

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Eatonton Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Sparta Highway 16 East Eatonton, GA 31024	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and review of the facility's policy titled Self-Administration of Drugs, the facility failed to ensure two of 17 sampled residents (R) (R29 and R48) were assessed for medication self-administration before allowing unsecured medications to be kept at the bedside. This deficient practice had the potential to place R29 and R48 at risk of unauthorized use of medication, inaccurate medication dosing, and a diminished quality of life.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Self-Administration of Drugs reviewed 12/27/2024, indicated, Intent- It is the intent to promote safe medication practices for patients that choose to self-administer medication. Guideline- To permit patients to self-administer their drugs and medication unless such practice for the patient is deemed unsafe. Procedure- Should the patient wish to self-administer his or her own drugs or medications, the patient should be permitted to do so. Drugs and medication should be stored in a safe and secure place designated by the Director of Nursing Services. The care planning team should assess each patient's mental, physical, and visual ability to determine if the patient is capable of self-administration of drugs and medications. Should the care planning team determine that the patient is unable to carry out this responsibility, due to safety concerns, the patient should not be permitted to self-administer his or her drugs or medication. Appropriate documentation as to whether or not the patient made a choice about self-administration of drugs should be in the patients' medical record. Statements intent of governing self-administration of drugs are outlined in the Pharmacy Services Manual. Inquiries concerning self-administration of drugs should be referred to the Director of Nursing Services.</p> <p>1. Review of R29's Face Sheet, found under the Face Sheet tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, Alzheimer's disease, unspecified, psychotic disorder with delusions due to known physiological condition and dysphagia following cerebral infarction.</p> <p>Review of R29's Care Plan, found under the Care Plan tab of the EMR, found that there was no care plan for self-administration of medication.</p> <p>Review of R29's EMR revealed no assessment for medication self-administration.</p> <p>Observation on 6/23/2025 at 9:12 am revealed R29 was asleep in her bed, and a medication cup that contained eight pills was on her overbed table.</p> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 6/23/2025 at 9:42 am revealed the medication cup with the eight medications was no longer in her room.</p> <p>In an interview on 6/23/2025 at 9:42 am, Certified Medication Aid (CMA)1 stated that R29 did not take her medication immediately. CMA1 confirmed the medications were on the side table and stated she had taken them away. CMA1 stated that the normal routine was for R29 to wake up and take the medication; if not, she would take it back. She further stated that sometimes, she may put the medications down and go to the next room, and if the resident did not take the medication, she would come back and take it back to the medication cart.</p> <p>In an interview on 6/25/2025 at 10:20 am, the Director of Nursing (DON) confirmed that R29 did not have a self-administration of medication assessment completed.</p> <p>2. Review of R48's Care Plan, under the care plan tab of the EMR, revealed there was no documentation in the care plan of the resident being able to administer his own medication.</p> <p>Review of R29's EMR revealed no assessment for medication self-administration.</p> <p>During an observation and interview on 6/23/2025 at 9:22 am, in R48's room, a container of eye drops labeled azelastine 0.05 percent (a prescription medication used to treat itching of the eye) was observed on the overbed table. R48 stated the eye drops were his and that he administered them once a day by himself. R48 further stated that the nursing staff come and check on them. Further observation revealed a cup of antacid medication on the bedside table. R48 stated he took them when he needed them.</p> <p>In an interview on 6/23/2025 at 9:45 am, CMA1 confirmed that R48 randomly consumes the antacid tablets and stated he eats them like candy. CMA1 confirmed the eye drops should not have been left in the resident's room.</p> <p>In an interview on 6/25/2025 at 10:21 am, the DON stated that R48 was not appropriate to self-administer medication. The DON stated that R48 is unable to tell you what the medication was for. The DON confirmed that R48 does not have a self-administration assessment.</p> <p>In an interview on 6/25/2025 at 11:02 am, the Regional Nurse Consultant confirmed R48 did not have an order for the antacid tablets and stated that the family brought them to the resident.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of the facility's policy titled Grievance/Concern Guidelines for Patients, the facility failed to document resident grievances and failed to provide a resolution for the grievance for one of 17 sample residents (R) (R6). This deficient practice had the potential to place R6 at risk of unresolved grievances.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Grievance/Concern Guidelines for Patients, dated 12/27/2024, revealed the intent of the facility was to assist, encourage, and educate the residents to file grievances or concerns and to assure the resident that after receiving a concern/grievance, the facility would actively seek a resolution and keep the resident apprised of their progress towards a resolution. The policy also stipulated that the Social Worker (SW) was responsible for entering the concern/grievance into the tracking system, with the investigation and appropriate action recorded.</p> <p>Review of R6's Face Sheet, found under the Face Sheet tab of the electronic medical record (EMR), revealed R6 was admitted to the facility on [DATE].</p> <p>Review of R6's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/28/2025 indicated R6 needed minimal assistance with activities of daily living (ADL's) and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating he was cognitively intact.</p> <p>During an interview on 6/23/2025 at 10:12 am, R6 stated that he had previously reported to multiple staff members that he was not receiving palatable food and never knew what he was going to be served each day because he was not provided with a menu of weekly meals and was not provided with a list of alternate food items. He stated that he had previously filed a grievance about the food with the kitchen lady, the SW, the Director of Nursing (DON), and the Administrator a few months ago. He stated that the four named staff members met with him in his room to discuss the food service. He further stated that he was not given a written grievance form and did not receive a written response or resolution to his reported grievance.</p> <p>Review of the facility-provided Grievance Log, dated from 7/1/2024 through 6/25/2025, revealed no grievances were documented as reported by R6 regarding food service.</p> <p>During an interview on 6/23/2025 at 11:32 am, the SW stated that she was the grievance coordinator for the facility and was aware of the grievance reported by R6 regarding the food service, and validated that the previous Dietary Manager (DM), the SW, the DON, and the Administrator, had visited R6 in his room (date unknown) to discuss his grievance regarding food service. She stated that the normal process for reporting and documenting a resident grievance was to complete a grievance form when the grievance was reported. The SW stated that within three days of the grievance report, she would document the resolution to the grievance and then provide a written grievance form to the resident who reported the grievance. She stated that she did not document R6's grievance regarding food service and did not provide R6 with a resolution of his grievance.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/2025 3:46 pm, the Administrator stated his expectation for a resident-reported grievance was that it should be documented by the SW with a documented response and/or resolution provided to the resident within three days of filing the grievance.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled Bed Hold During Hospital Stays and Therapeutic Leaves, the facility failed to ensure one of four residents (R) (R8) reviewed for hospitalizations, or their Resident Representative (RR), received written notice that specified the duration of the bed hold policy. Specifically, the facility failed to include the current rate for the reserve bed payment in the event the resident did not return within seven days. This failure had the potential to place R8 at risk of denial of re-admission and loss of their room following hospitalization.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Bed Hold During Hospital Stays and Therapeutic Leaves, dated 12/27/2024 indicated, .the intent of this nursing center to offer all residents and/or his/her designee the choice of either paying the appropriate amount to hold the bed when the resident goes to the hospital .the Financial Controller, or the Administrator's designee, should prepare a bed hold letter to be sent to the resident and/or his/her designee .This letter should specify the amount to be paid per day on private bed hold .</p> <p>Review of R8's Face Sheet, in the Electronic Medical Record (EMR) under the Resident tab, indicated she was initially admitted to the facility on [DATE] with a primary diagnosis of hereditary and idiopathic neuropathy.</p> <p>Review of R8's Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/30/2024 indicated the resident was discharged to a short-term general hospital.</p> <p>Review of R8's Discharge MDS with an ARD of 12/16/2024 indicated the resident had been discharged to a short-term general hospital.</p> <p>Review of R8's Resident/Patient Transfer Form, dated 8/28/2024, and provided by the facility indicated R8 was sent to the hospital with altered mental status (AMS).</p> <p>Review of R8's Resident/Patient Transfer Form, dated 12/16/2024, and provided by the facility indicated R8 was sent to the hospital with altered mental status (AMS).</p> <p>Review of R8's Notice of Transfer or Discharge dated 8/30/2024 and 12/16/2024, provided by the facility, indicated R8 was sent to the local hospital. The form had information regarding the Bed-hold policy - Medicaid Payor Source When a nursing home resident is admitted to a hospital, Medicaid will pay to hold the nursing home bed for seven (7) days. In the event that hospitalization is required for more than seven (7) days, you have the choice to either discharge from the nursing home or assume responsibility for payment to the nursing home to hold the bed. If you choose to hold the bed, you will be billed at the facility's approved daily state per diem rate In the next few days, you will be receiving a telephone call or a letter informing you of the daily rate needed to maintain a bed hold and the date the bed hold will begin . The form did not include the daily bed-hold rate.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/2025 at 2:16 pm, Licensed Practical Nurse Wound Care (LPNWC) stated that when a resident was sent to the hospital, the nurse completed a Transfer Form that indicated the reason for the transfer, and that no paperwork was sent by the charge nurse to the family. She stated she thought that either the Director of Nursing (DON) or Assistant DON (ADON) sent the bed hold/transfer notification to R8's Power of Attorney.</p> <p>During an interview on 6/26/2025 at 2:40 pm, the DON stated that the facility's policy was to mail the bed hold/transfer notification to the responsible party and was not aware if the form included the specific bed hold amount or where the Social Worker (SW) documented that the Bed Hold form was mailed to the POA.</p> <p>During an interview on 6/26/2025 at 2:40 pm, the SW stated that she used to document when she sent a Bed Hold notification to the POA, but she no longer did that. She stated her practice was to mail the Bed Hold to the POA, and she was not aware it should be documented. She further stated she was unaware that the document needed to include the specific charge of the reserve bed payment.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident, resident Power of Attorney (POA), and staff interviews and record review, the facility failed to ensure three of three dependent residents (R) (R29, R8, and R64) from a sample of 17 residents received showers according to the schedule. This failure had the potential to place the residents at risk for diminished self-worth, self-esteem, feelings of embarrassment, and/or medical issues.</p> <p>Findings include:</p> <p>1. Review of R29's Face Sheet, found under the Face Sheet tab of the electronic medical record (EMR), revealed R29 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease.</p> <p>Review of R29's Annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 4/28/2025 indicated R29 needed substantial/maximal assistance with bathing. Further review revealed R29 scored 10 out of 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition.</p> <p>Review of R29's ADL [Activities of Daily Living] Sheet, found under the ADL tab of the EMR, revealed that for the month of June 2025, R29 only received a bath/shower on 6/4/2025 and 6/23/2025.</p> <p>Review of R29's ADL Plan of Care, provided by the facility, for Self-Care Deficit revealed the resident had an intervention of assistance with ADLs as needed.</p> <p>In an interview on 6/23/2025 at 4:06 pm, R29 stated she missed her baths. She stated she was supposed to get her bath on Monday, Wednesday, and Friday, but she did not get them all of the time.</p> <p>In an interview on 6/25/2025 at 12:26 pm, Licensed Practical Nurse/Charge Nurse (LPN/CN) 1 referred to a sign which indicated shower schedules and confirmed R29 was scheduled for showers on Mondays, Wednesdays, and Fridays, during the second shift, because she likes to sleep late in the mornings. When asked where the care is documented, LPN/CN1 stated in the EMR. LPN/CN1 stated it is signed with that person's name, who completed the care.</p> <p>In an interview on 6/26/2025 at 11:17 am, the Director of Nursing (DON) stated that showers should be documented when given. The DON confirmed they did not have a policy related to showering and ADL care.</p> <p>2. Review of R8's Face Sheet, located in the EMR under the Face sheet tab, indicated she was admitted to the facility on [DATE] with a primary diagnosis of hereditary and idiopathic neuropathy.</p> <p>Review of R8's Quarterly MDS located in the EMR with an ARD of 3/21/2025 included a BIMS score of 10 out of 15, indicating moderate cognitive impairment. R8 required partial to moderate assistance with bathing.</p> <p>Review of R8's Care Plan, located in the EMR under the Care Plan tab, initiated 1/19/2024 included assistance with activities of daily living (ADLs) as needed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R8's Shower Documentation, provided by the facility, for January 2025 indicated that she received seven showers and refused bathing once; February 2025 indicated that she received two showers and refused bathing once; March 2025 indicated that she received one shower and refused bathing once; April 2025 indicated that she received five showers with no refusals; May 2025 indicated that she received three showers with no refusals; and June 2025 indicated that she received two showers with no refusals.</p> <p>During an interview on 6/23/2025 at 12:20 pm, R8 stated that she was supposed to get a shower three times a week on Mondays, Wednesdays, and Fridays, but that did not always happen. R8's POA1 was present during the interview and stated that R8 did not always receive her showers and that the facility staff would say that she refused, which was not true. R8 admitted to declining one shower in the past six months and stated that she would frequently ask for her shower on the scheduled days, but that the staff would not show up to bathe her.</p> <p>3. Review of R64's Face Sheet, located in the EMR under the Face sheet tab, indicated that she was admitted to the facility on [DATE] with a primary diagnosis of chronic atrial fibrillation.</p> <p>Review of R64's Quarterly MDS located in the EMR with an ARD of 4/9/2025 included a BIMS score of nine out of 15, indicating moderate cognitive impairment. R64 required substantial to maximum assistance with bathing and had impairment on one side of one upper extremity.</p> <p>Review of R64's Care Plan, located in the EMR under the Care Plan tab, revised 4/18/2025, included assistance with ADLs as needed.</p> <p>Review of R64's Shower Documentation, provided by the facility, for April 2025 indicated that she received one shower and refused bathing zero times. May 2025 indicated that she received zero showers and refused bathing zero times. June 2025 indicated that she received zero showers and refused bathing zero times.</p> <p>During an interview on 6/25/2025 at 11:43 am, R64 stated that she didn't know her bathing schedule and did not recall having her hair washed since she was admitted to the facility. R64 stated that she had not refused any showers and loved getting bathed. Additionally, she stated that she had not been showered very often but rather would receive bed baths.</p> <p>During an interview on 6/25/2025 at 11:53 am, R64's POA2 stated that he was not aware of her bathing schedule and could not verify that the resident was being bathed three times a week per facility schedule. R64's hair looked oily, and POA2 stated that he was taking her to have her hair washed and trimmed on 6/26/2025.</p> <p>During an interview on 6/26/2025 at 3:27 pm, Certified Nurse Aide (CNA)5 stated that when the CNAs bathed/showered a resident, the policy was for them to document the activity in the computer. If a resident refused a shower, that was to be documented in the EMR. If nothing is documented in the EMR, that would mean the activity wasn't performed. CNA5 stated they were not aware of R8 or R64 having a history of refusing to bathe or shower.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/2025 at 4:00 pm, the DON confirmed that there was no documentation for R8 and R64 to confirm whether showers had been completed or not. The DON stated that she had provided education to the CNAs on the importance of offering the resident a bath or shower on their scheduled day and documenting the refusal accordingly.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident, resident Power of Attorney ([NAME]), and staff interviews, record review, and review of the facility policy titled Restorative, the facility failed to ensure splint application was provided for one of one resident (R) (R64) sampled for Restorative Nursing from a sample of 17. This failure had the potential to place R64 at risk for increased contractures and decreased range of motion.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Restorative, provided by the facility dated 12/27/2024 stated, .This center promotes nursing interventions that assist the patient in his/her ability to adapt and adjust to living conditions . may be captured in a formalized restorative nursing care plan overseen by Nursing Supervisor(s) .The plan of care will be outlined in electronic medical record (EMR) and will be followed by staff trained in restorative care .Documentation of minutes of care provided will be documented in the EMR by staff providing restorative services.</p> <p>Review of R64's Face Sheet, located in the EMR under the Face sheet tab, indicated that she was admitted to the facility on [DATE] with a primary diagnosis of chronic atrial fibrillation and comorbidities including cerebral infarction due to thrombosis of the right middle cerebral artery.</p> <p>Review of R64's Quarterly Minimum Data Set (MDS) located in the EMR with an Assessment Reference Date (ARD) of 4/9/2025 included a Brief Interview for Mental Status (BIMS) score of nine out of 15, indicating moderate cognitive impairment. The MDS indicated R64 had impairment of one side of one upper extremity.</p> <p>Review of R64's Care Plan, located in the EMR under the Care Plan tab, revised 4/15/2025 included limited mobility with interventions including See Restorative Program.</p> <p>Review of R64's Restorative Care Plan, initiated 4/7/2025, included splint/brace application once daily for six days per week. The goal was patient will maintain current ROM [range of motion] of joint with use of splint to decrease risk of developing or worsening of contracture with no signs or symptoms of compromised skin integrity through the review period. Interventions included, gentle stretching of affected joint with .apply the following splint to affected joint for the stated time period: palmar grip splint on her L [left] hand for 2-4 [two to four] hours, assist patient with verbal and physical guidance and direction to teach how to apply, manipulate, and care with the following splint .</p> <p>Review of R64's Restorative Program documentation provided by the facility indicated that on 4/7/2025 and 4/29/2025 the splint was applied for 15 minutes; 5/7/2025 and 5/10/2025 the splint was applied for 45 minutes; 5/13/2025 the splint was applied for 15 minutes; 5/16/2025 and 5/20/2025 the splint was applied for 45 minutes; 5/23/2025 the splint was applied for 15 minutes; 5/29/2025 the splint was applied for five minutes; 5/31/2025 the splint was applied for 15 minutes; 6/16/2025 the splint was applied for 45 minutes; 6/20/2025, 6/24/2025 to 6/26/2025 for 15 minutes; and on 6/23/2025 the splint was applied for 45 minutes.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R64's Occupational Therapy Daily Note provided by the facility dated 2/17/2025 stated, .Pt [patient] demonstrated more difficulty performing digit extension today compared to previous sessions .Pt's personal hand splint was donned . for one hour .tolerated palmar grip splint for greater than two hours .Pt was educated on importance of using her palmar grip splint when supine in bed to help prevent digit contracture in flexion .staff were educated on the importance of continuing to wear her palmar grip splint later on in the day to prevent contracture and less stiffness in the morning .</p> <p>Review of R64's Occupational Therapy Daily Note provided by the facility dated 3/10/2025 stated, Pt demonstrated increased stiffness this morning .Pt tolerated PROM [passive range of motion] prior to donning palmar grip splint for three hours (3) .Pt is continuing to be educated on the importance of using her palmar grip splint when supine in bed to help prevent digit contracture in flexion in order to be able to don her resting hand splint. Pt and staff continue to be educated on continuing to wear her palmar grip splint later on in the day to prevent contracture .</p> <p>Review of R64's Occupational Therapy Daily Note provided by the facility dated 3/21/2025 stated, Pt tolerated PROM prior to donning palmar grip splint. Pt demonstrated less digit extension this morning .</p> <p>During an observation on 6/23/2025 at 10:33 am, R64 had a contracture noted to the left hand and was not wearing a splint.</p> <p>During an interview on 6/23/2025 at 10:33 am, Certified Nursing Assistant (CNA)4 confirmed that R64 was not wearing a hand splint at that time and was not aware of the need for the splint.</p> <p>During an observation on 6/25/2025 at 11:48 am, R64 was wearing a splint on the left wrist/hand.</p> <p>During an observation on 6/26/2025 at 2:14 pm, R64 was wearing her splint on the left hand/wrist.</p> <p>During an interview on 6/25/2025 at 11:48 am, R64 stated that before yesterday, she had not had a splint applied to her left hand and wrist on a consistent basis and was not sure when the splint was scheduled to be worn. R64 was able to confirm that she had a stroke in the past that caused paralysis to her left upper extremity.</p> <p>During an interview on 6/25/2025 at 11:53 am, R64's POA2 stated that R64 sustained a stroke in November 2024 that caused paralysis to the left upper extremity. He had previously brought two splints from home for her to use while at the facility to aid in opening her hand up (contracture prior to facility admission). The facility had put it on R64's left hand and wrist in the past, but it was very inconsistent. POA2 stated that he was not aware of a splint schedule and that he had never seen her with it in place, and he visited almost daily. He stated he had mentioned this concern in the past, and he had given up because he feared retaliation.</p> <p>During an interview on 6/26/2025 at 3:27 pm, CNA4 confirmed that R64's splint was included in her plan of care and that if the staff applied the splint, it should have been documented. She did not recall seeing the splint on R64's left hand and wrist until today.</p> <p>During an interview on 6/26/2025 at 4:38 pm, Registered Nurse (RN)1 stated that she had seen R64 wearing a splint off and on, but not daily.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/2025 at 5:00 pm, the Director of Rehabilitation (DOR) stated that R64 received occupational therapy from 1/9/2025 to 4/4/2025 and physical therapy from 1/14/2025 to 4/14/2025. Additionally, she stated that all nursing staff were in-serviced for application of splints and that it was the restorative nursing program's responsibility to apply the splints; however, sometimes she would do it even though it was not populated for her to document on the service.</p> <p>During an interview on 6/26/2025 at 5:22 pm, the Director of Nursing (DON) stated that the Certified Medication Aides (CMAs) used to apply the splints and did not recall when this task was switched over for the CNAs to perform. The DON stated that she was not aware that R64 was not receiving splint application or range of motion exercises. The DON stated the MDS nurse was responsible for running the restorative program and ensuring documentation was being completed for all residents with splints. The DON's expectation was for nursing staff to apply the splints as indicated on the Restorative Care Plan.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**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 Destruction: Collection Receptacle All Medications (Non-Controlled and Controlled), the facility failed to ensure discontinued medications were stored in a manner to maintain control and accountability for five of 17 sampled residents (R) (R2, R8, R54, R59, and R273). This failure had the potential to increase the risk for drug diversion or misappropriation of medications.</p> <p>Findings include:</p> <p>Review of the facility policy titled Medication Destruction: Collection Receptacle All Medications (Non-Controlled and Controlled), provided by the facility and dated [DATE] indicated, .When medications (non-controlled and controlled substance medications) are expired, discontinued from use, or the patient for whom they were ordered is no longer a patient, the drugs should be promptly removed from the active stock and inventoried by two licensed nurses (either Registered Nurse (RN) or Licensed Practical Nurse (LPN) . The medication is destroyed by two nurses disposing of the medication in an authorized collection receptacle and completing, signing, and dating the Certificate of Inventory and Destruction (CID). Medications should be disposed of into the Collection Receptacle within 3 business days from discontinuation of use.</p> <p>Review or R2's Physician Orders provided by the facility dated [DATE] included nystatin 100,000 units/gram topical ointment to be applied twice daily until [DATE] for candidiasis of skin and nails.</p> <p>Review of R8's Physician Orders provided by the facility dated [DATE] for Nystop 100,000 unit/gram topical powder to be applied once daily for 14 days under the bilateral breasts for candidiasis of skin and nails.</p> <p>Review of R54's Physician Orders provided by the facility dated [DATE] with a stop date of [DATE] for Novolin Flexpen 100 units/milliliter (ml) (three ml) subcutaneous insulin pen per sliding scale for diabetes mellitus.</p> <p>Review of R59's Physician Orders provided by the facility dated [DATE] for Nystop 100,000 unit/gram topical powder to be applied twice daily to an unspecified site with a stop date of [DATE] for candidiasis of skin and nails.</p> <p>Review of R273's Physician Orders provided by the facility dated [DATE] for Klor-Con 10 mEq (milliequivalent) tablet, extended release (ER), give one tablet by mouth once daily for chronic kidney disease and metformin 500 mg tablet dated [DATE], give one tablet by mouth twice daily for type two diabetes mellitus without complications.</p> <p>During an observation on [DATE] at 5:20 pm, Licensed Practical Nurse/Charge Nurse (LPN/CN)1 opened the medication storage room for the facility, which contained a drawer in the lower left side of the room, including a plastic bag with multiple residents' medications. At 6:01 pm, the Assistant Director of Nurses (ADON) entered the medication room to relieve LPN/CN 1 and confirmed the following medication storage concerns:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2 had two tubes of nystatin ointment USP 100,000 units/gram dispensed [DATE] and [DATE]. The ADON confirmed during an interview on [DATE] at 6:04 pm, the start date was [DATE], and the discontinued date of [DATE].</p> <p>R8 had Nystop powder 100,000 units/gram dispensed [DATE], unknown when opened or first used. The ADON confirmed during an interview on [DATE] at 6:04 pm that the medication was started on [DATE] and discontinued on [DATE].</p> <p>R54 had one Novolin R 100 unit/ml pen, unopened, unrefrigerated, dispensed on [DATE]. Interview on [DATE] at 6:04 pm, the ADON stated that the resident was still here and that the order was started on [DATE] and discontinued [DATE].</p> <p>R59 had Nystop powder 100,000 units/gram bottle dispensed [DATE], unknown when opened or first used. The ADON confirmed during an interview on [DATE] at 6:04 pm that the medication start date was [DATE] and was discontinued on [DATE].</p> <p>R273's Klor-Con tablets dispensed on [DATE], originally dispensed 90 tablets, 42 tablets remaining. The ADON stated during an interview on [DATE] at 6:04 pm, that the medication was filled at a local pharmacy. The resident was admitted on [DATE] and passed away on [DATE]. The medication should have been sent home with the family upon admission.</p> <p>R273's metformin 500 mg tablets were dispensed on [DATE], dispensed 180 tablets, 88 tablets remaining. The ADON confirmed during an interview on [DATE] at 6:04 pm that the resident was deceased and the medication started on [DATE] and was discontinued on [DATE] when the resident passed away unexpectedly.</p> <p>During an interview on [DATE] at 5:15 pm, LPN/CN 1 confirmed that discontinued medications were not properly discarded/disposed of for R2, R8, R54, R59, and R273. LPN/CC 1 stated that all medications that are discontinued for disuse or upon death should be recorded, and two nurses should witness and sign off on the medications being disposed of in the authorized, secured medication collection receptacle.</p> <p>During an interview on [DATE] at 6:05 pm, the ADON stated that all discontinued residents' medications that the resident has been discharged or passed away should be recorded on the CID medication log and properly disposed of in the authorized, secured medication collection receptacle. The ADON confirmed that the medications that were improperly stored were not listed on the medication log.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observations, staff interviews, record review, and review of the facility's policies titled Medication Storage in the Care Center, the facility failed to ensure that medications were properly stored in one of one medication storage rooms. This deficient practice had the potential to increase the risk of residents receiving medications with altered effectiveness.</p> <p>Findings include:</p> <p>Review of the facility policy titled Medication Storage in the Care Center, provided by the facility and dated 2023 stated, .Medications requiring 'refrigeration' or 'temperatures between 2&deg;C (36&deg;) and 8&deg;(46&deg;F) are kept in a refrigerator with a thermometer to allow temperature monitoring .</p> <p>During an observation on 6/25/2025 beginning at 5:20 pm, of the medication storage room with Licensed Practical Nurse/Charge Nurse (LPN/CN) 1 and the Assistant Director of Nurses (ADON) confirmed the following medication storage concerns:</p> <p>R1's NovoLog FlexPen was opened on 5/23/2025 with no expiration date. LPN/CN1 confirmed the pen was almost empty. LPN/CN1 further stated that all opened insulin should have the calculated expiration date, so the nurse knows when to stop using the pen. R1 also had a Lantus insulin pen with no first used date and no expiration date.</p> <p>R6 had an unopened Novolog FlexPen 100 units/ml, three-ml pen, dispensed 4/30/2025. The ADON confirmed that R6 remained in the facility and was still taking the medication. The ADON stated that she was unsure why the insulin was not in the refrigerator and that it would have to be discarded because it had not been refrigerated. The ADON confirmed that R6 started on Novolog on 5/12/2023, and stated the medication should have been kept refrigerated until opened. The pharmacy label indicated that the medication should be refrigerated until opened.</p> <p>R47 had one unopened Insulin Aspart 100 units/ml vial, not refrigerated, dispensed 5/3/2025. The ADON confirmed the start date of 4/22/2025, and the order remained active and should have been kept refrigerated until opened. The pharmacy label indicated that the medication should be refrigerated until opened.</p> <p>R54 had one unopened Novolin R 100 units/ml pen, unrefrigerated with a dispensed date of 4/23/2025. The ADON stated that the resident was still in the facility, and the medication should have been kept refrigerated until opened. The pharmacy label indicated that the medication should be refrigerated until opened.</p> <p>During an interview on 6/25/2025 at 5:15 pm, LPN/CN 1 stated that Humalog and Lantus should be discarded 28 days after opening.</p> <p>During an interview on 6/25/2025 at 6:05 pm, the ADON stated that it was the facility's expectation that, upon delivery of medications, any medications requiring refrigeration, such as insulin, should be refrigerated. The ADON confirmed that the medications were improperly stored.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled Documentation in the Medical Record, the facility failed to maintain an accurate medical record for one of 17 sampled residents (R) (R29). Specifically, the facility failed to ensure the staff member delivering care was also the staff member who documented the care related to Activities of Daily Living (ADLs) and showers.</p> <p>Finding include</p> <p>Review of the facility's policy titled Documentation in the Medical Record, dated 12/27/2024, indicated, . Pertinent observations, medications, services performed, etc., should be recorded in the patient's medical record.</p> <p>Review of R29's Face Sheet, found under the Face Sheet tab of the electronic medical record (EMR), revealed R29 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease, unspecified.</p> <p>Review of R29's Annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 4/28/2025 indicated R29 had a Brief Interview for Mental Status (BIMS) score of 10 (indicating moderate cognitive impairment) and needed substantial/maximal assistance with bathing.</p> <p>Review of the ADL Plan of Care, provided by the facility, under Self-Care Deficit revealed the resident had an intervention of assist with ADLS as needed, female Certified Nursing Assistants [CNA] only while showering initiated on 5/14/2025.</p> <p>Review of the ADL Sheet, found under the ADL Tab of the EMR, revealed that for the month of June, on 6/23/2025, the resident's shower was performed by CNA2.</p> <p>Interview on 6/25/2025 at 12:26 pm, Licensed Practical Nurse/Charge Nurse (LPN/CN) 1 was asked where the resident's shower preferences were located. LPN/CN1 stated in the chart. When asked how staff would know if a resident preferred not to have a male CNA perform care, she stated we only have one male CNA, and he typically bathes the male residents. When asked where the care was documented, LPNCN1 stated in the EMR. LPN/CN1 stated that when it was signed with that person's name, it was that person who completed the care.</p> <p>During an interview on 6/25/2025 at 2:58 pm, R29 confirmed that a female CNA gave her a bath.</p> <p>In an interview on 6/25/2025 at 2:59 pm, CNA2 stated he just goes through the resident's record and sees the resident's preferences related to ADL care. CNA2 stated some residents do not want a male CNA to bathe them, and if that is the case, CNA3 will work with me.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/25/2025 at 3:03 pm, CNA3 was asked, How do you know a resident's ADL preferences, for instance, showers? CNA3 stated the information was in the EMR. CNA3 stated some women do not want men to do their bath, so I do their bath. When asked if she bathed R29 on 6/23/2025, CNA3 stated, Yes. When asked how the staff code that care was completed. CNA3 stated, I sign for it as care being given. CNA3 stated that R29 would not let a male CNA bathe her, so I bathed her. The ADL Sheet was shown to CNA3, which indicated CNA2 signed as delivering the care, and CNA3 agreed it was not CNA2 who bathed the resident. CNA2 was shown the assignments in the EMR, and R29 was not listed as their resident. CNA3 stated that since R29 was not assigned to her, she could not code that she gave her a bath.</p> <p>In an interview on 6/26/2025 at 11:17 am, the Assistant Director of Nursing (ADON) confirmed that if a CNA is not assigned to a resident, they cannot document care delivered. The staff member would have to notify the assigned person that the care was delivered, and they would notate it in the medical record.</p>		