STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115655	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwell Health and Rehabilitation	260 Mj Taylor Road Adel, GA 31620

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 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** Based on observations, record review, and staff interviews, the facility failed to ensure the Wound Care Coordinator (WCC) followed infection control processes during wound care and supra-pubic catheter care for one of five residents (R) (R6) reviewed and observed for wound care and catheter care. This deficient practice had the potential to place R6 at risk of infection due to cross-contamination.Findings include:Review of R6's electronic medical record (EMR) revealed diagnoses including, but not limited to, quadriplegia, open wound of lower back and pelvis, pressure ulcer sacral region stage 4, and bed confinement status.Review of R6's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Section GG (Functional Abilities and Goals) documented that the resident was dependent for care. Section H (Bladder and Bowel) documented that the resident had an indwelling catheter. Section M (Skin Conditions) documented one unhealed stage 4 pressure ulcer, use of a pressure-reducing device for bed, a turning/repositioning program, nutrition or hydration interventions, pressure ulcer care, and application of nonsurgical dressings.Review of R6's care plan, with an onset date of 2/11/2025, revealed Problem areas of:1. Skin Integrity: Risk for impaired skin integrity due to impaired mobility and sensation, due to quadriplegia, and episodes of incontinence. Approaches included Low air loss mattress in place, start date 6/12/2025. Wound care as ordered, start date 3/3/2025. Apply lotion as needed for moist skin, incontinence care after each episode-2/11/2025. Offer fluids to maintain hydration, as indicated by the provider on 2/11/2025. Skin evaluation scheduled with daily care on 2/11/2025. Care plan last reviewed/revised 1/9/2026.2. Pressure Ulcer: [R6] has a stage IV pressure ulcer to his coccyx, start date 2/11/2025, edited 1/13/2026.3. Urinary Catheter: [R6] requires a suprapubic urinary catheter due to neurogenic bladder, start date 2/11/2025.4. ADLs Functional Status/Rehabilitation Potential Side Rail: [R6] is at risk for difficulty with bed mobility related to physical mobility impairment, as evidenced by the need for assistance with turning and repositioning.Review of R6's Physician Orders revealed an order dated 1/6/2026 of: Wound care: Coccyx wound care - Clean with Anasept spray, pack with Anasept gel moistened 2-inch kling gauze. Cover with sacral Allevyn. Use skin prep to peri wound. Catheter site - Clean with Anasept spray. Apply a drain sponge and secure it with tape. Change daily and PRN (as needed).Observation on 1/14/2026 at 9:57 am by the Wound Care Coordinator (WCC) performing wound care and catheter care for R6 revealed that during the procedures, the WCC removed the outer dressing and the packing from inside the deep wound bed and disposed of them in a trash can. The WCC sanitized her hands, changed gloves, cleaned the sacral wound with Anasept spray wound cleanser, then, using a long, cotton-tip applicator (medical Q-tip swab stick), WCC packed the wound with Anasept gel-moistened gauze that she had placed in Anasept gel beforehand. The WCC then applied skin prep to the surrounding skin and covered it with a dated [Name brand] dressing. Observation revealed the WCC did not change gloves and perform hand hygiene after cleaning the wound and before applying the gel-moistened gauze to the wound and covering it with a dressing. Continued observation of the WCC providing supra-pubic catheter care to R6 revealed the WCC sanitized her hands and put on gloves, cleaned the area around the catheter insertion site with Anasept wound cleanser, and applied a dated split drain sponge/dressing. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation revealed the WCC did not change gloves and perform hand hygiene after cleaning the site and before placing the dressing.In an interview on 1/14/2026 at 10:13 am, the WCC confirmed she did not sanitize her hands and change gloves after cleaning both wounds, and before applying new dressings. She stated she should have sanitized her hands and changed gloves after cleaning the wounds, when going from dirty to clean, and before applying the new dressing.In an interview on 1/15/2025 at 8:15 am, the DON (Director of Nursing) stated she was made aware by the WCC that she missed a step during wound care and did not sanitize her hands or change gloves after she cleaned the resident's wound, and before packing the wound and covering it with a new dressing. The DON confirmed that the WCC should always sanitize her hands and change gloves after cleaning a wound, and before applying a new dressing. The DON stated her expectation was for the nurse to use hand hygiene and standard infection control precautions to prevent cross-contamination during wound care, including when changing gloves, after removing the dirty/soiled dressing, after cleaning wounds, and during any care when going from dirty or soiled to clean.