STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115630	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Folkston Park Care and Rehabilitation Center	36261 North Okefenokee Drive Folkston, GA 31537

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 - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop and implement a person-centered comprehensive care plan for one of five residents (R) (R1) receiving a pureed diet. Specifically, the facility failed to address the resident's diet, behaviors of wandering into other residents' rooms, and seeking non mechanically altered food items. This failure resulted in R1 choking and expiring on 10/25/2025. The facility's failure to develop and implement a person-centered comprehensive care plan caused or was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy (IJ) was identified on 11/13/2025 and was determined to have existed on 10/25/2025. The Administrator and Regional Operations Manager were informed of the IJ on 11/13/2025. An acceptable Removal Plan was received on 11/17/2025. Based on the validation of the Removal Plan, the State Survey Agency determined that the corrective plans and the immediacy of the deficient practice were removed on 11/15/2025. Findings include:A review of the electronic medical record (EMR) revealed that on 10/25/2025 at approximately 9:03 am, Certified Nursing Assistant (CNA) BB was feeding a resident in Room A5 when she heard a thud and left Room A5 to find out the cause of the noise. When CNA BB entered Room A7, she found R1 on the floor, face down with a biscuit hanging out of his mouth. The CNA reported the incident to Licensed Practical Nurse (LPN) AA; LPN AA initiated emergency care at 9:06 am; Emergency Medical Services (EMS) was called at 9:09 am; the EMS team arrived at 9:13 am; and provided emergency services until 9:40 am before pronouncing R1 as expired at 9:40 am.A review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Pattern) revealed a Brief Interview for Mental Status (BIMS) was not conducted due to resident was rarely/never understood. Section GG (Functional Abilities) revealed that R1 was dependent with eating and personal hygiene. Section I (Active Diagnosis) revealed diagnoses that included but not limited to, Alzheimer's disease, cognitive communication deficit, need for personal care, and anxiety disorder. Section K (Swallowing disorder) revealed the resident was on a mechanically altered diet.A review of R1's diet order dated 8/17/2025 revealed, a large portion diet, pureed texture, nectar consistency, no rolls or bread with meals.Record review of R1's psychiatry note dated 9/23/2025 at 11:08 am revealed, the resident was on secure unit of facility due to wandering and exit-seeking behaviors. Staff reports increased agitation and impulsivity.Record review of R1's behavior note dated 10/17/2025 at 8:03 pm revealed, This resident is completely uncontrollable. He's become impossible to redirect. He is charging in other resident's rooms while they're completely unaware he's coming. He's just walking into other rooms getting into their beds, using they're restroom and completely leaving it covered in feces or urinating on the floor, and taking their food or drinks from them while in the dining room eating meals. He is completely out of sorts when he's up and alert. His new behavior is eating anything that's not edible. I had to take his pillows away from him because for the past 2 days, he has started eating the stuffing out of them. When I took them away, he started eating his blanket. A review of the care plan dated 10/1/2025 revealed that R1 had a potential for nutritional problems with interventions that included but not limited to, ensure 3 (three) compartment trays are used at all meals, provide and serve diet as order, (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and provide and serve supplements as ordered however, the care plan failed to address the resident's diet, behaviors of wandering into other residents' rooms, and seeking non mechanically altered food items. Further review of the care plan revealed, R1 had impaired cognitive function/dementia or impaired thought processes with interventions that included, administer medications as ordered with monitoring of side effects of medication and to cue, reorient, and supervise as needed.An interview with LPN AA on 11/17/2025 at 4:57 pm revealed that care plans can be seen in electronic records. She revealed that she receives a list with all the information about the patient such as diet and type of care to provide.An interview with the Weekend LPN Supervisor on 11/19/2025 at 10:58 am revealed that care plans were usually updated by management or the MDS coordinator. She stated that care plans can be seen in the EMR, but that they usually obtain the information from the 24-hour report, order reports, or word of mouth.An interview with Director of Nursing (DON) revealed that she was currently completing care plans until the new MDS coordinator started. She revealed that Cooperate was helping with care plans. She confirmed that R1 care plan was not updated to reflect his diet, behaviors of wandering into other residents' rooms and seeking non mechanically altered food items. The DON revealed that she had a board that she used to monitor when to update care plans. She confirmed that the care plan should be updated immediately.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled, Medication Administration Guidelines, the facility failed to notify the provider and obtain an order to administer medication for one of three sampled residents (R) (R7). This failure placed the resident at risk not to receive the treatment and care in accordance with professional standards of practice.Findings include:Review of the facility's policy titled, Medication Administration Guidelines dated June 2022 under Guidelines revealed, To enforce and adhere to the Nurse Practice Act and DEA (Drug Enforcement Administration) requirement of safe practice of administering medications. Under the section titled Medication Administration revealed, Prior to administering medications, there must be a physician order prescribing the medication.Review of the most recent Quarterly Minimal Data Set (MDS) dated [DATE] for Section C (Cognitive Pattern) revealed that R7 had a Brief Interview for Mental Status (BIMS) score of one indicating severe cognitive impairment. Section I (Active Diagnosis) revealed diagnoses that included but not limited to, congestive heart failure, hypertension, Alzheimer's disease, and metabolic encephalopathy.Review of R7's electronic medical record (EMR) revealed that R7 did not have an order for Benadryl (an allergy medication) as of 10/30/2025. Review of a nurse practitioner note dated 8/12/2025 revealed that R7 received Benadryl (allergy medication) however, review of R7's medication administration record (MAR) dated August 2025 revealed there was no documentation of Benadryl.During an interview on 11/18/2025 at 10:04 am with Licensed Practical Nurse (LPN) KK, Unit Manager confirmed that there was not an order for Benadryl (an allergy medication) nor was there documentation of Benadryl on the MAR for R7.An interview on 11/18/2025 at 11:29 am with the Director of Nursing (DON) confirmed that the R7 did not have an order for Benadryl and that it was not documented on the MAR. She confirmed that the nurse provided the Benadryl medication without an order. She revealed that the nurse found an old standing order in the narcotic box. She further revealed that standing orders were discontinued in 2024.An interview on 11/18/2025 at 2:27 pm with the Medical Director revealed that he did not recall receiving a call from the nurse on that day. He stated that if he had received a call that he would have ordered Benadryl (an allergy medication) and prednisone at the same time to address an allergic reaction. He stated that the resident was sent out the next morning when the Nurse Practitioner evaluated R7.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 record review and staff interviews, the facility failed to provide adequate supervision to prevent an avoidable accident for one of five residents (R) (R1) on A Hall (the secured memory unit) with a pureed diet. Specifically, R1 was ordered a pureed texture, nectar consistency, with no rolls or bread. R1 was left unsupervised, resulting in him obtaining a non-mechanically altered food and subsequently choking. This failure resulted in R1 expiring on 10/25/2025.The facility's failure to provide adequate supervision to prevent an avoidable accident caused or was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy (IJ) was identified on 11/13/2025 and was determined to have existed on 10/25/2025. The Administrator and Regional Operations Manager were informed of the IJ on 11/13/2025. An acceptable Removal Plan was received on 11/17/2025. Based on the validation of the Removal Plan, the State Survey Agency determined that the corrective plans and the immediacy of the deficient practice were removed on 11/15/2025.Findings include:A review of the electronic medical record (EMR) revealed that on 10/25/2025 at approximately 9:03 am, Certified Nursing Assistant (CNA) BB was feeding a resident in Room A5 when she heard a thud and left Room A5 to find out the cause of the noise. When CNA BB entered Room A7, she found R1 on the floor, face down with a biscuit hanging out of his mouth. The CNA reported the incident to Licensed Practical Nurse (LPN) AA; LPN AA initiated emergency care at 9:06 am; Emergency Medical Services (EMS) was called at 9:09 am; the EMS team arrived at 9:13 am; and provided emergency services until 9:40 am before pronouncing R1 as expired at 9:40 am.A review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Pattern) revealed a Brief Interview for Mental Status (BIMS) was not conducted due to resident was rarely/never understood. Section GG (Functional Abilities) revealed that R1 was dependent with eating and personal hygiene. Section I (Active Diagnosis) revealed diagnoses that included but not limited to, Alzheimer's disease, cognitive communication deficit, need for personal care, and anxiety disorder. Section K (swallowing disorder) revealed the resident was on a mechanically altered diet.Record review of R1's behavior note dated 9/22/2025 at 7:45 pm revealed, He continues to stuff his mouth with food causing him to choke. When I am present, I will feed him and instruct him to chew and swallow the food that's already in his mouth before putting more in but he continues to pack his mouth.Record review of R1's behavior note dated 10/17/2025 at 8:03 pm revealed, This resident is completely uncontrollable. He's become impossible to redirect. He is charging in other resident's rooms while they're completely unaware he's coming. He's just walking into other rooms getting into their beds, using they're restroom and completely leaving it covered in feces or urinating on the floor, and taking their food or drinks from them while in the dining room eating meals. He is completely out of sorts when he's up and alert. His new behavior is eating anything that's not edible. I had to take his pillows away from him because for the past 2 days, he has started eating the stuffing out of them. When I took them away, he started eating his blanket.Record review revealed a staffing assignment sheet for A Hall dated 10/25/2025 which indicated one LPN and one CNA were assigned to care for 23 residents with the following acuity: 17 residents at risk for elopement, 13 incontinent residents, one resident who requires two person total assistance with Activities of daily living (ADL) hygiene care, transferring, and bed mobility, and four residents who require total assistance with feeding. Interview on 10/27/2025 at 3:31 pm with LPN AA revealed the staffing pattern on A Hall was problematic. She revealed that the unit cares for residents with dementia and other cognitive impairments. She revealed that prior to the incident on 10/25/2025 with R1, she and one CNA were scheduled to care for the entire secured unit. She revealed that it was impossible to monitor and provide adequate care to all 23 residents. She revealed she and the CNA did the best they could but admitted that residents were not monitored. LPN AA revealed that R1 was constantly in and out of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	other residents rooms, attempting to eat their food. LPNA AA revealed R1 could not be redirected and staff had to follow him constantly. LPN AA revealed that there were multiple residents that required assistance with feeding, when she and the CNA were assisting with feeding that left no one to monitor the other residents, including those who wander. She revealed that she voiced her concerns to management, including the Administrator, but they ignored her. She stated the incident with R1 was avoidable but due to lack of staff the accident occurred. Interview on 10/27/2025 at 5:24 pm with CNA BB revealed the incident on 10/25/2025 with R1 was avoidable but that management refused to staff A Hall with more than one CNA and one nurse. She stated the unit required a lot of care. She stated if nurse was passing medication and she was assisting a resident it left no one to monitor the other residents, residents who have behaviors such as wandering in and out of the residents' rooms. She revealed R1 required constant monitoring because he was known to shove food that was not pureed into his mouth and other objects such as the stuffing of a pillow. She revealed that she asked for more staff on the unit to assist with ADL care and with assistance with feeding residents during meals because she knew the residents were being neglected.Interview on 10/28/2025 at 2:30 pm with the Director of Nursing (DON) revealed R1 was eating anything he could get his hands on. He had issues with shoveling food into his mouth and not chewing, he required assistance with feeding to ensure he ate appropriately and safely. She stated she was aware he was a wanderer and that he was discussed in risk management and they made him a feeder. The DON revealed there are numerous residents on the secured unit that wander in and out of other resident rooms and the hall. She admitted that one CNA and one nurse is not adequate to supervise A Hall and confirmed that the residents were not being monitored on 10/25/2025 when R1 choked to death. She revealed she asked corporate for help with staffing but instead they cut staff based on the census being low. She stated the facility does not staff the facility according to acuity but rather on census.Interview on 10/28/2025 at 2:50 pm with the scheduler revealed the facility was staffed according to census and not acuity. She revealed she was told by the DON on how to staff A Hall and confirmed it was staffed with one CNA and one nurse. She revealed five residents on that unit required assistance with feeding at the time R1 choked on 10/25/2025. She revealed those two staff cannot be observing, monitoring, or caring for the rest of the 22-23 residents. She revealed the residents were more at risk for accidents such as falls. She revealed she was familiar with R1 and his behaviors such as wandering and attempting to eat whatever he could. She revealed staff did the best they could and that the Administrator and corporate knew A Hall could use more staff to better monitor residents, but they cut staff to the facility instead of adding. Interview on 10/28/2025 at 3:03 pm with the Administrator revealed that A Hall unit was staffed with one CNA and one nurse. She revealed that after the incident with R1 on 10/25/2025, corporate approved an additional CNA to be scheduled for both day and night shifts. She admitted she was aware staffing was a concern but that the facility had not implemented any staffing changes. She confirmed she knew R1 had behaviors such as wandering but did not know his behaviors were increasing and was unaware R1 ate stuffing out of a pillow. She confirmed that there was no staff monitoring or supervising the other 21 residents including R1 on 10/25/2025 when the two staff scheduled were occupied with feeding two other residents.An interview with Medical Director on 10/30/2025 at 12:03 pm revealed that when he entered the facility to make rounds, he was told that R1 was having an emergency and found EMS providing emergency interventions. He called the time of death at 9:40 am on 10/25/2025 after 30 minutes of cardiopulmonary resuscitation. The Medical Director confirmed that the unit needed more staff especially since there was five residents needing assistant with feeding. He confirmed that R1 needed one-on-one care. He revealed that he was just made aware that there was one nurse and one aide on the hallway.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide sufficient nursing staff to monitor one of 23 residents (R) (R1) on A Hall (the secured memory unit), resulting in R1 choking and expiring on 10/25/2025. Specifically, the facility failed to have sufficient nursing staff to provide nursing and related services, considering the number, acuity, and diagnoses of the facility's resident population. The facility's failure to provide sufficient nursing staff and related services caused or was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy (IJ) was identified on 11/13/2025 and was determined to have existed on 10/25/2025. The Administrator and Regional Operations Manager were informed of the IJ on 11/13/2025. An acceptable Removal Plan was received on 11/17/2025. Based on the validation of the Removal Plan, the State Survey Agency determined that the corrective plans and the immediacy of the deficient practice were removed on 11/15/2025.Findings include:Review of R1's EMR revealed he was admitted to the facility with diagnoses that included but not limited to Alzheimer's Disease, unspecified, dementia in other diseases classified elsewhere unspecified severity, with agitation, and need for assistance with personal care.A review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognitive Pattern) revealed a Brief Interview for Mental Status (BIMS) was not conducted due to resident is rarely/never understood. Section GG (Functional Abilities) revealed that R1 was dependent with eating and personal hygiene. Section K (swallowing disorder) revealed the resident was on a mechanically altered diet.Record review of R1's behavior note dated 9/22/2025 at 7:45 pm revealed, He continues to stuff his mouth with food causing him to choke. When I am present, I will feed him and instruct him to chew and swallow the food that's already in his mouth before putting more in but he continues to pack his mouth.Record review of R1's psychiatry note dated 9/23/2025 at 11:08 am revealed, the resident was on secure unit of facility due to wandering and exit-seeking behaviors. Staff reports increased agitation and impulsivity.Record review of R1's neurologic progress note dated 10/7/2025 at 10:20 am revealed that residents mood and behavior was anxious and he was disruptive because he was charging into other residents' rooms and close the door and get into residents bed or bathroom.Record review of R1's behavior note dated 10/17/2025 at 8:03 pm revealed, This resident is completely uncontrollable. He's become impossible to redirect. He is charging in other resident's rooms while they're completely unaware he's coming. He's just walking into other rooms getting into their beds, using they're restroom and completely leaving it covered in feces or urinating on the floor, and taking their food or drinks from them while in the dining room eating meals. He is completely out of sorts when he's up and alert. His new behavior is eating anything that's not edible. I had to take his pillows away from him because for the past 2 days, he has started eating the stuffing out of them. When I took them away, he started eating his blanket. Record review revealed a staffing assignment sheet for A Hall dated 10/25/2025 which indicated one LPN and one CNA were assigned to care for 23 residents with the following acuity: 17 residents at risk for elopement, 13 incontinent residents, one resident who requires two person total assistance with Activities of daily living (ADL) hygiene care, transferring, and bed mobility, and four residents who require total assistance with feeding. Interview on 10/27/2025 at 3:31 pm with LPN AA revealed the staffing pattern on A Hall was problematic. She revealed that the unit cares for residents with dementia and other cognitive impairments. She revealed that prior to the incident on 10/25/2025 with R1, she and one CNA were scheduled to care for the entire secured unit. She revealed that it was impossible to monitor and provide adequate care to all 23 residents. She revealed she and the CNA did the best they could but admitted that residents were not monitored. LPN AA revealed that R1 was constantly in and out of other residents rooms, attempting to eat their food. LPNA AA revealed R1 could not be re directed and staff had to follow him constantly. LPN AA revealed that there were (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	multiple residents that required assistance with feeding, when she and the CNA were assisting with feeding that left no one to monitor the other residents, including those who wander. She revealed that she voiced her concerns to management, including the Administrator, but they ignored her. She stated the incident with R1 was avoidable but due to lack of staff the accident occurred. Interview on 10/27/2025 at 5:24 pm with CNA BB revealed the incident on 10/25/2025 with R1 was avoidable but that management refused to staff A Hall with more than one CNA and one nurse. She stated the unit required a lot of care. She stated if nurse was passing medication and she was assisting a resident it left no one to monitor the other residents, residents who have behaviors such as wandering in and out of the residents' rooms. She revealed R1 required constant monitoring because he was known to shove food that was not pureed into his mouth and other objects such as the stuffing of a pillow. She revealed that she asked for more staff on the unit to assist with ADL care and with assistance with feeding residents during meals because she knew the residents were being neglected.Interview on 10/28/2025 at 12:55 pm with CNA EE revealed the secured unit was staffed with one CNA and one nurse. She stated that sometimes during the weekdays front office staff will come to the unit to assist with feeding the residents, but the weekends were difficult because there were only two staff assisting with feeding and providing all care, which was not manageable. Interview on 10/28/2025 at 2:30 pm with the Director of Nursing (DON) revealed R1 was eating anything he could get his hands on. He had issues with shoveling food into his mouth and not chewing, he required assistance with feeding to ensure he ate appropriately and safely. She stated she was aware he was a wanderer and that he was discussed in risk management and they made him a feeder. The DON revealed there are numerous residents on the secured unit that wander in and out of other resident rooms and the hall. She admitted that one CNA and one nurse is not adequate to supervise A Hall and confirmed that the residents were not being monitored on 10/25/2025 when R1 choked to death. She revealed she asked corporate for help with staffing but instead they cut staff based on the census being low. She stated the facility does not staff the facility according to acuity but rather on census.Interview on 10/28/2025 at 2:50 pm with the scheduler revealed the facility was staffed according to census and not acuity. She revealed she was told by the DON on how to staff A Hall and confirmed it was staffed with one CNA and one nurse. She revealed five residents on that unit required assistance with feeding at the time R1 choked on 10/25/2025. She revealed those two staff cannot be observing, monitoring, or caring for the rest of the 22-23 residents. She revealed the residents were more at risk for accidents such as falls. She revealed she was familiar with R1 and his behaviors such as wandering and attempting to eat whatever he could. She revealed staff did the best they could and that the Administrator and corporate knew A Hall could use more staff to better monitor residents, but they cut staff to the facility instead of adding. Interview on 10/28/2025 at 3:03 pm with the Administrator revealed that A Hall unit was staffed with one CNA and one nurse. She revealed that after the incident with R1 on 10/25/2025, corporate approved an additional CNA to be scheduled for both day and night shifts. She admitted she was aware staffing was a concern but that the facility had not implemented any staffing changes. She confirmed she knew R1 had behaviors such as wandering but did not know his behaviors were increasing and was unaware R1 ate stuffing out of a pillow. She confirmed that there was no staff monitoring or supervising the other 21 residents including R1 on 10/25/2025 when the two staff scheduled were occupied with feeding two other residents.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, staff interviews, record review, and review of the facility's policy titled, Medication Administration Guidelines and Tube Feeding Management, the facility failed to ensure a medication error rate of less than five percent. There were three errors from 36 opportunities observed for a medication error rate of 8.33%. This deficient practice has the potential to place Residents (R) R2, R3, and R9 at risk of medical complications.Findings include:Review of the facility's policy titled, Medication Administration Guidelines dated June 2022 under Guidelines revealed, To enforce and adhere to the Nurse Practice Act and DEA (Drug Enforcement Administration) requirement of safe practice of administering medications. Under the section titled Medication Administration revealed, Prior to administering medications, there must be a physician order prescribing the medication.Some medications are NOT to be crushed. Facility to check with pharmacy before crushing medications.Review of the facility's policy titled Tube Feeding Management, dated January 2025 under the section titled Procedure revealed, that the placement of tube is verified and to check gastric contents for residual feeding.A review of the facility's list titled, Common Oral Dosage Forms that Should Not be Crushed revealed that asprin enteric coated was not to be crushed.1. A review of R2's Medication Administration Record (MAR) revealed the following order dated 6/16/2023 for Asprin EC tablet Delayed Release 81 mg (milligram) one tablet once a day by mouth.A review of physician orders for R2 dated 6/15/2023 revealed that may crush all medications per physician order.An observation on 11/13/2025 at 8:09 am of R2 medication administration on A Hall revealed that Licensed Practical Nurse (LPN) FF crushed an aspirin enteric coated (EC) tablet then mixed it with pudding2. A review of the Medication Administration Record (MAR) revealed the following order for R3 Asprin tablet Chewable 81mg one tablet once a day by mouth.A review of physician orders for R3 dated 4/23/2022 revealed an order, may crush all medications per physician orders.An observation on 11/13/2025 at 8:28 am of R3 medication administration on A hall revealed that Licensed Practical Nurse (LPN) FF crushed an aspirin enteric coated (EC) tablet then mixed it with pudding.An observation and interview with LPN FF on 11/13/2025 at 9:40 am revealed that she received a list of residents that need crushed medications. She confirmed that she crushed asprin 81mg enteric coated (EC) for R2 and R3. She revealed that she crushed them because the residents cannot swallow the pills whole. She stated that she learned in school that you were not to crush enteric coated medication. She revealed was not sure about a do not crush list. She confirmed that R3 had an order for asprin 81mg chewable but crushed and administered asprin EC 81mg to R3. She revealed that she had a bottle of asprin chewable on the A Hall cart available.3. A review of R9's Medication Administration Record (MAR) revealed the following order dated 6/18/2025 for hydrocodone 10-325 mg- one tablet, give via (by way of) gastrostomy tube (g-tube) every four hours as needed for pain.A review of physician orders for R9 dated 10/3/2024 revealed may crush all medications per physician orders. A physician order dated 4/14/2025 revealed that every shift flush peg tube with 30 ml (milliliters) of water before and after medications.An observation on 11/13/2025 at 11:54 am of medication administration on B hall revealed that LPN CC administered hydrocodone via g-tube. LPN CC crushed the pill and mixed it with 30 milliliters (ml) of water. She then proceeded to flush the tube with 30 ml of water before and after medication administration however, she did not check placement of the g-tube and residual prior to flushing the tube with 30 ml of water.An interview on 11/13/2025 11:59 am with LPN CC confirmed that she did not check placement of the g-tube and residual prior to flushing the tube with 30 ml of water. She revealed that she forgot to check placement. She confirmed that she needed to check placement before giving the hydrocodone.An interview with the Pharmacy Consultant on 11/18/2025 at 12:24 pm revealed that asprin enteric coated was on the do not crush list. She stated that the medication should not be crushed unless there was a specific order from the physician instructing to crush the asprin. She admits that asprin enteric coated 81mg and asprin chewable 81 mg cannot be used interchangeable.An interview with (continued on next page)

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	115630	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Folkston Park Care and Rehabilitation Center	36261 North Okefenokee Drive Folkston, GA 31537

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) on 11/18/2025 at 12:49 pm revealed that asprin enteric coated (EC) should not be crushed. She confirmed that asprin enteric coated was found on the facilities Common Oral Dosage Forms that Should Not be Crushed list. She confirmed that the order for R2 aspirin EC was not changed when he required medications to be crushed. She confirmed that R3 has an order for asprin 81mg chewable and that was what the nurse should have given. The DON revealed that she expect staff to follow the policies. She revealed that the expectation was that the nurse check placement before administering medication or anything in the tube. She revealed that the policy states that placement should be verified before administering medication through a g- tube.An interview on 11/18/2025 at 4:50 pm with LPN OO revealed that when administering medication through a g-tube, the placement should be checked prior to administering medication. Each medication should be crushed individually and flushed prior to and after administering medication with the ordered amount of water.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, the facility failed to ensure pureed therapeutic diets were properly prepared for one out of eight residents (R) (R4) receiving a therapeutic pureed diet. This deficient practice had the potential to cause medical complications and place the resident at risk for unmet nutritional needs.Findings include:Record review of R4's electronic health record (EHR) revealed R4 had diagnoses that included but not limited to Alzheimer, dementia, amnesia, transient ischemic attack (TIA), and dysphasia.Record review of R4's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the following assessment for Section C (Cognitive Patterns) revealed, a Brief Interview of Mental Status (BIMS) score of 99 which indicated severe cognition impairment. Section K (Swallowing/Nutritional status) revealed that the resident received a mechanically altered diet (which required change in texture of food or liquid, puree food).Review of R4's Physician Order Form (POF) revealed a dietary order dated 8/18/2025 for regular pureed texture, thin consistency.Observation 11/15/2025 at 1:26 pm on revealed R4 in the dining room sitting at a table with two other residents, eating her meal, a non-pureed diet independently without staff assistance. Continued observation of the resident meal revealed beef (appearance was lumpy with mixture of ground beef, corn was thick, lumpy with kernels, and bread was thick and lumpy). Review of the R4's meal tray revealed a diet for pureed, thin consistency.During an observation at the time of interview on 11/15/2025 at 1:30 pm of R4's meal with the Administrator and Corporate Nurse, both administrative staff confirmed that R4's meal was of non-pureed consistency. The Administrator reported that the facility did not have a dietary manager and this error was a result lack of guidance. The Administrator reported that her plan was to educate the dietary staff on pureed preparation. She described the risk for any resident on a puree diet receiving food of non-puree consistency could potentially cause choking/aspiration.Interview on 11/24/2025 at 1:00 pm, the Registered Dietician (RD) revealed, that she was able to review the photo of R4's meal. The RD described the meal as non-pureed due to dietary staff failure to achieve the ultimate consistency of ensuring that each food item was completely pureed. She described the beef as containing ground particles of beef, corn as containing mixture of the husk, and the roll as lumpy. She reported that the rice food item was the only true consistent puree item on the plate.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on staff interviews, record reviews, and review of the facility's documents titled, Licensed Nursing Home Administrator and Director of Nursing (DON), the administration failed to provide sufficient nursing staff to monitor one of 23 residents (R1) on A Hall (the secured memory unit). This resulted in an avoidable choking accident and the death of R1 on 10/25/2025. Specifically, Administration knew there was insufficient staffing on A Hall (secured memory unit) and failed to staff A Hall in manner that efficiently maintained the highest practicable physical, mental, and psychosocial well-being of each resident. The failure to take action caused R1 to be left unsupervised, resulting in his death. The facility's failure to provide sufficient nursing staff caused or was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy (IJ) was identified on 11/13/2025 and was determined to have existed on 10/25/2025. The Administrator and Regional Operations Manager were informed of the IJ on 11/13/2025. An acceptable Removal Plan was received on 11/17/2025. Based on the validation of the Removal Plan, the State Survey Agency determined that the corrective plans and the immediacy of the deficient practice were removed on 11/15/2025.Findings include:Review of the facility's document titled, Licensed Nursing Home Administrator under the Job Duties and Responsibilities section revealed, Oversee that residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents. Under the Human Resources section revealed, Maintain responsibility for an adequate number of appropriately trained professional and auxiliary personnel being on duty at all times to meet the needs of the residents.Review of the facility's document titled, Director of Nursing under the Job Summary: revealed, The primary purpose of the Director of Nursing position is to plan, organize, develop and direct the overall operation of the Nursing Department to ensure that the highest degree of quality care is maintained at all times.Review of the staffing sheets from September 1, 2025, through October 27, 2025, for A Hall (the secured memory unit) revealed that the unit was staffed with one CNA and one nurse. The census on the unit ranged from 21 to 23 residents during those two months.Record review revealed a staffing assignment sheet for A Hall dated 10/25/2025 which indicated one Licensed Practical Nurse (LPN) and one Certified Nurse Assistant (CNA) were assigned to care for 23 residents with the following acuity: 17 residents at risk for elopement, 13 incontinent residents, one resident who requires two person total assistance with Activities of daily living (ADL) hygiene care, transferring, and bed mobility, and four residents who require total assistance with feeding. Interview on 10/28/2025 at 2:30 pm with the Director of Nursing (DON) revealed there were numerous residents with behaviors on the secured unit. She confirmed that one CNA and one nurse was not adequate to supervise A Hall and confirmed that the residents were not being monitored on 10/25/2025 when R1 choked to death. She revealed she asked corporate for help with staffing but instead they cut staff based on the census being low. She revealed that the facility did not staff the facility according to acuity but rather on the census.Interview on 10/28/2025 at 3:03 pm with the Administrator revealed that the A Hall unit was staffed with one CNA and one nurse. She confirmed she was aware that lack of staffing was a concern for the unit but that the facility had not implemented any staffing changes.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review the facility failed to accurately maintain medical records for one of three sampled residents (R) (R7). Specifically, the facility failed to ensure R7's allergies was updated. This failure has the potential to place resident at risk for an allergic reaction or clinical decline.Findings include:Review of the most recent Quarterly Minimal Data Set (MDS) dated [DATE] for Section C (Cognitive Pattern) revealed that R7 had a Brief Interview for Mental Status (BIMS) score of one indicating severe cognitive impairment. Section I (Active Diagnosis) revealed diagnoses that included but not limited to, congestive heart failure, hypertension, Alzheimer's disease, and metabolic encephalopathy.Review of the electronic medical record (EMR) on 10/30/2025 revealed that R7 had no known allergies however, review of the hospital discharge record dated 8/13/2025 revealed that R7 had allergies to codeine, dilaudid, morphine and lisinopril.During an interview on 11/13/2025 at 9:40 am with Licensed Practical Nurse (LPN) FF, she confirmed that R7 electronic medical record (EMR) had no known allergies listed upon review. She revealed that allergies would have been listed in red.During an interview on 11/18/2025 at 10:04 am with LPN KK, she confirmed that the EMR for R7 reflected that the resident had no known allergies listed on his profile upon review. Following his readmission on [DATE], the discharge hospital records demonstrated resident had allergies to dilaudid, codeine, morphine, and lisinopril. She confirmed that she should have updated the EMR when R7 was readmitted on [DATE] with the listed allergies. She revealed that the process was that when a resident returns from the hospital she would enter all the medications and allergies that were approved by the Medical Director. She revealed that she then place a check mark next to the medication or allergy that the Medical Director would like to continue and a X mark next to the medication or allergy that the Medical Director did not want to continue.An interview on 11/18/2025 at 10:54 am with Consultant Pharmacy revealed that she reviewed medical records monthly. The review consists of all the electronic records which includes allergies. She revealed that when a resident was readmitted , allergies were to be reviewed. She confirmed the EMR for R7 listed no known allergies. She revealed that admissions and readmissions reviews were completed between 24 and 72 hours, which included reviewing the hospital paperwork. She revealed that she reviewed the admission paperwork for 8/13/2025 that demonstrated resident had allergy to Dilaudid, Codeine, Morphine, and Lisinopril on 8/18/2025 then again in September and October but the allergies were not updated.An interview on 11/18/2025 at 11:29 am with the Director of Nursing (DON) confirmed that the EMR for R7 list the resident as having no known allergies. She revealed that the Unit Manager enters the order and the floor nurse enters the orders after hours and on the weekend. She revealed that the weekend supervisor will also help put in the admission orders. She revealed that the allergies would be reviewed and included with this process. The unit manager or nurse would then put a check by the medication or allergies that the Medical Director would like to continue and then enter the information into the EMR.

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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. Based on observation, interviews, and record review, and review of the facility's policy titled, Infection Control Preventionist, the facility failed to use gloves to handle pills to crush medication for two of seven sampled residents (R) (R2 and R3). This deficient practice had the potential to place residents at high risk for infection.Findings include:A review of the of the facility's policy titled, Infection Control Preventionist dated January 2025 under the Policy section revealed that the ICP [Infection Control Preventionist] is responsible for the center's activities aimed at preventing healthcare associated infections by ensuring that the sources of infections are isolated to limit the spread of infectious organisms. Under the Duties section revealed, The ICP conducts rounds, discusses and monitors infection prevention practices with staff members, collects infection data from departments, maintains records for each case of HAI, conducts outbreak investigations, trains staff members on incidents of infection and reports such incidents to the appropriate person/department, and ensures availability of supplies required for infection prevention activities. 1. A review of order dated 6/15/2023 for R 2 revealed may crush all medications per physician orders.An observation on 11/13/2025 at 8:09 am of R2 medication administration on A Hall revealed that Licensed Practical Nurse (LPN) FF used her bare hands to pick up pills to place in a pouch to crush medication.2. A review of order dated 4/23/2022 for R3 revealed may crush all medications per physician order.An observation on 11/13/2025 at 8:28 am of R3 medication administration on A hall revealed that Licensed Practical Nurse (LPN) FF used her bare hands to pick up pills to place in a pouch to crush medication.Interview on 11/13/2025 at 9:40 am with Licensed Practical Nurse (LPN) FF confirmed she used her bare hands to pick up pills to place in a pouch to crush medication. She confirmed that she was not using gloves to pick up the pills to place in pouch for R2 and R3. She acknowledged that she should always wear gloves to handle residents' pills.An interview on 11/18/2025 at 10:45 am with Registered Nurse Unit Manager/Infection Preventionist confirmed that nursing staff were to wear gloves when handling residents' pills.An interview on 11/18/2025 at 12:49 pm with the Director of Nursing (DON) revealed that she expect nursing staff to wear gloves when handling residents' pills.