STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115604	A. Building B. Wing	01/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brown's Health and Rehabilitation	226 South College Street Statesboro, GA 30458

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **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 Resident Self-Administration of Medication, the facility failed to ensure unauthorized medications were not stored at the bedside for one of 27 sampled residents (R) (R25). This deficient practice had the potential to place R25 at increased risk for the use of unauthorized medications. Findings include:Review of the facility's policy titled Resident Self-Administration of Medication, dated 8/3/2025, revealed the Policy section stated It is the policy of this facility to support each resident's right to self -administer medications. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. The Policy Explanation and Compliance Guidelines section included, . 8. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party.Review of the electronic health record (EHR) for R25 revealed diagnoses including, but not limited to, osteomyelitis, atrial fibrillation, cardiac arrhythmia, hypertension, and gastroesophageal reflux (GERD).Review of the admission Minimum Data Set (MDS) for R25, dated 10/15/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview Mental Status Score (BIMS) of 15, which indicated little to no cognitive impairment.Review of the care plan for R25 revealed no care plan for medication self-administration.Review of the active physician orders for R25, dated1/9/2026, revealed active orders for Omega-3 oral capsule 1000 milligram (mg), and Nasonex nasal suspension 50 microgram (mcg)/actuation (ACT). Further review revealed no orders for medication self-administration. Review of the EHR for R25 revealed there was no self-administration assessment/evaluation. Observation and interview with R25 in the resident's room, on 1/9/2026 at 10:23 am, revealed a bottle of OTC (over-the-counter) nasal spray and a prescription bottle of mometasone fumarate (nasal spray) sitting on the resident's bedside rolling table, within view of other residents and/or visitors entering the room. Further observation revealed one bottle of Omega Acid Ethyl [NAME] pills and a prescription bottle of potassium pills on the dresser stand. R25 stated that the medications were being used without staff supervision.During an observation and interview on 1/9/2025 at 2:55 pm, the Assistant Director of Nursing Unit Nurse (ADON) confirmed the medications were in the resident room. She reported being unaware of the medications in the room. She confirmed the R25 was at risk of receiving additional doses of the same medications because all the medications found in the resident's room were also on the nurse's medication cart and were being administered daily to the resident. The ADON instructed Registered Nurse (RN) AA to remove the medications from the resident room.During an interview on 1/9/2027 at 2:39 pm, RN AA confirmed that all medications were removed from R25's room today. In addition, she reported that R25 and the resident's family have a previous history of bringing in unauthorized medications and received education about the risk of self-administering medications without nurse supervision. She reported recently removing medications from the R25's room a few weeks ago.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interviews, record review, and review of the facility's policy titled Oxygen Safety (Use and Storage), the facility failed to ensure an environment free from potential accident hazard by failing to ensure an oxygen cylinder was secure in a cylinder holder for one of seven residents (R) (R50) receiving oxygen therapy. This deficient practice had the potential to place R50 at increased risk of avoidable accidents. Findings include:Review of the facility's policy titled Oxygen Safety (Use and Storage) dated 12/1/2024, revealed the Policy section stated It is the policy of this facility to provide a safe environment for resident, staff, and the public. This policy addresses the use and storage of oxygen and oxygen equipment. The Policy Explanation and Compliance Guidelines section included, . 4. Oxygen Storage - c. Cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty.Review of the electronic health record (EHR) for R50 revealed diagnoses including, but not limited to, senile degeneration of the brain and Parkinson's disease.Review of the Quarterly Minimum Data Set (MDS) for R50, dated 10/14/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview Mental Status (BIMS) score of seven, indicating severe cognitive impairments. Section O (Special Treatments, Procedures, and Programs) documented that the resident did not receive oxygen therapy. Review of the active physician orders for R50, dated 1/9/2026, revealed an active documented order dated 10/10/2025 of: Check oxygen saturation every shift for SOB (shortness of breath) apply oxygen 2 LPM via NC (two liters per minute by nasal cannula) for O2 sats less than 90% (percent). Record review of the Hospice care plan for R50 revealed a focus area for advanced care planning interventions. Interventions included Comfort measures: . Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort.Observation on 1/9/2026 at 11:41 am in R50's room revealed an unsecured cylinder tank sitting on the floor between the resident's bed and a dresser. Further observation revealed R50 lying in bed, and the oxygen cylinder was within the resident's reach. In an interview on 1/9/2026 at 11:49 am, Licensed Practical Nurse (LPN) CC and Registered Nurse (RN) AA both reported being unaware of the oxygen cylinder tank in R50 room. RN AA removed the cylinder tank from the room and reported that, most likely, the Hospice staff left it in the room. LPN CC and RN AA reported that the facility policy required the oxygen cylinder to be secured in a holder to prevent tipping and explosions.In an interview on 1/9/2026 at 11:50 am, Certified Nursing Assistant (CNA) BB reported providing Activities of Daily Living Care (ADL) to R50 earlier that morning and stated she did not observe the unsecured cylinder tank in the room. She reported receiving in-services on monitoring unsecured oxygen cylinder tanks and the danger of not using a cylinder holder, which can cause the tank to tip over and explode.In an interview on 12/12/2026 at 10:11 am, the Assistant Director of Nursing (ADON) stated she was unaware of the unsecured oxygen cylinder in R50's room. She stated that her expectations were that all staff, including non-nursing staff, were responsible for monitoring for safety issues related to oxygen cylinders. She reported that her plans were to provide education on free-standing oxygen to facility staff and Hospice Staff.