STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115593	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayview Nursing Home	12884 Cleveland Street West Nahunta, GA 31553

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 0656 Level of Harm - 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 observation, staff interviews, record review and review of the facility's policy titled Using the Care Plan, the facility failed to follow the care plans for two out of 27 sampled Residents (R) (R51) related to falls, and R17 related to oxygen . Actual harm occurred on 12/3/2025 when R51, who had increased confusion and required assistance from staff with Activities of Daily Living (ADL) care, was left on the toilet unassisted and unsupervised by a Certified Nursing Assistant (CNA). Subsequently, R51 was found on the floor in a puddle of blood after attempting to get off the toilet. As a result of the fall, R51 sustained a laceration to the left scalp and a fractured right distal fibula.Findings include: A review of the facility's policy titled Using the Care Plan revised dated 4/18/2017 under Policy revealed, The care plan shall be used in developing the resident's daily care routines and will be available to staff personal who have responsibility for providing care or services to the resident. Under the section titled Policy Interpretation and Implementation, revealed, 2. The nurse supervisor uses the care plan to coordinate care. 1. A review of the electronic medical record (EMR) revealed prior to the incident on 12/3/2025, R51 had diagnoses that included but was not limited to, history of falling, repeated falls, unspecified osteoarthritis, urinary tract infection (UTI), and stroke. A review of R51's care plan dated 6/30/2021 revealed, a focus that indicated Resident has an ADL self-care performance deficit r/t (related to) Limited Mobility, the interventions included but not limited to, Toilet Use: Resident requires assistance from staff for toileting, Transfers: Resident requires assistance from staff to move between surfaces PRN (as needed) with revision date of 7/9/2021, Provide supportive care, assistance with mobility as needed dated 7/13/2021. Further review of the care plans revealed, a focus that indicated [R51's Name] is at risk for Falls r/t history of falls, impaired mobility. Interventions included but not limited to, anticipate and meet needs, attempt to re-orient when confusion is noted, and be sure call light is within reach and encourage her to use it for assistance as needed. Review of the Facility Reported Incident Case #202513561 dated 12/3/2025 at 9:27 pm revealed, Staff assisted resident to the restroom and stepped out to give her privacy. Staff came to check on resident and she was on the floor. She had a laceration to her head and was complaining of pain to her leg. Staff sent resident to [Name of Hospital], Resident's daughter Just notified facility that hospital says she does have a fracture in her leg. Resident Is currently on antibiotics for a UTI, which has contributed to more confusion. Resident's family members reported to nursing staff this afternoon that resident did not seem like herself, which is most likely due to the resident's confusion from UTI. Investigation will be conducted; however, we believe that resident attempted to get herself off the toilet due to her increased confusion from UTI, resulting in her fall. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of progress note dated 12/8/2025 revealed, R51 returned to facility s/p(status post) hospitalization for fall, Fracture right distal fibula, laceration to scalp laceration. Alert with some confusion. A phone interview on 12/20/2025 at 1:05 pm with the MDS Nurse confirmed that nursing staff should be following the care plans. The MDS Nurse revealed that CNAs were made aware of any interventions that should be used for R51 which include that she was to receive supervision with transfers to and from restroom and touching assistance if needed. The MDS Nurse revealed that the best practice for the CNA that took her to restroom was that R51 should have been given privacy by cracking the door and staying in the room until she was finished. Interview on 12/21/2025 at 1:30 pm with the Administrator confirmed that it would have been best practice for CNA DD to have waited for R51 in the room or outside door of restroom when the resident was care planned for one person assist with transfers to and from the restroom with touching assistance. The Administrator confirmed that R51 was a one person assist with ADLs and transfers however, the CNA went to give a shower for another resident instead of staying in the room. [Cross Reference – F689] 2. Review of the electronic health record (EHR) for R17 revealed diagnoses including, but not limited to, COPD and atherosclerotic heart disease of native coronary artery without angina pectoris Review of the MDS for R17, dated 11/14/2025, for Section O (Special Treatment Procedures, Program) revealed the resident received oxygen therapy. Review of R17's care plan last revised on 12/13/2025, a Focus area that revealed, the resident has COPD. The Goal was for the resident to be free of s/sx (signs/symptoms) of respiratory infections. The Interventions included, but were not limited to, O2 (oxygen) by nasal prongs at 2 (two) L (liters) per minute continuously. Review of the physician orders for R17 revealed an order dated 11/14/2025 for oxygen at two liters per minute (LPM) via (by way of) nasal cannula continuous every shift. Observation on 12/19/2025 at 10:40 am to12:00 pm revealed R17 receiving oxygen at one and a half (1.5) liters per minute LPM via nasal cannula from the oxygen concentrator. Observation on 12/20/2025 at 11:20 am revealed R17 receiving oxygen at one (1) LPM via nasal cannula from the oxygen concentrator. During an interview on 12/20/2025 at 4:01 pm, the Director of Nursing (DON), confirmed that the oxygen was not set per the physician's order for R17. During an interview by phone with the MDS Coordinator BB on 12/21/2025 at 11:11 am, the MDS Coordinator reported that her expectation was for the resident to receive oxygen based on the physician order. [Cross Reference F695]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and family interviews, record review and review of the facility's policy titled Safety and Supervision of Residents, and Fall Management the facility failed to provide adequate supervision to prevent accidents for one of four sampled residents (R) (R51) reviewed for falls. Actual harm occurred on 12/3/2025 when R51, who had increased confusion and required assistance from staff with Activities of Daily Living (ADL) care, was left on the toilet unassisted and unsupervised by a Certified Nursing Assistant (CNA). Subsequently, R51 was found on the floor in a puddle of blood after attempting to get off the toilet. As a result of the fall, R51 sustained a laceration to the left scalp and a fractured right distal fibula.Findings include:A review of the facility 's policy titled Safety and Supervision of Residents dated 3/23/2017 under Policy revealed Our facility strive to make the environment as free from accidents hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility -wide priorities. Under the section titled, Residents - Oriented Approach to Safety revealed, 4. Implementing interventions to reduce accidents risks and hazards shall include the following: (a.) communicating specific interventions to all relevant staff; (d.) ensuring that interventions are implemented.A review of the facility's policy titled Fall Management dated 5/17/2017 under the section titled Policy Statement revealed, It is the policy of this facility that the administration and staff provide a safe environment for all residents. The facility is aware that its residents are at a higher risk for falls and injury than the general population. The facility will assess residents with fall risk, will evaluate each resident individually and provide, to the best of the facilities ability, interventions to decrease the likelihood of falls.It is also the policy of the facility to provide fall management guidelines for the staff to utilize and developing a plan of care to decrease the likelihood of a resident experience in the fall. Under the section titled Post Fall Guidelines revealed, 5. The nurse is responsible for assuring adequate nursing attention and interventions. (either by the nurse and or the certified nursing assistant) are initiated in attempts to prevent further injury to the residents, to decrease the likelihood of additional falls, and to assure the residents that his or her needs are addressed. A review of the electronic medical record (EMR) revealed prior to the incident on 12/3/2025, R51 had diagnoses that included but was not limited to, history of falling, repeated falls, unspecified osteoarthritis, urinary tract infection (UTI), and stroke. Further review revealed, fracture of upper and lower end of right fibula and laceration without foreign body of scalp was added on 12/8/2025.A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for R51 under Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition; Section GG (Functional Abilities) revealed that R51 was dependent with toileting hygiene which included the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movements. Dependent with chair/bed to chair transfers and Toilet transfer was not attempted due to medical condition or safety concerns.Review of the Facility Reported Incident Case #202513561 dated 12/3/2025 at 9:27 pm revealed, Staff assisted resident to the restroom and stepped out to give her privacy. Staff came to check on resident and she was on the floor. She had a laceration to her head and was complaining of pain to her leg. Staff sent resident to [Name of Hospital], Resident's daughter Just notified facility that hospital says she does have a fracture in her leg. Resident Is currently on antibiotics for a UTI, which has contributed to more confusion. Resident's family members reported to nursing staff this afternoon that resident did not seem like herself, which is most likely due to the resident's confusion from UTI. Investigation will be conducted; however, we believe that resident attempted to get herself off the toilet due to her increased confusion from UTI, resulting in her fall.Review of progress note dated 12/8/2025 revealed, R51 returned to facility s/p(status post) hospitalization for fall, Fracture right distal fibula, laceration to scalp laceration. Alert with some confusion.Review of the Follow up (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Report dated 12/10/2025 revealed witness statements from CNA DD and CNA EE. CNA DD revealed, Resident [R51] called to go the bathroom.Resident stated she wanted privacy and CNA told her to pull call light when finished. After CNA's got done they got another resident up for shower. Resident call light started to go off from the bathroom and another CNA went to grab sheets to make residents bed for when they got out the shower. CNA [EE] went to get bathroom call light at 6:44 pm and noticed resident laying on the ground. CNA called the nurse to come help with resident. CNA EE revealed, Resident had pulled emergency light in bathroom and when I had opened the door I found resident on floor face down in a puddle of blood. Resident lost balance when trying to wipe.Interview on 12/19/2025 at 9:58 am with R51's family revealed R51 had a fracture to her right ankle from the fall. R51's family expressed concerns about the resident's safety and the facility being short staffed. R51's family revealed that CNA DD left R51 on the toilet and forgot to go back and check on her.Interview on 12/20/2025 at 1:53 pm with CNA DD confirmed that she was the one who wheeled R51 in the bathroom and helped her sit on the toilet. She asked the resident if she wanted her privacy and she said yes. So, she shut the bathroom door. While resident was in the restroom, she went to another resident to give a shower. While taking the resident to the shower, she saw and heard the call light going off for R51. She asked CNA EE if they would go and check on her because the emergency call light was going off in the bathroom. Prior to CNA EE responding to the emergency call light, she stopped at the linen closet to get linen for the resident that CNA DD was showering. CNA DD stated she completed the shower, continuing to take the resident back to her room. CNA DD saw the CNA EE stick her head out the door calling for help. CNA DD confirmed that it was about 10 to 15 minutes before anyone went to check on her because she had finished giving the other resident a shower by the time CNA EE called for help. CNA DD admitted that she did not go back to check on her although she was the one who took her to bathroom and assisted her on the toilet.Interview on 12/20/2025 at 1:15 pm with Unit Manager (UM)/ Registered Nurse (RN) CC revealed that she was very familiar with R51, and she always asked for privacy. However, she revealed that CNA DD should have cracked the door and stayed in the room or close by the room to respond when R51 was ready to receive help. She confirmed that it was not best practice to leave the resident while using the toilet because she was a one person assist for transfers to and from and touching assist.Interview on 12/21/2025 at 1:30 pm with the Administrator confirmed that it would have been best practice for CNA DD to have waited for R51 in the room or outside door of restroom when the resident was care planned for one person assist with transfers to and from the restroom with touching assistance. The Administrator confirmed that R51 was a one person assist with ADLs and transfers however, the CNA went to give a shower for another resident instead of staying in the room.

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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 observations, staff interviews, record review, and review of the facility's policy titled Oxygen Administration, the facility failed to ensure that one of 16 residents (R) (R17) receiving oxygen was administered oxygen therapy in accordance with the physician orders. This deficient practice had the potential to place R17 at risk for respiratory complications and a diminished quality of life.Findings include:Review of the facility policy titled Oxygen Administration, dated 2/25/2024, under the Policy Statement revealed, The purpose of this procedure is to provide guidelines for safe oxygen administration. Under the Policy Interpretations and Implementation section revealed, 1. Verify that there is a physician's order for this procedure. Review the physician 's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident.Review of the electronic health record (EHR) for R17 revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD), hypertension, and atherosclerotic heart disease of native coronary artery without angina pectoris.Review of the admission Minimum Data Set (MDS) for R17, dated 11/21/2025, revealed that Section O (Special Treatment Procedures, Program) revealed the resident received oxygen therapy continuously. Section C (Cognitive Patterns) revealed a Brief Interview Mental Status Score (BIMS) score of eight, which indicated moderate cognitive impairments.Review of the physician orders for R17 revealed an order dated 11/14/2025 for oxygen (O2) via(by) NC (nasal cannula) at 2 (two) liters per minute (LPM) continuous every shift.Observation on 12/19/2025 at 10:40 am to12:00 pm revealed R17 sitting in wheelchair receiving oxygen with the flow rate set to one and a half (1.5) liters per minute (LPM) via nasal cannula from the oxygen concentrator.Observation on 12/20/2025 at 11:20am, R17 was observed in her room oxygen with the flow rate set to one (1) LPM via nasal cannula from the oxygen concentrator.During an observation of the resident oxygen concentration with Licensed Practical Nurse (LPN) AA on 12/20/2021 at 11:29 am, LPN AA confirmed that R17's oxygen was set to 1 LPM and adjusted it to 2 LPM. LPN AA reported that resident was not known to have a history of changing her oxygen setting on the concentrator.During an interview on 12/20/2025 at 4:01 pm, the Director of Nursing (DON) reported being unaware that R17 was receiving oxygen on an incorrect flowrate. She reviewed the photograph of the oxygen setting on 12/19/2025 at 1.5 O2 Sat (oxygen saturation) and on 12/20/2025 at 1 LPM O2 Sat. She reported that her expectations was for staff to ensure that the flowrate was set per physician order and to check to ensure the rating was set using an eye level position to ensure the correct setting. She reported having no known factual evidence from her staff that R17, the resident 's hired sitter, or the resident's spouse could have possibly adjusted the dial (flow meter) on the oxygen concentrator. She acknowledged that resident was not care planned for behaviors of adjusting her flow meter. The DON confirmed that if a resident with a diagnosis of COPD received less oxygen or too much oxygen, it placed them at risks of adverse effects.