STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115584	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gordon Health and Rehabilitation	1280 Mauldin Road NE Calhoun, GA 30703

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 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. Based on observations, staff interviews, record review, and review of the facility's policy titled Medication Administration-General, and Insulin Administration Policy, the facility failed to maintain professional standards of practice for three medication observations from a total of 33 medications observed. Specifically, the facility failed by signing that medication was administered but not due until the following day and failed to accurately administer insulin from a pen device. This deficient practice increased the risk of adverse clinical outcomes. Findings include: Review of the facility's policy titled Insulin Administration, dated 12/31/2025, documented the following guidelines for insulin pen administration: .10. Inject the insulin by quickly inserting the needle straight in at a 90-degree angle per manufacturer instruction.11. Use your thumb to press down on the dose knob until it stops.12. Needle should remain in subcutaneous tissue for 10 seconds to allow all of the medication to be administered properly.Review of the facility's policy titled Medication Administration-General, reviewed 04/15/2025, documented the following guidelines for medication administration: .Prior to medication administration, the Nurse or Certified Medication Aide (CMA) identifies the patient and verifies the patient, reads the administration directions on the MAR {medication administration record}, and verifies the correct medication, dose, and directions for use. Following medication administration, immediately thereafter, the medication should be documented as given on the patient's MAR/TAR {treatment administration record} by the person who administered the medication. At the end of each medication pass, the person administering the medications reviews the MAR to ascertain that necessary doses were administered and that administered doses were documented. The individual who administered the medications should complete documentation of administration of medications prior to going off duty.1. On 03/31/2026 at 8:20 AM, Certified Medication Aide (CMA) AA was observed conducting the 8:00 AM medication pass for resident (R) R51. CMA AA stated she needed to administer two different insulins: 10 units of Humalog and 45 units of insulin Lantus. She further stated that a licensed nurse must double-check insulin administration to prevent errors. The CMA AA called Licensed Practical Nurse (LPN) HH, to observe the administration.The CMA AA prepared the insulins without concern and administered 10 units of Humalog subcutaneously into the abdomen, then immediately withdrew the needle. Insulin leakage was observed at the injection site. CMA AA then administered 45 units of Lantus and again immediately withdrew the needle without waiting for the recommended 10 seconds, resulting in additional leakage. LPN HH did not voice any concerns at that time.At the conclusion of the observation, upon review LPN HH stated nothing was done incorrectly. CMA AA was also unable to identify any areas for improvement. When asked whether the insulin pen should have been held in place against the skin to prevent leakage, LPN HH acknowledged this should have been done. CMA AA confirmed that she forgot to hold the pen in place and withdrew it immediately.2. Review of the MAR for R20 revealed an order for potassium chloride 10 mEq (milliequivalents) to be administered every 48 hours and was scheduled for the 8:00 AM medication pass on 03/31/2026. CMA BB documented the potassium as administered on the MAR, but it was not given during the observation.In an interview conducted on 03/31/2026 at 11:55 AM, CMA BB confirmed that the medication was not administered but was documented on the MAR as administered. CMA BB stated she did not handle this correctly, as the correct process is to administer (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications and document them immediately following administration. She explained that the medication strip package was dated by the pharmacy for the following day, which was 04/01/2026 and did not match the MAR. CMA BB confirmed she marked the medication as administered on the MAR without giving it and that the next shift would administer the medication without documenting it since the package and MAR do not match.In an interview conducted on 03/31/2026 at 12:00 PM, the Director of Nursing (DON) stated that medical records should accurately reflect the care provided and that medication administration should be documented immediately and accurately. She further stated that any discrepancies should be reported promptly to the pharmacy and licensed nursing staff. Regarding insulin pen use, the DON stated staff are expected to hold the pen in place for 5-10 seconds to ensure an accurate dose is delivered. The DON acknowledged that the CMA's actions were not consistent with facility expectations.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, staff interviews, record review, and policy review, the facility failed to ensure a medication error rate of less than five percent during medication administration review. Four errors were identified from 33 opportunities, resulting in a 12 percent (%) medication error rate. The deficient practice placed residents at risk for inaccurate dosing and adverse clinical outcomes.Findings include:Review of the facility's policy titled Insulin Administration, dated 12/31/2025, documented the following guidelines for insulin pen administration: .10. Inject the insulin by quickly inserting the needle straight in at a 90-degree angle per manufacturer instruction.11. Use your thumb to press down on the dose knob until it stops.12. Needle should remain in subcutaneous tissue for 10 seconds to allow all of the medication to be administered properly.Review of the facility's policy titled Medication Administration-General, reviewed 04/15/2025, documented the following guidelines for medication administration: .Prior to medication administration, the Nurse or Certified Medication Aide (CMA) identifies the patient and verifies the patient, reads the administration directions on the MAR {medication administration record}, and verifies the correct medication, dose, and directions for use. Following medication administration, immediately thereafter, the medication should be documented as given on the patient's MAR/TAR {treatment administration record} by the person who administered the medication. At the end of each medication pass, the person administering the medications reviews the MAR to ascertain that necessary doses were administered and that administered doses were documented. The individual who administered the medications should complete documentation of administration of medications prior to going off duty.On 03/31/2026 at 8:20 AM, Certified Medication Aide (CMA) AA was observed conducting the 8:00 AM medication pass for resident (R) R51. CMA AA stated she needed to administer two different insulins: 10 units of Humalog and 45 units of insulin Lantus. She further stated that a licensed nurse must double-check insulin administration to prevent errors. The CMA AA called Licensed Practical Nurse (LPN) HH, to observe the administration.The CMA AA prepared the insulins without concern and administered 10 units of Humalog subcutaneously into the abdomen, then immediately withdrew the needle. Insulin leakage was observed at the injection site. CMA AA then administered 45 units of Lantus and again immediately withdrew the needle without waiting for the manufacturer's recommended 10 seconds, resulting in additional leakage. LPN HH did not voice any concerns at that time.At the conclusion of the observation, LPN HH was interviewed regarding what, if anything, had been performed incorrectly during the insulin administration. LPN HH stated that nothing had been done incorrectly. CMA AA was also unable to identify any areas for improvement. When asked whether the insulin pen should have been held in place against the skin to prevent leakage, LPN HH then acknowledged that this should have been done. CMA AA confirmed that she forgot to hold the pen in place and withdrew it immediately.On 03/31/2026 at 8:52 AM, CMA BB was observed conducting the 8:00 AM medication pass for R20. The resident had a lidocaine patch in place on the left shoulder. CMA BB removed the existing patch and applied a new one. During interview, CMA BB stated the patch should have been removed the previous night and that removal had been documented on the MAR as completed, but it was not removed.Further review of the MAR revealed potassium chloride 10 mEq {milliequivalents} was documented as administered on 03/31/2026, however, it was not given. CMA BB stated she documented it as administered despite not giving it because the pharmacy packaged the medication in the strip for the following day (4/1/2026 at 8:00 AM) and indicated the next shift would administer it without documentation.In an interview conducted on 03/31/2026 at 12:00 PM, the Director of Nursing (DON) stated staff are expected to follow physician orders, document medication administration accurately and timely, and report discrepancies immediately. She acknowledged these practices were not consistent with facility expectations. The DON further stated lidocaine patches are to be removed at bedtime and documented at the time of removal, and that failure to remove the patch as ordered may cause increased medication absorption and skin irritation. Regarding insulin pen use, the DON (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated staff are expected to hold the pen in place for 5-10 seconds to ensure an accurate dose is delivered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and review of the facility's policy titled Standard Precaution/ Use of Personal Protective Equipment (PPE), the facility failed to ensure medications were prepared and administered using appropriate infection control practices and safe medication handling techniques to prevent contamination for two residents (R) (R20 and R21) of three residents observed during a medication pass. This deficient practice increased the risk of cross contamination and spread of infection to residents and staff.Findings include:Review of the facility's policy titled Standard Precautions/Use of PPE, last reviewed 12/27/2025, documented the following guideline for hand hygiene: During the delivery of healthcare, avoid unnecessary touching of surfaces near the patient to prevent contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces.Review of the facility's policies titled Hand Hygiene, and Pharmacy Services: Medication Administration - General, revealed no documented protocol or procedure that addressed handling medications with bare hands or dropped medications. On 03/31/2026 at 8:47 AM, Certified Medical Aide (CMA) BB was observed during the 8:00 AM medication pass for R21. CMA BB opened the floor stock container of medications and placed the pills into her palm before transferring them into a medication cup, including vitamin C tablet, aspirin tablet, vitamin D3 capsule, and a multivitamin tablet. During this process, CMA BB dropped the vitamin C tablet onto the medication cart surface, picked up the tablet with her bare fingers, placed it into the medication cup, and administered the tablets to R21. On 03/31/2026 at 8:52 AM, CMA BB was observed during the 8:00 AM medication pass for R20. Second observation revealed that CMA BB prepared vitamin B12, Mucinex ER, senna plus, and vitamin D3 for administration. She placed the medications from the containers into the container lid and then used her bare fingers to transfer the medicine into the medication cup and administered it to R20. In an interview immediately following the medication pass, CMA BB confirmed she touched the medications with her hands and stated she should have transferred them to the lid and then to the medication cup. CMA BB stated that if a tablet falls, it should be discarded and replaced.In an interview conducted on 03/31/2026 at 12:00 PM, the Director of Nursing (DON) stated she provides training and competencies for CMAs and that they are taught not to touch medications with bare hands and to discard any dropped medication; however, she acknowledged this is not specific on the competency checklist. The DON added that this practice is emphasized on the CMA exam, including a question addressing proper handling of dropped medications. In an interview conducted on 03/31/2026 at 4:00 PM, the Infection Preventionist (IP), who is also the Assistant Director of Nursing (ADON) and a Registered Nurse (RN), stated that staff are expected not to touch medications with bare hands and to discard any dropped medication. She explained that replacement doses should be obtained either from floor stock, the emergency (E) box, or the pharmacy.Review of a grievance filed on 09/29/2025 documented an allegation that a nurse dropped a medication on the floor, picked it up, and administered it to a resident. The grievance documented the facility investigated and confirmed the allegation.In an interview conducted on 03/31/2026 at 4:10 PM with the Social Services Director who conducted the investigation, she stated she did not notify the Infection Preventionist or the DON and did not re-educate staff following the incident, acknowledging that additional action should have been taken to prevent recurrence.In an interview conducted on 03/31/2026 at 4:15 PM, the DON stated she was not aware of the incident and reiterated her expectation that staff do not touch medications with bare hands and that any dropped medication must be discarded.