unit Manager stated that the nebulizer equipment should be rinsed out after use and stored in a plastic bag. During an interview on 8/8/2025 at 11:03 am, the DON stated that the nebulizer equipment should be wiped out after use, the tubing changed out once a week, and it should be stored where it is clean and dry or in a bag when not in use. During an interview on 8/8/2025 at 3:12 pm, the Nurse Practitioner stated the nebulizer mask should have been cleaned after use and stored in a bag to prevent infection. During an interview on 8/8/2025 at 11:30 pm, the Administrator stated she deferred all questions to the clinical team related to the use, cleaning, and storing of nebulizer machines, but stated the staff should be following their policy. 4. A review of R24's admission Record revealed that the resident had a medical history that included diagnoses of obstructive sleep apnea and dependence on other enabling machines and devices. A review of R24's Quarterly MDS assessment, with an ARD of 7/30/2025, revealed R24 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received non-invasive mechanical ventilator treatment. A review of R24's Care Plan Report included a focus area initiated on 8/9/2023. The document revealed that R24 had an altered respiratory status and difficulty breathing related to sleep apnea. Interventions directed staff on CPAP settings, to titrate pressure per physician orders by way of nasal pillow, nose mask, and full-face mask as per the resident's preferences and tolerance.A review of R24's Order Summary Report that contained active orders as of 8/8/2025, revealed an order dated 2/6/2025, for CPAP settings at 14 at bedtime and naps as tolerated. There was also an order dated 5/15/2024, to cleanse the CPAP water chamber with soap and water weekly and rinse it out before putting distilled water into it.During an observation on 8/4/2025 at 11:36 am, revealed, a CPAP machine was revealed on R24's nightstand with the mask lying on top of the machine. There was dried debris noted in the mask, and there was no bag to store the mask in. During an interview on 8/8/2025 at 9:39 am, the LPN UM stated the CPAP mask should be stored in a plastic bag when not in use and cleaned once a week, and as needed, according to the facility's policy and procedure. During an interview on 8/8/2025 at 11:03 am, the DON stated the CPAP mask should be wiped out after use and the tubing cleaned weekly with soap and water. The DON stated the mask should be stored in a plastic bag or something to keep it clean and dry.During an interview on 8/8/2025 at 3:12 pm, the Nurse Practitioner stated the CPAP mask should be cleaned after use and stored in a bag. During an interview on 8/8/2025 at 11:30 pm, the Administrator stated she deferred all questions related to the use of the CPAP and cleaning and storing of the equipment to the clinical team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on staff and resident interviews, record review, and review of the facility's policy titled Behavior Management Standard, the facility failed to discuss the risks and benefits and obtain informed consent before the administration of a psychotropic medication for one of five residents (R) (R4) reviewed for unnecessary medications.Findings included:A review of the facility's policy titled Behavior Management Standard, dated January 2025, indicated, The resident or their responsible party has the right to be informed about the resident's condition; treatment options; risks/benefits and expected outcomes of treatment for the purpose of making informed choices about the use of medications including the right to refuse care and treatment.A review of R4's admission Record revealed that the resident had a medical history that included diagnoses of vascular dementia, seizures, and nontraumatic subdural hemorrhage.A review of R4's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/20/2025, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS assessment indicated R4 received an antipsychotic medication within the last seven days of the look-back assessment period.A review of R4's Care Plan Report included a focus area initiated 8/4/2025 that revealed the resident used psychotropic medications related to behavior management and dementia. Interventions directed staff to educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of psychotropic medications being given.A review of R4's Psychotropic Medication Informed Consent for the antipsychotic quetiapine fumarate was signed by the resident with no date, and signed by Licensed Practical Nurse (LPN)10, dated August 5th, with no year.A review of R4's Medication Administration Record [MAR] for the timeframe 7/10/2025 through 7/30/2025, revealed an order entry for quetiapine fumarate (an atypical antipsychotic) 50 milligrams (mg) at bedtime for two weeks, with a start date of 7/14/2025 and a stop date of 7/30/2025. Documentation indicated the medication was administered to the resident daily from 7/14/2025 through 7/29/2025, for a total of 16 days. The MAR revealed another order entry for quetiapine fumarate 25 mg at bedtime with a start date of 7/31/2025. Documentation indicated the medication was administered to the resident on 7/31/2025.A review of R4's Medication Administration Record [MAR] for the timeframe 8/1/2025 through 8/31/2025 revealed an order entry for quetiapine fumarate 25 mg at bedtime for two weeks, with a start date of 7/31/2025. Documentation indicated the medication was administered to the resident daily from 8/1/2025 through 8/4/2025.During an interview on 8/6/2025 at 1:29 pm, R4 stated they did not know what the medication they were taking was or what it was for, but that on 8/5/2025, the nurse asked them to sign a paper to indicate it was okay to give it. R4 stated they signed the form because the nurse told them they would only be taking the medication for another couple of days. During an interview on 8/8/2025 at 10:25 am, LPN10 stated she was not aware that consents were needed for the use of psychotropic medications. She stated she obtained consent for R4's quetiapine when she was asked to by the Director of Nursing (DON).During an interview on 8/8/2025 at 9:39 am, the LPN Unit Manager (LPN UM) stated she found out the prior week that it was the nursing staff's responsibility to complete the consent forms for psychotropic medications. She stated the social worker had been obtaining consents previously. The LPN UM stated consent for the medication should be obtained before administering the medication. She stated she was not aware that R4 did not have consent for their quetiapine. During an interview on 8/8/2025 at 11:03 am, the DON stated the social worker was responsible for obtaining the consents for psychotropic medications, but she had been doing them in the social worker's absence since 7/30/2025. The DON stated consent should be obtained as soon as possible, within 72 hours of receiving the order. The DON stated she had just completed an audit and must have missed R4. During an interview on 8/8/2025 at 11:30 pm, the Administrator stated that consents for psychotropic medications should be obtained prior to the medication being administered, and the clinical team was responsible for obtaining the consent.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on staff and resident interviews, record review, and review of the facility's policy titled Freedom of Abuse - Abuse Prevention: Fast Alerts, the facility failed to report an allegation of abuse and neglect for two of two residents (R) (R66 and R14) reviewed for abuse out of a total sample size of 42 residents. Specifically, the facility failed to report an allegation of abuse/neglect made on 10/16/2024 by R66 that Certified Nursing Assistant (CNA)15 was rough during the provision of care and did not check on the resident or provide incontinence care from 6:00 pm to 6:00 am on 10/16/2024. Also, the facility failed to report an allegation of verbal abuse made on 10/22/2024 by R14 that CNA15 yelled at them.Findings included:A review of the facility's policy titled Freedom of Abuse - Abuse Prevention: Fast Alerts, dated January 2025, indicated, Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.A review of R66's admission Record revealed that the resident had a medical history that included a diagnosis of chronic pain. The admission Record indicated that the resident was discharged from the facility on 11/05/2024.A review of R66's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/8/2024, revealed R66 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff assistance for toileting hygiene and frequently experienced urinary and bowel incontinence during the seven-day assessment look-back period.A review of R66's Care Plan Report included a focus area initiated 10/31/2024, which indicated the resident had mixed bladder and bowel incontinence related to activity intolerance, impaired mobility, and diuretic use. Interventions directed staff that the resident used disposable briefs, and that staff were to change the briefs per routine and as needed (initiated 10/31/2024), and for staff to clean the perineal area with each incontinence episode (initiated 10/31/2024).A review of R66's medical records revealed a document titled Employee Counseling Form, signed by the former Director of Nursing (DON) on 10/17/2024 and by CNA15 on 10/18/2024, indicated R66 reported CNA15 did not check on the resident or provide incontinence care the entire 12-hour shift of 10/16/2024 from 6:00 pm to 6:00 am. The form further revealed CNA15 was rough with [the resident] during care. The form indicated R66 requested that CNA15 have no further contact with them.A phone interview was attempted with R66 on 8/8/2025 at 11:45 am and 8/9/2025 at 12:05 pm. No return call was received.During a telephone interview on 8/9/2025 at 9:07 am, the former DON stated she did not recall the incident with R66 and did not recall the resident. The former DON stated she did not think she reported the incident for abuse. She stated the resident being left soiled and care being rough were allegations that required reporting to the Abuse Coordinator and to the state agency.During an interview on 8/8/2025 at 10:45 am, the Administrator stated that the allegation that CNA15 did not change R66's brief and rough handled the resident on 10/17/2024 was an allegation of abuse and neglect and should have been reported to the state agency.2. A review of R14's admission Record revealed that the resident had a medical history that included the diagnoses of moderate intellectual disabilities and irritable bowel syndrome.A review of R14's Quarterly MDS assessment, with an ARD of 6/16/2025, revealed R14 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. The MDS assessment indicated the resident was dependent on staff assistance for toileting hygiene and was frequently incontinent of urine and always incontinent of bowel.A review of R14's Care Plan Report included a focus area initiated 7/18/2023, which indicated the resident had mixed bladder and bowel incontinence related to activity intolerance, impaired mobility, and cerebral palsy. Interventions directed staff that the resident used disposable briefs, and that staff were to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change the briefs per routine and as needed (initiated 7/18/2023) and for staff to clean the perineal area with each incontinence episode (initiated 7/18/2023).A review of R14's medical record revealed a document titled Resident Grievance/ Concern/ Complaint Report, dated 10/22/2024 and signed by the Licensed Practical Nurse Unit Manager (LPN UM), indicated R14 was very upset that CNA15 yelled at them for having a bowel movement (BM) on themself. Per the report, the resident was very upset and stated they were going to have to find another place to go.A review of R14's medical record revealed a document titled Worksite Employee Warning Notice, signed by the former DON and dated 10/23/2024, indicating R14 stated CNA15 yelled at them for having a BM and soiling their sheets. Per the document, the resident accepted an apology from CNA15 but did not want CNA15 to provide care to them in the future.During an interview on 8/8/2025 at 11:25 am, R14 did not recall the incident in which a staff member yelled at them. During a telephone interview on 8/9/2025 at 8:43 am, the former DON stated she recalled R14's complaint on 10/22/2024. The former DON said the allegation that CNA15 yelled at R14 was an allegation of abuse. She stated the facility administration was aware of the allegation, but she did not recall if the allegation was reported to the state agency. The former DON stated that the Administrator was the Abuse Coordinator and would have made the report.During an interview on 8/8/2025 at 10:45 am, the Administrator stated that the allegation that CNA15 yelled at R14 on 10/22/2024 was considered an allegation of abuse and should have been reported to the state agency.During a follow-up interview on 8/8/2025 at 11:04 am, the Administrator stated the former Administrator should have reported the allegation regarding R14 and R66 to the state agency within two hours, but did not.During an interview on 8/9/2025 at 1:59 pm, the DON reviewed R14's and R66's incidents and stated they were allegations of abuse and should have been reported to the state agency.During an interview on 8/9/2025 at 2:47 pm, the Administrator stated her expectation for reporting abuse was that staff were to immediately report to the Abuse Coordinator, and the Abuse Coordinator had two hours to report to the state agency from the time the allegation occurred. The Administrator confirmed the allegations regarding R14 and R66 should have been reported to the state agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on staff interviews, record review, and review of the facility's policy titled Freedom of Abuse - Abuse Prevention: Fast Alerts, the facility failed to investigate an allegation of abuse and neglect for two of two residents (R) (R14 and R66) reviewed for abuse out of a total sample size of 42 residents.Findings included:A review of the facility's policy titled Freedom of Abuse - Abuse Prevention: Fast Alerts, dated 1/2025, indicated, All alleged violations involving mistreatment, sexually inappropriate behaviors, and abuse or neglect will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state and federal law.1. A review of R66's admission Record revealed the resident had a medical history that included a diagnosis of chronic pain. The admission Record indicated the resident was discharged from the facility on 11/5/2024.A review of R66's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/8/2024, revealed R66 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff assistance for toileting hygiene and frequently experienced urinary and bowel incontinence during the seven-day assessment look-back period.A review of R66's medical records revealed a document titled Employee Counseling Form, signed by the former Director of Nursing (DON) on 10/17/2024 and by CNA15 on 10/18/2024, indicated R66 reported CNA15 did not check on them or provide incontinence care the entire 12-hour shift of 10/16/2024 from 6:00 pm to 6:00 am. The form further revealed CNA15 was rough with [the resident] during care. The form indicated R66 requested that CNA15 have no further contact with them.2. A review of R14's admission Record revealed that the resident had a medical history that included the diagnoses of moderate intellectual disabilities and irritable bowel syndrome.A review of R14's Quarterly MDS assessment, with an ARD of 6/16/2025, revealed R14 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. The MDS assessment indicated the resident was dependent on staff assistance for toileting hygiene and was frequently incontinent of urine and always incontinent of bowel.A review of R14's medical records revealed a document titled Resident Grievance/ Concern/ Complaint Report, dated 10/22/2024 and signed by the Licensed Practical Nurse Unit Manager (LPN UM), indicated R14 was very upset that CNA15 yelled at them for having a bowel movement (BM) on themself. Per the report, the resident was very upset and stated they were going to have to find another place to go.A review of R14's medical records revealed a document titled Worksite Employee Warning Notice, signed by the former DON and dated 10/23/2024, indicating that R14 stated CNA15 yelled at them for having a BM and soiling their sheets. Per the document, the resident accepted an apology from CNA15 but did not want CNA15 to provide care for them in the future.During an interview on 8/9/2025 at 2:51 pm, the Administrator stated she was unaware if the allegations regarding R14 and R66 were investigated because she was unable to locate any documented evidence of an investigation.During an interview on 8/9/2025 at 4:23 pm, the Regional Nurse Consultant (RNC) stated that an investigation should have been conducted for the allegations regarding R14 and R66. The RNC said she was not aware of an investigation, and there was no evidence that an investigation occurred.During a follow-up interview on 8/9/2025 at 4:27 pm, the Administrator stated her expectation was that an investigation should have been conducted regarding the allegations of abuse and neglect and that the facility should have retained documentation of the investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on staff interviews and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) Level I was updated and resubmitted following the onset of a new mental illness diagnosis for one of 42 sampled residents (R) (R46) reviewed for PASARR.Findings included:A review of R46's admission Record revealed that the resident had a medical history that included diagnoses of vascular dementia with anxiety (onset date 7/1/2025), generalized anxiety disorder (onset date 11/1/2023), and other bipolar disorder (onset date 4/1/2025).A review of R46's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/25/2025, revealed R46 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident had active diagnoses to include anxiety disorder and bipolar disorder.A review of R46's Care Plan Report, included a focus area revised 4/25/2023, that indicated the resident used anti-anxiety medications related to a diagnosis of anxiety disorder. The Care Plan Report also included a focus area revised 5/1/2022, which indicated the resident used antidepressant medication related to a diagnosis of bipolar disorder.A review of R46's record revealed no evidence to indicate that a PASARR Level I was completed once the resident received a new mental illness diagnosis of bipolar disorder on 4/1/2025 or anxiety on 7/1/2025.During an interview on 8/7/2025 at 4:57 pm, the Regional Nurse Consultant stated that after reviewing R46's medical record, she determined that, based on the resident's current diagnoses, a review for a PASARR Level II should have been requested when the new diagnoses presented, and she was not sure why it was not done.During an interview on 8/8/2025 at 9:49 am, the MDS Coordinator stated that PASARR forms were completed by the admission staff, who initiated the PASARR and completed the PASARR Level I. The MDS Coordinator stated that if a resident acquired a new mental illness diagnosis, a new PASARR would be completed. The MDS Coordinator stated that a new PASARR should have been completed for R46. During an interview on 8/8/2025 at 8:00 am, the Administrator stated R46 should have had a new PASARR submitted, and she was not sure why it was not done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, staff interviews, record review, and review of the facility's policy titled Resident Hygiene, the facility failed to ensure nail care was provided for one of two residents (R) (R39) reviewed for activities of daily living (ADL) care. Findings included:A review of the facility's policy titled Resident Hygiene, dated January 2025, revealed that Nail care includes daily cleaning and regular trimming. Nail trimming for diabetic residents is per the MD [medical doctor] order. Podiatry care is scheduled as needed for those residents with identified podiatry needs. A review of R39's admission Record revealed that the resident had a medical history that included diagnoses of type 2 diabetes mellitus and the need for assistance with personal care. A review of R39's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/31/2025, revealed R39 had a Staff Assessment for Mental Status (SAMS), which indicated the resident was severely impaired in cognitive skills for daily decision-making. The MDS indicated the resident was dependent on staff assistance for bathing. A review of R39's Care Plan Report included a focus area initiated 6/9/2025, which indicated the resident required assistance with ADL care. Interventions directed staff to check nail length, trim and clean on bath day, and as necessary, and to report any changes to the nurse (initiated 6/9/2025).During an observation on 8/4/2025 at 12:45 pm, R39 was observed lying in their bed. The resident's toenails on both feet were long and extended approximately a half inch past the end of their toes. During an observation on 8/6/2025 at 9:14 am, R39 was observed lying in their bed. The resident's toenails on both feet remained long and extended a half inch past the end of their toes. A review of R39's medical records revealed a document titled Facility Visit History, dated 8/6/2025, which included a list of residents who had been seen by podiatry services from 5/5/2021 to 7/16/2025. R39 was not included on this list.During an interview on 8/6/2025 at 9:59 am, Certified Nursing Assistant (CNA)3 stated she kept R39's fingernails clean with daily care, but that the nursing staff did the trimming of the fingernails. She stated that she believed that the nurses cut the resident's toenails or that the podiatrist came in to cut them. During an interview on 8/7/2025 at 10:45 am, the Licensed Practical Nurse Unit Manager (LPN UM) stated that nail care was performed on Sundays by the CNAs. She stated that clipping or filing, and cleanliness were done daily and during showers. She stated that toenail care was completed by the podiatrist who came to the facility and trimmed toenails; however, if something needed immediate attention, it was taken care of. During a concurrent observation and interview on 8/7/2025 at 10:53 am, LPN UM inspected R39's feet and observed that on the resident's left foot, the big toenail was long, and the third and fourth toenails were long and curved over the top of each toe. All five toenails on the resident's right foot were long and extended approximately a half inch past the top of the toe, with the toenail on the large toe observed to be chipped. The LPN UM stated the resident should have been on the podiatry list and seen by the podiatrist, and she was not sure why they were not. The LPN UM stated she would get clippers and address the resident's toenails right away.During an interview on 8/8/2025 at 9:39 am, the Director of Nursing (DON) stated that nail care was generally done on Sundays, during ADLs, and as needed during bath or showers. She stated that CNAs were responsible for the cleaning portion of the nail care, and the nurses did the trimming. She stated that if a CNA saw a concern with a resident's toenails, they were to report the concern to the nurse. The DON stated the nurse should attempt to file or clip the nails, but if unable to trim the toenails, then the resident should be placed on the list to be seen by the podiatrist. The DON stated the CNA should have notified the nursing staff of R39's nails, and the concern should have been addressed by the assigned nurse or the podiatrist.During an interview on 8/8/2025 at 7:52 am, the Administrator stated that her expectation was for residents' toenails to be taken care of, and if the CNA saw a concern, they should go to the nurse immediately. The Administrator stated that if the nurse could not clip the toenails, they should refer the resident to the podiatrist. She said there was no reason R39's toenails should be long.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, staff interviews, and record review, the facility failed to follow up on outside physician recommendations, which caused a delay in treatment for one of two residents (R) (R47) reviewed for skin conditions. Findings included: A review of R47's medical records revealed the resident had a medical history that included a diagnosis of seborrheic dermatitis.A review of R47's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/12/2025, revealed R47 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. A review of R47's Care Plan Report included a focus area revised 4/15/2025, which indicated the resident had a potential for impairment to skin integrity related to eczema, edema, fragile skin, limited mobility, diabetes mellitus, and peripheral vascular disease. A review of R47's dermatology Office Visit Note dated 7/31/2025, revealed recommendations for treatment for the resident's diagnosis of seborrheic dermatitis on their face and ears included triamcinolone twice a day for two weeks on, then two weeks off, and ketoconazole 2% cream twice a day for two weeks on and then two weeks off. The note indicated recommendations for treatment for the diagnosis of actinic keratosis on the resident's body were for fluorouracil every night at bedtime for 30 days.A review of R47's Order Recap Report for the timeframe 3/1/2025 through 8/31/2025 revealed an order dated 7/31/2025, to cleanse the right side of the forehead with wound cleanser, pat dry, apply triamcinolone cream mixed with moisturizer, and cover with a small bandage every shift for 14 days, then off for 14 days. There was no evidence of an order for the ketoconazole and fluorouracil recommended by the dermatologist.During a concurrent observation and interview on 8/4/2025 at 1:30 pm, the surveyor noted R47 had a skin cancer removed from their left temple area. R47 stated it took them a year to get an appointment with the dermatologist to have it removed. During an interview on 8/6/2025 at 10:43 am, the Nurse Practitioner (NP) stated she gave the current orders for the treatment of the area to R47's right temple. The NP stated that the consultation from the dermatologist was not provided to her, and she had not seen the recommendations for the other areas of concern on the resident's body identified by the dermatologist. During an interview on 8/6/2025 at 12:15 pm, Licensed Practical Nurse (LPN)11 acknowledged that she was the treatment nurse and the only treatment orders that she received for R47 were for basic after-care treatment. LPN11 stated she did not get the dermatology notes or recommendation. LPN11 stated that when a resident came back from an outside physician appointment without paperwork, the nurse on the floor or the unit manager (UM) should call the physician's office and request it. During an interview on 8/8/2025 at 10:30 am, the LPN UM stated that the nurse assigned to the resident should follow up if a resident did not come back with paperwork from an outside appointment; however, it was also her responsibility to follow up. The LPN UM stated she did not know why R47's appointment was not followed up on, and she had not seen the consultation and could not say if there was a delay in treatment. During an interview on 8/8/2025 at 11:03 am, the Director of Nursing (DON) stated the nurse assigned to care for the resident should follow up when the resident went to an appointment. The DON stated that if the resident returned to the facility without paperwork, the UM should call to get the paperwork and see if there was a new order. The DON stated she was not aware that there were orders on the documentation from the dermatology office for other treatments besides the cancer removal area on the resident's temple. The DON stated she thought the resident already had those orders in place, and she could not say it was a delay in treatment. During an interview on 8/8/2025 at 11:30 am, the Administrator stated the UM should follow up on any resident appointments, and if the resident came back without paperwork, then they should call the physician's office to get the paperwork. The Administrator stated it was a delay in treatment because there was no follow-up done. During an interview on 8/8/2025 at 1:36 pm, the Regional Nurse Consultant stated the facility did not have a policy on following up after an outside provider appointment. During a follow-up interview on 8/8/2025 at 3:12 pm, the NP stated there had been an issue with follow-up from the outside provider (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	since she started in March 2025. The NP stated she would go through the residents' charts and see that they went to the doctor and had recommendations, but nothing was done. The NP stated that the records needed to be available for her to review, and not having the records made the resident's record inaccurate, and it caused a delay in treatment for R47 when the documents from the dermatologist were not received and followed up on.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 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 observation, staff and resident interviews, record review, and review of the facility's policy titled Respiratory System Management, the facility failed to ensure respiratory equipment was available and functioning properly for one of four residents (R) (R24) reviewed for respiratory services.Findings included:A review of the facility's policy titled Respiratory System Management, dated January 2025, indicated Continuous Positive Airway Pressure (CPAP) or Bi-Level Positive Airway Pressure (BIPAP) Policy. CPAP/BIPAP is provided to residents who have a physician's order. The procedure specified, 10. The nurse or respiratory therapist should observe the resident with the mask on for proper fit.A review of R24's admission Record revealed that the resident had a medical history that included diagnoses of obstructive sleep apnea and dependence on other enabling machines and devices.A review of R24's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/30/2025, revealed R24 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS assessment indicated the residents received non-invasive mechanical ventilator treatment.A review of R24's Care Plan Report included a focus area initiated 8/9/2023, which indicated the resident had altered respiratory status and difficulty breathing related to sleep apnea. Interventions directed staff on CPAP settings, to titrate pressure per physician orders by way of nasal pillow, nose mask, and full-face mask as per the residents' preferences and tolerance.A review of R24's Order Summary Report that contained active orders as of 8/8/2025 revealed an order dated 2/6/2025, for CPAP settings at 14 at bedtime and naps as tolerated. During an observation on 8/4/2025 at 11:36 am, the surveyor noted a CPAP machine on R24's nightstand with the mask lying on top of the machine.During an interview on 8/4/2025 at 11:45 am, R24 stated they needed a new CPAP mask and had been asking the facility for about three months. R24 stated they were told that since they brought the machine in from home, they would have to contact the company they got it from. Per R24, they did not have access to that information. R24 stated their sleep was getting worse, and their snoring was bad.During an observation on 8/5/2025 at 11:03 am, the surveyor noted a CPAP machine on R24's nightstand, but the mask was not visible.During an observation on 8/6/2025 at 9:33 am, the surveyor noted a CPAP machine on R24's nightstand with no mask or tubing attached.During a follow-up interview on 8/6/2025 at 12:34 pm, R24 stated that the staff placed the mask in their drawer, and the CPAP machine still had not been replaced. R24 stated it had been a long time, and they really needed it. According to R24, they thought the facility had supplies available and did not know why the facility had not replaced their CPAP mask.During an interview on 8/6/2025 at 9:50 pm, Licensed Practical Nurse (LPN)2 stated R24 had a CPAP but only wore it as needed. LPN2 stated R24 did tell him that they needed a new mask and hose, so he passed it on in the report, but could not remember when or to whom, and he did not follow up on it.During an interview on 8/7/2025 at 10:53 am, the Director of Nursing (DON) stated R24 told her about their CPAP mask on 7/31/2025, and she told the resident that she would look into it. The DON stated her plan was to call the resident's family and see where they got the machine and equipment so she could have that company come out and fit the resident for a mask. The DON stated she had not gotten to it yet. During a follow-up interview on 8/8/2025 at 11:03 am, the DON stated that when a resident needed a new CPAP mask, the facility should reach out to the durable medical equipment company to get replacement parts. Per the DON, the facility was responsible for ensuring it had the supplies needed to provide care that was ordered by the physician.During an interview on 8/8/2025 at 3:12 pm, the Nurse Practitioner (NP) stated that if a resident had orders for the use of a CPAP, the facility needed to ensure they had the supplies to provide the treatment. The NP stated she was not aware that R24 was not able to wear their CPAP at night. During an interview on 8/8/2025 at 11:30 pm, the Administrator stated she deferred all questions related to the use of the CPAP machine to the nursing staff, but the acquisition of supplies should be the responsibility of the clinical staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the medical records were complete and accurate for two of 14 sampled residents (R) (R10 and R47). Findings included:A review of R10's admission Record revealed the resident had a medical history that included a diagnosis of cerebral infarction due to thrombosis of an unspecified precerebral artery.A review of R10's Annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/1/2025, revealed R10 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS assessment indicated that the resident currently used tobacco.A review of R10's Care Plan Report included a focus area initiated on 9/27/2022, which indicated the resident smoked.A review of R10's smoking assessment dated [DATE] indicated that the resident did not smoke, vape, or dip.During an interview on 8/4/2025 at 3:28 pm, R10 stated they smoked cigarettes.During an interview on 8/6/2025 at 9:54 am, Certified Nursing Assistant (CNA)3 stated R10 smoked cigarettes.During an interview on 8/7/2025 at 10:19 am, the Licensed Practical Nurse Unit Manager (LPN UM) stated that all residents were assessed for smoking when they were admitted to the facility. The LPN UM stated R10 smoked and required supervision from staff while they were outside smoking. During an interview on 8/7/2025 at 2:04 pm, the Director of Nursing (DON) stated that there was a smoking assessment in R10's electronic medical record dated December 2024.During an interview on 8/8/2025 at 8:47 am, the Activities Director (AD) stated she had been employed at the facility for three and a half years, and ever since she worked at the facility, she had known R10 to smoke. The AD stated she did not recall a time when R10 did not smoke.During a follow-up interview on 8/8/2025 at 9:31 am, the DON stated she was not sure why the December 2024 smoking assessment was completed to indicate the resident did not smoke.During an interview on 8/8/2025 at 7:43 am, the Administrator stated she was aware that R10 smoked, and she was unsure why the assessment was not accurate. The Administrator stated she expected the assessments to be accurate.2. A review of 47's admission Record revealed that the resident had a medical history that included polyneuropathy, shortness of breath, insomnia, type 2 diabetes mellitus, seasonal allergic rhinitis, anemia, and essential hypertension.A review of 47's Quarter MDS assessment, with an ARD of 5/12/2025, revealed R47 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident received insulin injections, antidepressant, antibiotic, diuretic, opioid, and hypoglycemic medications.A review of 47's Medication Admin [Administration]Audit Report from the timeframe 8/1/2025 - 8/6/2025, revealed the following medications were administered one hour or more later than ordered:-Insulin Lispro, scheduled to be administered at 7:00 am, was documented as being administered late on 8/1/2025, 8/2/2025, 8/3/2025, and 8/5/2025.-Insulin Lispro, scheduled to be administered at 11:00 am, was documented as being administered late on 8/1/2025, 8/2/2025, 8/3/2025, and 8/4/2025.-Insulin Lispro, scheduled to be administered at 12:00 pm, was documented as being administered late on 8/3/2025.-Insulin Lispro, scheduled to be administered at 4:00 pm, was documented as being administered late on 8/2/2025, 8/3/2025, and 8/4/2025.-Potassium Chloride, scheduled to be administered at 9:00 am, was documented as being administered late on 8/2/2025 and 8/4/2025.-Potassium Chloride, scheduled to be administered at 5:00 pm, was documented as being administered late on 8/2/2025.-Cranberry, scheduled to be administered at 9:00 am, was documented as being administered late on 8/4/2025.-Glycolax, scheduled to be administered at 9:00 am, was documented as being administered late on 8/4/2025.-Glycolax, scheduled to be administered at 9:00 pm, was documented as being administered late on 8/1/2025.-Lasix, scheduled to be administered at 9:00 am, was documented as being administered late on 8/4/2025.-Lasix, scheduled to be administered at 9:00 pm, was documented as being administered late on 8/1/2025.-Docusate Sodium, scheduled to be administered (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 9:00 am, was documented as being administered late on 8/4/2025. -Docusate Sodium, scheduled to be administered at 9:00 pm, was documented as being administered late on 8/1/2025. -Ferrous Sulfate, scheduled to be administered at 9:00 am, was documented as being administered late on 8/4/2025.-Losartan, scheduled to be administered at 9:00 am, was documented as being administered late on 8/4/2025.-Protein Oral Liquid, scheduled to be administered at 9:00 am, was documented as being administered late on 8/4/2025.-Multivitamin with minerals, scheduled to be administered at 9:00 am, was documented as being administered late on 8/4/2025.-Claritin, scheduled to be administered at 9:00 am, was documented as being administered late on 8/4/2025.-Mucinex, scheduled to be administered at 9:00 am, was documented as being administered late on 8/4/2025.-Mucinex, scheduled to be administered at 9:00 pm, was documented as being administered late on 8/1/2025.-Clonidine, scheduled to be administered at 1:00 pm, was documented as being administered late on 8/4/2025.-Clonidine, scheduled to be administered at 9:00 pm, was documented as being administered late on 8/1/2025 and 8/3/2025.-gabapentin, scheduled to be administered at 9:00 pm, was documented as being administered late on 8/4/2025.-Tresiba, scheduled to be administered at 9:00 pm, was documented as being administered late on 8/4/2025. -Trazodone, scheduled to be administered at 9:00 pm, was documented as being administered late on 8/1/2025.During an interview on 8/7/2025 at 3:31 pm, Licensed Practical Nurse (LPN)9 stated she tried to sign the medications out as she went, but sometimes she did not sign the medications out on the MAR until later when she had more time. She stated that the medications were given on time; she just did not sign them out right when she gave them. During an interview on 8/8/2025 at 11:03 am, the Director of Nursing (DON) stated medications should be signed out on the MAR after the resident had taken them and should not be signed out at a different time. During an interview on 8/8/2025 at 11:30 pm, the Administrator stated that once a medication was given, it should be signed out at that time. She stated the record would not be accurate to document at a different time. During an interview on 8/8/2025 at 3:12 pm, the Nurse Practitioner stated medications should be documented at the time they were given; otherwise, the record was inaccurate.