

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115582	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER Heritage Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 2255 Frederica Road Saint Simons Island, GA 31522	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and a review of the facility's policy titled Preventative Maintenance Schedules, the facility failed to repair the furniture in one of 43 rooms (room [ROOM NUMBER]) and failed to ensure a homelike environment in four additional rooms (Rooms 101, 102, 103, and 107). Identified issues included a broken bed footboard, cracked and taped windows, holes in walls, loose baseboards, rusty door jambs, a missing bathroom door, and stained ceilings and floors. These deficiencies increase the risk of infection and injury and do not support a safe, clean, and homelike environment. Findings Include: Review of the facility's policy titled Preventive Maintenance Schedules documented the following INTENT: It is the intent of this center that preventive maintenance schedules be developed and implemented to ensure that the building and equipment are maintained in a safe and operable manner. 1. Observation and interview with R14 on 04/14/2026 at 9:55 AM revealed that the bed in room [ROOM NUMBER] had exposed broken particles on the right patient side of the footboard. R14 reported that maintenance was aware of the broken area. She stated the footboard had been broken for four months. Observation on 04/14/2026 at 2:49 PM revealed that the bed in room [ROOM NUMBER] continued to have exposed broken particles on the right patient side of the footboard. R14 reported she was told that maintenance ordered a replacement that would take three months to arrive. Observation on 04/15/2026 at 9:15 AM revealed that the room [ROOM NUMBER] bed footboard continued to have a broken area with exposed particles on the right side of the residents footboard. Observation and concurrent interview with the Maintenance Supervisor on 04/16/2026 at 9:41 AM revealed that the room [ROOM NUMBER] bed footboard had a sharp exposed particle on the patient side. He stated he was not sure how long the footboard had been broken. He stated he could not replace the bed because no other electric bed was available. He reported that he ordered the replacement part last month but did not have a receipt of the order. 2. Observation on 04/14/2026 at 10:06 AM revealed that room [ROOM NUMBER] had a broken window with tape placed over the cracked area. Observation on 04/14/2026 at 2:54 PM revealed that the window crack was taped to prevent it from spreading, according to R48. The window header was exposed. Observation on 04/15/2026 at 9:59 AM revealed that room [ROOM NUMBER] had tape covering cracks in both the top and bottom windowpanes. The window header remained exposed. Observation and concurrent interview on 04/16/2026 at 9:41 AM with the Maintenance Supervisor revealed that during landscaping, rocks were blown into the window, creating the crack. Tape was placed to keep the crack from spreading. He stated he was unsure how long ago this occurred. He reported that repairs are entered into TELS (electronic maintenance system) but admitted the crack was never entered into TELS, calling it an oversight. 3. Observation on 04/14/2026 at 10:37 AM revealed that room [ROOM NUMBER] had a hole in the wall and a baseboard coming off the wall under the window next to Bed B. Observation on 04/14/2026 at 2:43 PM revealed the same hole in the wall and loose baseboard under the window next to Bed B. Observation on 04/15/2026 at 9:56 AM again revealed a hole in the wall and a baseboard coming off the wall under the window next to Bed B. Observation and concurrent interview on 4/16/2026 at 9:41 AM with the Maintenance (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Supervisor confirmed the hole in the wall and the loose baseboard. He stated a bed had run into the wall. He reported he was not aware of the damage.4.Observation on 04/14/2026 at 10:48 AM of room [ROOM NUMBER] revealed a dark black stain on the ceiling tile above Bed A. A brown stain was observed on the ceiling tile above Bed B. A brown rusty stain was noted on the ceiling tracking. A stain on the floor extended from the dresser under the window to the closet next to Bed B.Observation on 04/14/2026 at 2:48 PM of room [ROOM NUMBER]revealed rusty brown discoloration on the ceiling strips holding the tiles in room [ROOM NUMBER]. A brown substance was observed on the floor under the window. The ceiling tiles above Bed B had a brown stain. A dark black substance was observed above Bed A.Observation on 04/15/2026 at 9:44 AM of room [ROOM NUMBER] revealed a dark black spot on the ceiling tile above Bed A, a brown stain on the ceiling tile above Bed B, and brown rusty spots on the ceiling tracking. A brown stain remained visible on the floor from the dresser, under the window, and to the closet.Observation and concurrent interview with the Maintenance Director on 4/16/2026 at 9:41 AM confirmed the ceiling stains in room [ROOM NUMBER], the floor stain, and the rusty stains on the ceiling tracking. He stated he did not have a routine plan to replace ceiling tiles or ceiling tracking. He admitted the ceiling tiles needed to be replaced and acknowledged he was not aware of the condition, calling it an oversight. He stated he could obtain short tracks to replace or clean and prime the tracking.5.Observation on 04/14/2026 at 10:55 AM of room [ROOM NUMBER] revealed that the baseboard between the exterior door and bathroom entrance in room [ROOM NUMBER] was coming off the wall. The bathroom door was missing. A brown rusty stain was observed along the bathroom door jamb.Observation on 04/14/2026 at 2:42 PM of room [ROOM NUMBER] revealed the same loose baseboard, missing bathroom door, and brown rusty stain on the left side of the door jamb.Observation on 04/15/2026 at 9:50 AM revealed that the baseboard remained loose, the bathroom door was still missing, and a rusty brown stain was present on the left side of the door jamb.Observation and concurrent interview on 4/16/2026 at 9:41 AM with the Maintenance Director confirmed the loose baseboard, rusty stain on the door jamb, and missing bathroom door. He stated the door was removed because the resident could not access the bathroom. He stated the room was set up for two residents. He admitted he was not aware of the loose baseboard or rusty stains. He stated he did not have a scheduled plan to routinely check rooms and that repairs are addressed as they are reported. He stated that anyone-including nurses, certified nursing assistants, and leadership-can enter a repair into TELS. He reported that he becomes aware of repair needs only when they are entered into TELS.Interview on 04/16/2026 at 10:19 AM with the Director of Nursing revealed that the facility utilizes the TELS system for maintenance needs. She reported that anyone, including nursing and certified nursing assistants, can enter repair requests into TELS. She stated that staff should enter repair needs immediately.Interview on 04/16/2026 at 10:40 AM with the Administrator revealed that everyone is responsible for reporting repairs. Repairs are to be entered into the TELS system, which alerts maintenance. Reporting should be completed within the shift unless the repair is an emergency. The TELS program includes a schedule for routine maintenance. All leaders are to evaluate the environment and resident grooming daily, entering rooms with resident permission. Depending on the repair, most can be completed within 8 hours unless outside services are needed. She reported that beds can be swapped out and that a bed would be taken out of service to determine the needed repair.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, staff interviews, record review, and review of the facility's policy titled Patient's Plan of Care, the facility failed to develop or implement a comprehensive, person-centered care plan for one of 33 sampled residents (R) (R3). This deficient practice had the potential to place R3 at risk for unmet needs, medical complications, and diminished quality of life. Findings Include: Review of the facility's policy titled Patient's Plan of Care documented the following GUIDELINE: Each patient will have a person-centered comprehensive care plan developed and implemented to address the patient's medical, physical, mental, and psychosocial needs while also honoring their preferences and goals. Review of the Quarterly Minimum Data Set (MDS) assessment for R3, dated 03/26/2026, revealed Section C (Cognitive Patterns) with a Brief Interview for Mental Status (BIMS) score of 09, indicating moderate cognitive impairment. Section I (Active Diagnoses) revealed diagnoses including, but not limited to, anxiety, bipolar disorder, muscle weakness, and urinary retention. Section N (Medications) revealed that the resident was receiving an antipsychotic, an antidepressant, and an opioid. Review of the care plan for R3 dated 01/29/2026 revealed that antidepressant use was not addressed. Review of physician orders for R3 dated 12/18/2025 revealed an order for fluoxetine 40 milligrams (mg), one capsule orally daily, for a diagnosis of bipolar depression. Review of physician orders for R3 dated 01/20/2026 revealed an order for trazodone 100 mg, one tablet orally at bedtime, for a diagnosis of insomnia. Review of physician orders for R3 dated 01/20/2026 revealed an order for antidepressant medication use (trazodone). The order instructed staff to observe the resident closely for significant side effects including dry mouth, blurred vision, constipation, urinary retention, hypotension, appetite changes, headache, insomnia, and weight changes. Special instructions included observing sadness, negative comments, depressed mood, rejection of care, and withdrawal. Review of physician orders for R3 dated 02/10/2026 revealed an order for antidepressant medication use (fluoxetine). The order instructed staff to observe the resident closely for significant side effects including dry mouth, blurred vision, constipation, urinary retention, hypotension, appetite changes, headache, insomnia, and weight changes. Special instructions included observing sadness, negative comments, depressed mood, rejection of care, and withdrawal. Interview on 04/15/2026 at 4:31 PM with the Registered Nurse MDS Coordinator revealed that R3's care plan did not address antidepressant use. She confirmed that antidepressants are required to be included in the care plan. She stated that templates were available for antidepressants and for trazodone. She reported that residents are discussed each morning, including review of antipsychotic and antidepressant medications, and that new medications should be added to the care plan. Interview on 04/16/2026 at 10:19 AM with the Director of Nursing (DON) revealed that residents who are prescribed psychotropic medications, antidepressants, and other high-risk medications should have these reflected in their care plans. She stated that if a resident receives a new medication, the care plan would be updated during morning meetings or during the weekly team meeting.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled Medication Administration-General, the facility did not ensure that medication was administered as ordered by the medical provider for one resident (R7) of 33 sampled residents. This practice had the potential to place R7 at risk for a clogged gastrostomy tube, medical complications, worsening health conditions, and hospitalization. Findings Include: Review of the facility's policy titled, Medication Administration-General, effective date 04/15/2025 under GUIDELINE documented. Medications are administered in accordance with a valid prescriber order. If a medication order is unrelated to the patient's current diagnoses or condition (s), the prescriber is contacted for clarification prior to administration of the medication. The interaction with the prescriber is documented in the nursing notes or elsewhere in the medical record as appropriate. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for R7 under Section I (Active Diagnosis) revealed diagnoses that included, but not limited to, hypertension, Cerebral infarction due to thrombosis of right middle cerebral, gastrostomy status, anxiety disorder, gastrostomy infection, and dysphagia. Review of care plan dated 04/10/2026 revealed resident has potential complications related to anticoagulant therapy with interventions to include administer anticoagulants as ordered, monitor lab work as ordered, and observe for signs of active bleeding. Resident requires feeding tube related to dysphagia. She will not exhibit signs of complications from feeding tube or enteral feeding solution. Interventions include check placement and patency of feeding tube before feeding or medication administration. Review of physician order dated 03/13/2026 for R7 for Eliquis (apixaban) 2.5 milligrams (mg) one tablet via g-tube (gastrostomy tube) twice a day. May crush tablet and suspended in 60 ml (milliliters) of water or D5W (dextrose 5% water solution) and deliver immediately through g-tube. Observation and interview on 04/15/2026 at 7:53 AM with Registered Nurse (RN) AA revealed that RN AA crushed medications separately and administered each medication separately for R7. She mixed each medication with 10-15 ml of water. She confirmed that she mixed Eliquis (anticoagulant) in 15 ml of water then administered medication. She confirmed that medication order read to suspend or mix Eliquis in 60 ml of water or D5W. She confirmed that she should follow the order. Interview on 04/16/2026 at 8:54 AM with RN BB revealed that medications can have special instructions that are in the doctor's order. The nurse should follow the doctor's orders. Interview on 04/16/2026 at 10:19 AM with Director of Nursing (DON) revealed that medications can have special instruction that are on the orders. This prints on the order and medication administration record. This part of giving the medication and part of the order. Nurses are to follow physician orders.		