STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115605	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waycross Health and Rehabilitation	1910 Dorothy Street Waycross, GA 31501

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** 50941 Based on observations, resident and staff interviews, record review, and review of the facility's policy titled Pharmacy Services: Bedside Storage of Medication, the facility failed to assess one of 29 sampled residents (R) (R48) for the ability to self-administer medications prior to leaving medications at the bedside. This deficient practice had the potential to place R48 at risk of unsafe medication use. Findings include: Review of the facility's undated policy titled Pharmacy Services: Bedside Storage of Medication revealed the Guideline section included, The Pharmacy supports bedside medication storage for patients who are able to self-administer medications upon the written order of the prescriber and when it is deemed appropriate in the judgment of the nursing center's interdisciplinary patient assessment team. Review of R48's clinical record revealed diagnoses including, but not limited to, dementia, chronic kidney disease, anxiety, and hypertension. Review of R48's Admission Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 3 (indicating severe cognitive impairment). Review of R48's care plan revealed no care plan for self-administration of medication. Review of R48's Physicians Orders revealed no order for medication self-administration. Review of the clinical record revealed there was no assessment for medication self-administration. During concurrent observation and interview on 3/18/2025 at 10:30 am, R48 stated he had pain medication in a bottle in his room. Observation revealed that the bottle contained white pills with red writing on them. In an interview on 3/18/2025 at 11:23 am, Certified Medication Aide (CMA) AA stated she was unaware that R48 had medication at his bedside. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/18/2025 at 11:29 am, the Director of Nurses (DON) stated that she was unaware that R48 had medications at the bedside. She further stated that residents should not have any medications at the bedside. In an observation on 3/18/2025 at 11:32 am, CMA AA and the DON verified that R48 had a bottle of pills on his over-bed table. The DON removed the pills from R48's room and discussed not having medications at the bedside with the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39786 Based on observation, staff interviews, and review of the facility's policy titled Wound Care, the facility failed to ensure staff followed infection control processes during wound care for one of 10 residents (R) (R38) reviewed for wound care. This deficient practice had the potential to place R38 at risk of infection due to cross-contamination. Findings include: Review of the facility's policy titled Wound Care, reviewed 12/27/2024 revealed the Intent section stated, It is the intent of this center to provide guidelines for clean technique in providing wound care. The Guideline section included, . Perform hand hygiene. Put on appropriate Personal Protective Equipment (PPE) and first pair of clean gloves. Remove the soiled dressing and place into a bag at the bedside . Remove gloves and perform hand hygiene. Put on second clean gloves. Cleanse the wound using Normal Saline . Remove gloves, perform hand hygiene and apply third pair of gloves. Apply peri-wound protectant and apply clean dressing as ordered. Remove gloves and perform hand hygiene and repeat the process if performing another dressing change. Review of R38's electronic medical record (EMR) revealed diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of R38's Physician Orders revealed an orders including, but not limited to, 12/23/2024: Cleanse left upper arm abscess area with N/S (normal saline), pat dry, apply skin barrier wipe to surrounding peri wound, apply honey alginate and cover with composite dressing every Monday, Wednesday, and Friday, Dx (diagnosis): cutaneous abscess of left upper limb. 3/8/2025: Cleanse skin graft to left thigh with NS, pat dry, apply skin barrier wipe to peri-wound, apply petroleum gauze and cover with composite dressing every Monday, Wednesday, and Friday-Dx: skin donor, autologous, 12/23/2024: Cleanse wound on right side of neck with NS, pat dry, apply skin barrier wipe to surrounding peri-wound, apply wet-to-dry gauze and cover with composite dressing daily, Dx: pressure ulcer stage 2. Review of R38's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section M (Skin Conditions) documented one stage 2 pressure ulcer, open lesion(s), pressure ulcer care, application of nonsurgical dressings, and application of ointments/medications. Review of R38's care plan, with an onset date of 12/24/2022, revealed a Care Area/Problem of Skin breakdown: at risk for/actual breakdown. Interventions included Treatments/dressings as ordered per physician, applications of ointments/medication to skin, observe for and report signs/symptoms of infection, and enhanced barrier precautions. Observation of wound care for R38 on 3/19/2025 starting at 11:15 am and concluding at 11:40 am revealed the Wound Care Nurse (WCN)/Registered Nurse (RN) gathered and set up supplies, donned PPE and entered R38's room. The wound nurse performed wound care and dressing change(s) as follows: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Left arm abscess: The WCN/RN placed a clear plastic trash bag at the foot of R38's bed, removed dressing from R38's left upper arm/below the shoulder and discarded in the plastic trash bag. Wound nurse changed gloves but did not wash or sanitize hands, cleaned site with normal saline, changed gloves but did not wash or sanitize hands, applied skin prep to surrounding skin, covered wound bed with a small medi-honey dressing, and covered/secured with a bordered composite dressing. 2. Left thigh skin graft: The WCN/RN pulled back the bedding and exposed R38's left leg with a dressing on the upper thigh, asked R38 if he was alright and positioned his leg for comfort. She then removed the dressing, changed gloves but did not wash or sanitize hands, applied skin prep to surrounding skin, covered wound bed with petroleum gauze, covered/secured with bordered composite dressing. 3. Right outer neck: The WCN/RN removed R38's oxygen nasal cannula from his nose, removed the right side neck dressing, changed gloves but did not wash or sanitize hands, cleaned site with normal saline, changed gloves but did not wash or sanitize hands, applied skin prep to surrounding skin, changed gloves but did not wash or sanitize hands, applied wet to dry gauze to wound bed, covered with 4x4 gauze folded in half, secured with bordered composite dressing, and reapplied R38's oxygen. In an interview on 3/19/2025 at 11:42 am, outside of R38's room, the WCN/RN acknowledged she did not sanitize her hands when changing gloves during the wound care. She stated she thought it was acceptable to only change the gloves. In an interview on 3/19/2025 at 12:53 pm, the Director of Nursing (DON) confirmed the WCN/RN should sanitize her hands during wound care when changing gloves, after removing the dirty/soiled dressing and after cleaning the wound. The DON revealed her expectation was for all nurses to sanitize their hands when they change gloves during wound care, or during any care when going from dirty or soiled to clean.