| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115679 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Comfort Creek Nursing and Rehabilitation Center | 10200 U.S. Hwy 1 South<br>Wadley, GA 30477 |

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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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and facility policy review, the facility failed to ensure the kitchen's large manual can opener blade and its base, microwave oven, and food preparation pots and pans were clean and/or dry when stored and failed to cover and/or date opened food stored in one of one facility kitchen. The facility also failed to ensure an opened container of thickened apple juice was dated when opened, and discard when its best if used by date had expired in one of two nursing unit resident refrigerators. These failures had the potential to create an environment for food-borne illnesses which could affect 67 residents who consumed food prepared from the facility's kitchen. Findings include:<br><br>1. Observation during the initial kitchen inspection on 04/27/2026 from 11:00 AM to 11:40 AM, with the Dietary Manager (DM) present, revealed the following unclean food preparation and service equipment:<br><br>a. The kitchen's large manual can opener was unclean with accumulated dried and sticky substances on its blade and table base attachment.<br><br>b. A large stock pot, that was stored and ready for use, was unclean with dried food substances on its interior cooking surface.<br><br>c. The kitchen's microwave oven was unclean with accumulated dried food substances and splatters in its inner cooking compartment.<br><br>d. Five food preparation pans, that were stacked tightly on top of other pans and ready for use, had moisture on them. One of these wet food preparation pans was also unclean with grits on its interior cooking surface.<br><br>During an interview on 04/27/2026 at 11:15 AM, the DM confirmed the kitchen's manual can opener and its base attachment, stock pot, microwave oven, and food preparation pans were stored unclean and/or wet. The DM stated kitchen staff should make sure food preparation equipment was clean and dry prior to storing it for use.<br><br>2. Further observation during the initial kitchen inspection on 04/27/2026 from 11:00 AM to 11:40 AM, with the (DM) present, revealed the following concerns with food storage:<br><br>a. Observation of the kitchen's dry storage area revealed one opened and undated 56-ounce package of dried stuffing, and two opened and undated 16-ounce packages of dried alfredo sauce mix that were stored open to air and unprotected from possible contamination.<br>(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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | b. Observation of one of the kitchen's reach-in refrigerators revealed an opened 46-ounce container of thickened tea with lemon flavor did not have a date to indicate when it was opened.<br><br>During an interview on 04/27/2026 at 11:30 AM, the DM confirmed the above opened and undated food in the dry storage room that was stored open to air and the opened container of thickened tea in refrigeration storage that was undated. The DM stated staff should date food when opened and cover it completely when placing it into storage.<br><br>3. During an observation of items stored inside the facility's front hall pantry resident refrigerator on 04/27/2026 at 11:50 AM, with the DM present, revealed an opened and undated 46-ounce container of thickened apple juice with an expired best if used by date of 04/07/2026.<br><br>During an interview on 04/27/2026 at 11:50 AM, the DM confirmed the container of thickened apple juice was opened, undated and had an expired best if used by date of 04/07/26. The DM stated it was the responsibility of the dietary and nursing staff to date items when opened, to check expiration dates on products, and to discard any food or beverages that had expired dates.<br><br>Review of the facility's undated policy titled, Cleaning and Sanitizing Areas and Equipment, specified, All kitchen areas and equipment shall be maintained in a sanitary manner and be fee of buildup of food, grease, or other soil. The facility will provide sanitary foodservice that meets state and federal regulations .<br><br>Review of the facility's undated policy titled, Food Storage, specified, Policy Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by means designed to prevent contamination. Procedure . 15. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated . |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to determine a root cause for two of two residents (R) R1 from eloping from the facility on two separate occasions and R22 wandering into other residents room. The facility's failure to determine a root cause in R1 exiting the facility and R22 entering other resodents room increases the risk of accidents or injury. Findings include:<br><br>1. Review of the admission Record found under the Profile tab of the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, auditory hallucinations, and anxiety.<br><br>Review of the Elopement Evaluation found under the Assessments tab of the EMR, , dated 01/14/2025 revealed R1 has a history of wandering, wandering aimlessly, and identified R1 as an elopement risk.<br><br>Review of the High Risk Event-Chart Audit documents, provided by the facility, revealed R1 eloped from the facility on 01/22/2026. Interventions added to prevent additional elopements by R1 included staff education, adding occupational therapy for therapeutic exercise and additional assessments and medical examination. There was no documentation of a root cause analysis of how the resident was able to elope from the building.<br><br>Review of the Care Plan under the Care Plan tab of the EMR, revealed a focus of care included Risk for wandering/elopement related to exit seeking behaviors. The goal included R1 will not leave the facility unattended, which was created on 01/14/2025. Interventions included 15 minute observation checks, providing purposeful activities, schedule time for walks and to identify triggers for wandering/elopement.<br><br>Review of the Logbook Observation documents provided by the facility revealed the electronically locked doors, that only open after keypad code is entered monthly.<br><br>Review of the facility's document titled, Elopement dated 02/09/2026 indicated, This nurse was walking down the hallway and noticed resident walking outside of A- Hall with walker. Immediate Action Taken- Maintenance Director and Project Manager were outside and escorted resident back into building. Skin assessment completed without injuries observed.<br><br>Review of the Nursing Progress Notes, found under the Prog [Progress] Note tab of the EMR, dated 02/09/2026, revealed R1 was noted to be outside and unaccompanied. Staff immediately went to R1 and assisted her back into the facility.<br><br>An interview with the Administrator (formerly the Director of Nursing) on 04/29/26 at 11:15 AM confirmed R1 eloped on 01/09/26 with interventions added to R1's care plan which included 15 minutes checks and staff education. The Administrator stated that R1 eloped a second time on 02/09/2026. The Administrator stated that staff were again educated and R1's care plan was reviewed and the resident was placed on one on one observations. The Administrator confirmed the facility did but interventions in place but failed to perform a root cause analysis.<br><br>Review of the facility's document titled, Elopement Management, dated January 2025, indicated,<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Clinical process that addresses a resident's risk of elopement from the premises or a safe area without authorization and/or necessary supervision to do so. Identification and implementation of individualized approaches to provide the resident with a safe and secure environment. Evaluation of the resident's individualized plan of care and validation of effectiveness of interventions.<br><br>2. Review of the Face Sheet located in the Profile tab of the electronic medical record (EMR) revealed R22 was admitted to the facility on [DATE] with dementia, adjustment disorder with disturbance of conduct, and altered mental status.<br><br>Review of R22's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/19/2026, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 99 out of 15, which indicated R22's cognitive function was severely impaired.<br><br>Review of R22's Care Plan, dated 04/07/2026, located under the Care Plan tab of the EMR, revealed that R22 was at risk for wandering/elopement related to exit seeking behaviors, in place of an intervention to check R22's location regularly during and between rounds during waking hours.<br><br>Review of the Face Sheet located in the Profile tab of the EMR revealed R13 was admitted to the facility on [DATE] with diagnosis of right femur fracture, neuralgia and neuritis, and dysphagia.<br><br>Review of R13's quarterly MDS with an ARD of 04/09/2026, located in the EMR under the MDS tab, revealed a BIMS score of nine out of 15, which indicated R13's cognitive function was moderately impaired.<br><br>Review of R13's Care Plan, dated 04/24/2026, located under the Care Plan tab of the EMR, revealed that R13 had the potential to be verbally aggressive related to dementia and schizoaffective disorder, in place of an intervention for staff to intervene as necessary and room change as necessary to avoid verbal abuse.<br><br>Review of the Face Sheet located in the Profile tab of the EMR revealed R67 was admitted to the facility on [DATE] with diagnosis of cerebral infarction affecting left non-dominant side, contracture on the left hand, and dysphagia.<br><br>Review of R67's quarterly MDS with an ARD of 02/03/2026, located in the EMR under the MDS tab, revealed a BIMS R67's score of 14 out of 15, which indicated R67's cognitive function was completely intact.<br><br>Review of R67's Care Plan, dated 02/27/2026, located under the Care Plan tab of the EMR, revealed that R67 was at risk for harm: self-directed or other-directed related to dementia, psychotic disturbance, mood disturbance and anxiety, in place an intervention that if resident poses a potential threat to injure self or others, notify provider and staff to intervene as necessary to protect resident and/or others.<br><br>During an observation on 04/27/2026 at 11:06 AM, R22 wandered around the hallway, was clean, with non-skid shoes on and not disheveled.<br><br>During an observation on 04/28/2026 at 1:27 PM, R22 entered R13 and R67's room. R13 yelled at R22 to leave the room, get out of here, leave the room! Staff did not check or monitor R22's location nor responded to R13's yelling. R22 exited the room and there was no sign on the door to deter other<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | residents from entering the room.<br><br>During an observation on 04/28/2026 at 1:43 PM, R22 was observed touching the medication cart in the B hall and had to be re-directed back to his room.<br><br>During an interview on 04/28/2026 at 1:37 PM, Certified Nursing Aide (CNA) 3 stated, .R22 would go into other residents' rooms. It happens a lot. When R8 is walking around, he usually speaks to himself. Most of time, he would go into R13 and R67's room, R13 would yell out, come get him out of my room!.<br><br>During an interview on 04/28/2026 at 3:48 PM, Certified Medication Aide (CMA) 1 stated, R8 may go into other residents' rooms, and we catch him before he goes in.<br><br>During an interview on 04/30/2026 at 1:18 PM, R67 stated, .He always comes in here. R22, that guy. I always tell him to get out, or I will beat him up! It happens all the time!<br><br>During an interview with the Administrator on 04/28/2026 at 3:40 PM revealed we do re-orient him back to his room. I have not observed him going into any other residents' rooms. The Administrator confirmed no incidents that happened regarding resident going into other residents' rooms. I don't see any documentation that he is care planned for going into residents rooms, and if this is a new behavior and we will address it.<br><br>During a review of a video footage on 04/30/2026 at 11:55 AM, the video footage played by the Maintenance Director and the Administrator showed R22 entering R13 and R67's room on 04/28/26 at around 1:27 PM while R22 entered the room. MD and Administrator acknowledged that they observed on the video footage that R22 entered R13 and R67's room. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and facility policy review, the facility failed to respect resident rights when they failed to provide Activities of Daily Living (ADLs) care of their choice for two out of two dependent residents (Resident (R) R15 and R16) reviewed for ADLs assistance out of a total of 24 sampled residents. This failure had the potential to adversely affect residents' dignity, comfort, and quality of life.Findings Include:<br><br>1. Review of the facility's policy titled Resident Hygiene, dated January 2025, revealed that residents were to be bathed as needed, to include a sponge bath and/or bed bath, or more often, including a shower at least twice weekly.<br><br>Review of R15's admission Record, located in the Electronic Medical Record (EMR) under the Profile tab. indicated the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to stiff person syndrome (SPS).<br><br>Review of R15's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/23/2026, located in the EMR under the MDS tab, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 out of 15, indicating the resident was cognitively intact. The assessment further revealed under Section F, titled Preferences for Routine and Activities, that bathing, either in a tub, shower, or bed bath, was somewhat important to her. The assessment also revealed the R15 required extensive assistance by two staff for bed mobility and was totally dependent on staff.<br><br>Review of R15's care plan located in the EMR under the Care Plan tab, dated 04/07/26, indicated R15 required assistance with self^care.<br><br>Review of R15's Kardex located in the EMR under the Tasks tab (used by Certified Nurse Aides (CNA) to direct resident care) under Bath/Shower for the past 30 days revealed R15 had received only bed baths and no showers. Further review of the Kardex revealed R15 had not refused any care.<br><br>During an interview on 04/27/2026 at 12:45 PM, R15 reported she had not received a shower since February and stated she would like to receive one.<br><br>During an interview on 04/28/2026 at 2:52 PM, Unit Manager (UM) 2 stated resident showers were scheduled for two days per week or more if needed. UM2 further stated there was no shower book or log and that all documentation was recorded in the EMR under the Tasks tab on the Kardex. UM2 confirmed that R15's Kardex did not indicate any showers for the past 30 days.<br><br>During an interview on 04/29/2026 at 1:50 PM, CNA 1 confirmed ADL care was documented in the EMR on the Kardex and stated that after three refusals, staff were to indicate the refusal on the Kardex, with the nurse documenting in the EMR.<br><br>2. Review of R16's admission Record located in the EMR under the Profile tab indicated the resident was admitted to the facility on [DATE] with diagnoses including, but not limited to, quadriplegia (C5–C7 incomplete) and a cervical disorder.<br><br>Review of R16's quarterly MDS with an ARD of 04/10/2026 indicated the resident's BIMS score was<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 15 out of 15, indicating the resident was cognitively intact. The assessment further revealed the resident identified bathing, either in a tub, shower, or bed bath, as very important to him. The assessment indicated the R16 required extensive assistance from two staff for bed mobility and was totally dependent on two staff for transfers.<br><br>Review of R16's care plan located in the EMR under the Care Plan tab, dated 06/23/22, indicated the resident required assistance with bathing.<br><br>Review of R16's Kardex located in the EMR under the Tasks tab under Bath/Shower for the past 30 days revealed R16 had not received any showers. Further review of the Kardex revealed that R16 had not refused any care.<br><br>During an interview on 04/27/2026 at 12:23 PM, R16 stated the last time he had received a shower was on 12/08/25.<br><br>During an interview on 04/28/2026 at 2:52 PM, UM2 stated resident showers were scheduled for two days per week or more if needed and confirmed there was no shower log, with documentation completed in the EMR under the Kardex. UM2 confirmed R16's Kardex did not indicate any showers for the past 30 days. The Kardex however did indicate the resident received a bed bath.<br><br>During an interview on 04/29/2026 at 1:50 PM, CNA1 confirmed ADL care was documented on the Kardex and that refusals were to be documented after three occurrences.<br><br>During an interview on 04/29/2026 at 3:45 PM, the facility Administrator stated that all residents were to receive regular hygiene care. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals were stored in a secure manner for one of one resident (Resident (R)16) out of a sample size of 24. Specifically, medications requiring licensed nursing administration were stored unsecured and accessible in the resident's room, despite the resident not self^administering medications. This failure placed the residents at risk for unauthorized access, misuse, and improper medication management.<br><br>Findings include:<br><br>Review of the facility policy titled Medication Administration, dated 01/2025, indicated that residents may self^administer medications only after an assessment had been completed. The policy further indicated licensed nursing staff are responsible for maintaining medications in a secure area and ensuring safe medication management. Review of R16's admission Record located in the Electronic Medical Records (EMR) under the Profile tab revealed the resident was admitted on [DATE] with diagnoses including, but not limited to, quadriplegia (C5–C7 incomplete) and a cervical disorder. Review of R16's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/10/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. The MDS further indicated that the resident required extensive assistance from two staff for bed mobility and was totally dependent on two staff for transfers. Review of R16's Care Plan located in the EMR under the Care Plan tab, dated 06/23/2022, indicated the residents were allowed to keep Ketoconazole shampoo at the bedside, with staff responsible for application. There was no documentation of the Hydrocortisone 2.5% topical cream being able to held at bedside. Review of R16's Physician Orders located in the EMR under the Orders tab, revealed active orders for Hydrocortisone 2.5% topical cream to be applied every 12 hours and Ketoconazole shampoo to be kept at the bedside. Review of R16's Self^Administration of Medication Assessment located in the EMR under the Assessment tab, dated 02/02/2023, indicated the resident wished to keep Ketoconazole shampoo received from the Veterans Administration at the bedside for nursing staff to administer. During an observation and interview with R16 on 04/27/2026 at 12:46 PM, revealed two boxed and labeled tubes of Hydrocortisone topical cream resting unsecured on a water dispenser next to R16's bed. R16 stated the topical creams and medicated shampoo were prescribed by his Veterans Administration (VA) physician and kept in his room. The resident further stated he was physically unable to apply the medications or wash his hair due to quadriplegia and confirmed that only nursing staff applied his prescribed creams and shampoo. During an observation and interview on 04/28/2026 at 2:06 PM, the Unit Manager (UM) 1 confirmed the Hydrocortisone topical cream was stored unsecured on the water dispenser in the resident's room along with the Ketoconazole shampoo which is stored in the resident's bathroom. During an interview on 04/29/2026 at 3:45 PM, the Administrator stated R16 was unable to self^administer topical medications and that only licensed nursing staff were permitted to apply prescription creams and shampoos. She further stated it was the facility's expectation that medications be stored securely. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observations and interviews, the facility failed to provide a safe and clean environment for residents in the dining room. The facility's failure to maintain dining room chairs with cleanable surfaces without tears in the seating of the chairs has the potential to affect residents who sit in the dining room. An observation of the eating at the dining room tables on 04/27/2026 at 12:15 PM revealed five dining room chairs with tears in the seats.<br><br>An interview on 04/27/2026 at 11:45 AM with the Director of Nursing (DON) confirmed the five dining room chairs with tears in the seat with the exposed non-cleanable material. The DON confirmed the chairs must be cleanable and the tears in the seats render the seat uncleanable.<br><br>. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of Resident Assessment Instrument (RAI) manual the facility failed to ensure an accurate Minimum Data Set (MDS) assessment was submitted for the usage of side rails for one of one resident (R) R5 reviewed for physical restraints out of a total sample of 28. The failure to code the MDS correctly could potentially lead to inaccurate federal reimbursements, inaccurate resident care planning, and improper use of physical restraints. Findings Include:<br><br>Review of R5's admission Record, located under the Profile tab of the electronic medical record (EMR), indicated R5 was admitted on to the facility on [DATE] with diagnoses of Alzheimer's disease and cognitive communication deficit.<br><br>Review of R5's quarterly MDS, with an Assessment Reference Date (ARD) of 03/19/2026 and located under the MDS tab of the electronic medical record (EMR), revealed the assessment specified the resident used side rails daily and had a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated he was severely cognitively impaired.<br><br>Observation of R5 on 04/27/2026 at 12:27 PM, on 04/28/2026 at 9:58 AM, and on 04/29/2026 at 9:38 AM revealed the resident was in bed without side rails or any physical restraints present.<br><br>During an interview on 04/29/2026 at 9:46 AM, Licensed Practical Nurse (LPN) 3 stated that she frequently cared for R5 and the resident had never utilized bedside rails or any physical restraints.<br><br>During an interview on 04/29/2026 at 10:04 AM, the Minimum Data Set Coordinator (MDSC) stated R5 did not utilize bedside rails or any physical restraints. The MDSC reviewed R5's quarterly MDS assessment of 03/19/26 and stated the assessment erroneously coded that the resident used side rails daily. The MDSC states she would submit an immediate correction for this MDS coding error.<br><br>During an interview on 04/30/2026 at 11:40 AM, the Administrator stated the facility did not utilize physical restraints and confirmed R5's quarterly MDS of 03/19/2026 inaccurately reflected that he was physically restrained with the use of side rails daily. The Administrator stated it was her expectation that MDS assessments would be accurate. The Administrator stated the facility did not have a policy for the accurate completion of MDS assessments but utilized the RAI manual for any MDS issues.<br><br>Review of the RAI manual, dated 10/2024 and located at https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf, indicated, . In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115679 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Comfort Creek Nursing and Rehabilitation Center | 10200 U.S. Hwy 1 South<br>Wadley, GA 30477 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of out one wandering resident's (R) R22 care plan and updated with appropriate interventions. (Cross Reference F689) Findings include:<br><br>Review of the Face Sheet located in the Profile tab of the electronic medical record (EMR) revealed R22 was admitted to the facility on [DATE] with dementia, adjustment disorder with disturbance of conduct, and altered mental status.<br><br>Review of R22's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/19/2026, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 99 out of 15, which indicated R22's cognitive function was severely impaired.<br><br>Review of R22's Care Plan, dated 04/072026, located under the Care Plan tab of the EMR, revealed that R22 was at risk for wandering/elopement related to exit seeking behaviors, in place of an intervention to check R22's location regularly during and between rounds during waking hours. The care plan did not address interventions related to wandering into other residents' room.<br><br>During an observation on 04/27/2026 at 11:06 AM, R22 wandered around the hallway, was clean, with non-skid shoes on and not disheveled.<br><br>During an observation on 04/28/2026 at 1:43 PM, R22 was observed touching the medication cart in the B hall and had to be re-directed back to his room.<br><br>During an interview on 04/28/2026 at 1:37 PM, Certified Nursing Aide (CNA) 3 stated, .R22 would go into other residents' rooms. It happens a lot. When R8 is walking around, he usually speaks to himself. Most of time, he would go into R13 and R67's room, R13 would yell out, come get him out of my room!<br><br>During an observation on 04/28/2026 at 1:27 PM, R22 entered R13 and R67's room. R13 yelled at R22 to leave the room, get out of here, leave the room! Staff did not check or monitor R22's location nor responded to R13's yelling. R22 exited the room and there was no sign on the door to deter other residents from entering the room.<br><br>During an interview on 04/28/2026 at 3:48 PM, Certified Medication Aide (CMA) 1 stated, R8 may go into other residents' rooms, and we catch him before he goes in.<br><br>During an interview on 04/30/2026 at 1:18 PM, R67 stated, .He always comes in here. R22, that guy. I always tell him to get out, or I will beat him up! It happens all the time!<br><br>During an interview with the Administrator on 04/28/2026 at 3:40 PM indicated, We do re-orient him back to his room. I've not observed him going into any other residents' rooms. The Administrator confirmed no incidents that happened regarding R22 going into other residents' rooms. There is no documentation that he is care planned for going into residents' rooms, and if this is a new behavior and we will address it. |

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|---|---|---|---|
| | 115679 | A. Building<br>B. Wing | 04/30/2026 |

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|---|---|
| Comfort Creek Nursing and Rehabilitation Center | 10200 U.S. Hwy 1 South<br>Wadley, GA 30477 |

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|---|---|
| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure communication sheets were completed for one of one resident (R) R8 reviewed for dialysis out of a total sample of 28 residents. This failure had the potential to affect the current facility census of 70 residents. Review of the Face Sheet located in the Profile tab of the electronic medical record (EMR) revealed R8 was initially admitted to the facility on [DATE] with end stage renal disease,<br><br>Review of R8's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/04/2026, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated R8's cognitive function was severely impaired.<br><br>Review of R8's Care Plan, located under the Care Plan tab of the EMR, on page 37 of 46 revealed that R8 required hemodialysis related to renal failure, in place are interventions that included, resident to be provided with lunch in proper storage container to take with him to dialysis on scheduled days and to send communication forms with resident to dialysis as indicated and follow up as needed.<br><br>Review of Physicians' Orders, located under the Orders tab of the EMR, revealed R8 had an order to schedule medications according to dialysis treatment schedule, so prescribed medications are held or not scheduled before hemodialysis, or are administered, or sent with the resident to be administered at hemodialysis, as appropriate.<br><br>During an interview on 04/27/2026 at 11:03 AM, Licensed Practical Nurse (LPN) 4 stated, .R8 goes to dialysis every Tuesday, Thursday, and Saturday. We do not have a communication sheet that gets sent to the dialysis clinic. We only do a pre- and post- dialysis evaluation, and we put it in the progress notes.<br><br>During an interview on 04/29/26 at 9:59 AM, Unit Manager (UM) 2 stated, R8 gets picked up by transport on his dialysis days. We only do a pre- and post- dialysis evaluation. We don't use or have dialysis communication sheets.<br><br>During an interview on 04/29/26 at 10:34 AM, the dialysis charge nurse stated, .R8 began dialysis treatment with our center on 12/17/25. We do require that the facility send a dialysis communication form. R8 is the only one that doesn't consistently bring a dialysis communication sheet. We required the dialysis communication sheet in case the patient had a change of condition, or our physician wrote a new order for the patient and when the resident arrives at the dialysis center, we need to know what R8's baseline is prior to starting dialysis.<br><br>During an interview on 04/29/2026 at 11:32 AM, the transport dispatcher stated, .We started transporting R8 on 12/17/2025. The pick-up was at 3:00 PM and chair time was at 4:00 PM.<br><br>Review of the facility's policy titled, Renal Dialysis Management dated, 10/2017, located in page three of eight, under Procedure D, item two, When resident is sent to renal dialysis unit: Complete the facility dialysis communication record to accompany the resident and under Procedure E, When resident returns from renal dialysis unit, item one, review physician's progress note, new orders and/or test reports and the dialysis communication record – Dialysis center returned with the resident. |

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|---|---|---|---|
| | 115679 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Comfort Creek Nursing and Rehabilitation Center | 10200 U.S. Hwy 1 South<br>Wadley, GA 30477 |

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation interviews and review of the manufactures instructions for use, the facility failed to follow the manufacturer's instructions for the administration of insulin to one resident of one resident, (R) R55, identified by the facility as having orders for insulin administration by an insulin pen. The facility's failure to follow the manufacturer's guidelines placed residents who received insulin from an insulin pen at risk to receive an incorrect dose. Findings include:<br><br>Observation on 04/29/2026 at 4:30 PM revealed Licensed Practical Nurse (LPN) 4 performed a blood glucose test for sliding scale insulin administration. After blood glucose monitoring, R55 required 10 units of NovoLog insulin. LPN 4 obtained a NovoLog insulin pen, verified the orders, set the dose to be administered to R55 as 10 units, and prepared to administer the insulin. Upon discussion with LPN4, she confirmed she had not primed the disposable needle attached to the insulin pen. LPN 4 stated she had never been told how to prime the pen.<br><br>Interview with the Administrator/Director Of Nursing on 04/29/26 at 4:35 PM revealed she was unaware of the need to prime the insulin pen.<br><br>Review of the Manufacturer's Instructions for Use revealed that after the disposable needle is attached to the insulin pen, the pen must be primed by dialing and activating a two-unit dose to expel air from the needle prior to administering the ordered dose to the resident. |