STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115578	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Acres Health and Rehabilitation	313 Allen Memorial Drive,sw Milledgeville, GA 31061

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, resident interviews, and record reviews, the facility failed to ensure two of three residents (R) (R55 and R69) sampled for Activity of Daily Living (ADLs) care, out of a total sample of 38, received care and services for ADLs. Specifically, the facility failed to ensure the removal of facial hair for R69 and baths and showers for R55. The deficient practice had the potential to place R55 and R69 at increased risk for unmet needs and a diminished quality of life. Findings include: 1. Review of the electronic medical record (EMR) for R69 revealed diagnoses including, but not limited to, muscle weakness, difficulty in walking, unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety Review of the Quarterly Minimum Data Set (MDS) assessment for R69, dated 7/8/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 5 (indicating severe cognitive impairment). Section GG (Functional Abilities and Goals) documented that R69 required substantial to maximal assistance with ADLs. Review of the care plan for R69 revealed a Focus area of Resident requires assistance with ADLs related to muscle weaknesses. Interventions included, but were not limited to, the resident needing assistance with ADLs as needed, bathing/showering as needed or as required, and requiring substantial to maximal assistance for personal hygiene and care. Observation on 8/12/2025 at 12:10 pm revealed R69 had a reasonable amount of thick white and black facial hair visible under her chin. Observation on 8/13/2025 at 9:14 am revealed R69 continued to have a reasonable amount of thick white and black facial hair visible under her chin. Observation on 8/14/2025 at 1:00 pm revealed R69 was sitting in a wheelchair in her room watching television, and continued to have a reasonable amount of thick white and black facial hair visible under her chin. In an interview on 8/12/2025 at 3:10 pm, a family member stated she visited R69 often. She stated she noticed R69 had facial hair, and she was sure the resident would want it removed if she was cognitively aware. In an interview on 8/14/2025 at 1:23 pm, Certified Medical Aide (CMA) EE stated staff was required to shave residents on their scheduled shower days unless they saw a need to do it immediately. In an interview on 8/14/2025 at 1:31 pm, Certified Nursing Assistant (CNA) FF revealed that she was responsible for the care of R69 more, and she had just received a bath on 8/13/2025. CNA FF confirmed that R69’s ADLs, including facial hair removal, should be done on her scheduled shower days. In an interview on 8/14/2025 at 1:50 pm, Licensed Practical Nurse (LPN) GG revealed that R69's scheduled shower days were Monday, Wednesday, and Friday on the day shift. LPN GG verified that R69 had visible facial hair on her chin and stated it needed to be removed and should have been done during her scheduled shower days. In an interview on 8/14/2025 at 2:30 pm, the Director of Nursing (DON) stated the facility did not have an ADL policy. She confirmed that R69 had visible facial hair on her chin. She revealed her expectation was for staff to provide ADL care and showers to residents as scheduled. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the EMR for R55 revealed he was admitted to the facility with diagnoses to include Alzheimer's disease with early onset, unspecified disorientation, cognitive communication deficit, and major depressive disorder. Review of the Quarterly Minimum Data Set assessment, dated 5/10/2025, for R55 revealed Section C (Cognitive Patterns) documented a BIMS score of 4 (indicating severe cognitive impairment). Section GG (Functional Abilities and Goals) documented the resident was dependent on staff for oral hygiene, toileting hygiene, showers/bathing, and personal hygiene. Review of the care plan for R55 revealed a “Care Area/Problem” related to self-care deficit, last reviewed and continued on 8/12/2025. The goal was for R55 to accept assistance with ADLs, and needs will be met during the next review period, last reviewed and continued on 8/12/2025. Interventions included assistance with ADLs as needed, reviewed, and continued on 8/12/2025. Review of the EMR revealed R55 resided in room [ROOM NUMBER]. Review of the “Bath Schedule” revealed room [ROOM NUMBER] (R55) was scheduled for showers on Tuesdays, Thursdays, and Saturdays. Review of the “Point of Care” data sheets, dated 7/14/2025 through 8/14/2025, revealed that out of 14 shower opportunities, R55 received six showers on 7/19/2025, 7/26/2025, 7/31/2025, 8/2/2025, 8/9/2025, and 8/14/2025. There was no documentation to indicate that R55 refused his scheduled showers during the specified time period. In an interview on 8/14/2025 at 3:30 pm, CNA AA confirmed that R55 had 14 opportunities for showers from 7/14/2025 through 8/14/2025, but only six showers were documented. CNA AA stated that if the shower was not documented, the shower did not happen. In an interview on 8/14/2025 at 3:45 pm, CNA BB stated he was not sure why showers for R55 were not documented. In an interview on 8/14/2025 at 4:20 pm, the DON stated she expected showers to be completed as scheduled or as needed, and should include nail care and grooming needs. She stated the documentation of ADL care needed to be consistent and reflect the care and services provided. She stated she was unable to determine if the showers were given during the identified period and confirmed that, without documentation, she would assume they were not.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled Medication Administration-General, the facility failed to ensure medications were administered as ordered by the physician to one of nine residents (R) (R20) observed for medication administration. This deficient practice had the potential to place R20 at an increased risk of adverse effects from the medication and a diminished quality of life. Findings include:Review of the facility's policy titled Medication Administration-General, review date 4/15/2025, revealed the Intent section stated, To facilitate that medications are administered as prescribed, in accordance with good nursing principles. The Guidelines section included, . Prior to medication administration, the Nurse or Certified Medication Aide (CMA): . Reads the administration directions on the MAR [medication administration record] and verifies correct medication, dose, and directions for use.Review of the Face Sheet for R20 revealed admission on [DATE]. Diagnoses included, but were not limited to, spastic diplegic cerebral palsy, anxiety disorder, essential hypertension, and muscle weakness.Review of the physician's orders for R20 revealed an order dated 5/9/2025 for amlodipine 5 milligrams (mg) tablet [a medication used to treat high blood pressure], one tablet by mouth one time per day. Hold if blood pressure (BP) is less than 110/60. Hold if systolic BP less than 110. Hold if diastolic BP less than 60. Review of the MedAid (medication aide) MAR dated 8/1/2025 to 8/14/2025 for R20 revealed amlodipine 5 mg tablet was administered on 8/3/2025, and the BP was documented as 90/67, and on 8/13/2025, and the BP was documented as 88/77.In an interview on 8/14/2025 at 4:09 pm, the Director of Nursing (DON) confirmed that the MedAid MAR for R20 documented that amlodipine 5 mg oral tablet was administered when the resident's BP was below the ordered parameters for holding the medication on 8/3/2025 and 8/13/2025. The DON stated the charge nurse should have been notified, and a follow-up should have been completed. In an interview on 8/14/2025 at 4:19 pm, Licensed Practical Nurse (LPN) CC verified that the MedAid MAR for R20 documented that amlodipine 5 mg oral tablet was administered when the resident's BP was below the ordered parameters for holding the medication on 8/3/2025 and 8/13/2025. She stated that the CMA should have notified her, she would have notified the physician, and the resident would have been monitored for changes.