

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115613	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Gibson Health Opco LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  434 Beall Springs Road Gibson, GA 30810	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50878</b></p> <p>Based on staff interviews, record review, and review of the facility's policy titled Comprehensive Care Plans, the facility failed to develop and implement a comprehensive person-centered care plan that addressed the care and treatment for one of one Resident (R) (R318) reviewed with an indwelling catheter. The deficient practice had the potential to increase the risks of infections.</p> <p>Findings include:</p> <p>Review of the undated facility's policy titled Comprehensive Care Plan under the Policy statement revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental, and psychological needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.</p> <p>Review of clinical records revealed, R318 was admitted with diagnoses that included, but not limited to, hyperosmolality and hypernatremia, dehydration, essential hypertension, adult failure to thrive, retention of urine, pressure ulcer of sacral region (stage 3), pressure-induced deep tissue damage of right heel, muscle weakness (generalized), and urinary tract infection.</p> <p>Review of the Order Audit Report dated 2/24/2025 revealed, R318 has orders for a [Name] Catheter18 Fr [French], 10cc [cubic centimeters] bulb every day shift every 30 days for Urinary retention. Change [Name] AND as needed for Urinary retention. May change as needed for occlusion or accidental removal.</p> <p>Review of the care plan dated 11/30/2023, revealed R318 has a urinary catheter due to urinary retention and is totally incontinent of bowels. The resident is at risk for complications such as UTIs (urinary tract infections) and skin breakdown due to incontinence. Intervention included but not limited to Provide pericare after each incontinent episode. However, there were no care plan areas that addressed catheter care and treatment.</p> <p>Interview on 2/27/2025 at 2:27 pm with Certified Nursing Assistant (CNA) FF revealed, she was unsure what catheter care meant. She stated the area was cleaned during catheter changes (every 30 days).</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 115613
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 2/26/2025 at 2:35 pm with Licensed Practical Nurse (LPN) CC revealed that the policy was to perform catheter care at each catheter bag change (monthly) or as needed. LPN CC confirmed there was no evidence of documentation that catheter care was performed since 9/19/2024.</p> <p>Interview on 2/27/2025 at 3:25 pm with the Director of Nursing (DON) confirmed there was no documentation in the EMR that catheter care had been performed for R318.</p> <p>Cross Reference F684</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50940</b></p> <p>Based on observations, staff interviews, and review of the facility's policy titled Insulin Pen, and review of the manufacturer's instructions titled Instructions for use [Name] Pen Pen-injector (Insulin Lispro) injection, to ensure care and services were provided in accordance with accepted professional standards for one of four residents (R) (R368) observed during medication administration. Specifically, the facility failed to prime the insulin pen prior to use for R368. This deficient practice had the potential to affect the resident's blood glucose level and have a negative impact on the resident's quality of life.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Insulin Pen, revised 4/16/2024, under the Policy Explanation and Compliance Guidelines revealed, 6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir .11. Procedure . h. Prime the insulin pen: (i) Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears.</p> <p>Review of the manufacturer's Instructions for use [Name] Pen Pen-injector (Insulin Lispro) injection under the section titled Priming your Pen revealed, Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin.</p> <p>Review of R368's orders dated 2/25/2025 revealed, [Name] Kwik-Pen Subcutaneous Solution Pen Injector 100 unit/ml (milliliter) (Insulin Lispro), inject as per sliding scale.</p> <p>During observation of medication administration on 2/26/2025 at 11:32 am with Licensed Practical Nurse (LPN) AA who was observed performing a blood sugar check without concerns and subsequently administering four (4) units of insulin subcutaneously for a blood sugar level of 243. LPN AA retrieved the R368's insulin pen, attached a disposable, single-use insulin needle, and dialed the administration dose to 4 units as per doctors ordered. LPN AA then entered the R368's room and administered the insulin to R368 without priming the needle to remove air and to ensure an accurate insulin dose.</p> <p>During an interview on 2/26/2025 at 11:35 am with LPN AA revealed that she usually primes the insulin pen but admitted that she was nervous and forgot to do so today.</p> <p>During an interview on 2/26/ 2025 at 1:30 pm with the Director of Nursing (DON) revealed, there were two perspectives on whether insulin pens need to be primed-some believe priming is necessary, while others consider it unnecessary. The DON agreed to double check for it in their policies.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50878</b></p> <p>Based on staff interviews, record review, and review of the facility's policy titled, Catheter Care Policy, the facility failed to ensure one of one Resident (R) (R318) with an indwelling catheter received treatment and care in accordance with professional standards of practice. The deficient practice had the potential to increase the risks of infections.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Catheter Care Policy, revised 11/1/2023 under the Policy statement revealed, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheter care are in use. Under the section titled, Policy Explanation revealed, 1. Catheter care will be performed every shift and as needed by nursing personnel.</p> <p>Review of R318's Electronic Medical Record (EMR) revealed, diagnoses that included, but not limited to retention of urine, pressure ulcer of sacral region (stage 3), pressure-induced deep tissue damage of right heel, muscle weakness (generalized), and urinary tract infection (UTI).</p> <p>Review of R318's Order Audit Report dated 2/24/2025 revealed, an order for a [Name] Catheter18 Fr [French], 10cc [cubic centimeters] bulb every day shift every 30 days for Urinary retention. Change [Foley] AND as needed for Urinary retention. May change as needed for occlusion or accidental removal. However, there were no orders to address catheter care every shift.</p> <p>Review of the EMR for Treatment Administration Records (TAR) revealed a lack of documentation for catheter care and cleaning for R318 during October 2024, November 2024, and December 2024.</p> <p>Interview on 2/27/2025 at 2:27 pm with Certified Nursing Assistant (CNA) FF revealed, she was unsure what catheter care meant. She stated the area was cleaned during catheter changes (every 30 days).</p> <p>Interview on 2/26/2025 at 2:35 pm with Licensed Practical Nurse (LPN) CC initially stated she needed to reference the policy, then stated she expected catheter care to be performed when the catheter was changed monthly. She revealed that the policy was to perform catheter care at each catheter bag change (monthly) or as needed. LPN CC confirmed there was no evidence of documentation that catheter care was performed since 9/19/2024.</p> <p>Interview on 2/27/2025 at 3:25 pm with the Director of Nursing (DON) confirmed there was no documentation in the EMR that catheter care had been performed for R318. He continued that the staff had not been documenting catheter care in the EMR and they would begin immediately. He stated the policy was to perform catheter care once monthly or as needed. When asked about concern of her UTI's the DON stated, that the resident was on a prophylactic antibiotic and the catheter care policy was followed.</p>		