STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115691	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Medical Nursing Care Ctr	501 East McCarty St Sandersville, GA 31082

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 0689 Level of Harm - Minimal harm or potential for actual harm 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** 52274 Based on staff interviews, record review, and review of the facility's policy titled [Facility's Name] Fall Management Guide, the facility failed to identify a fall, investigate the fall to determine a root cause, and implement interventions to ensure protection from future potential falls for one of four residents (R) (R3) reviewed for falls. Findings included: Review of the facility's policy titled, [Facility's Name] Fall Management Guide, updated 06/21/2024, revealed, If a fall occurs: Incident report/staff education will be completed by the investigating nurse along with a nursing note. DON [Director of Nursing] completes fall investigation once investigating nurse has completed these steps. The policy also indicated, Determine the cause of the fall and decide how a similar fall could be prevented for each resident. Review of a Nursing Home Summary Sheet indicated the facility admitted R3 on 7/9/2012. Diagnoses included muscle weakness. Review of a Fall Risk Assessment Form, dated 3/25/2024, indicated R3 had a total score of 15. The Fall Risk Assessment Form revealed a total score of 10 or more indicated a resident was at risk for falls. Review of a Fall Risk Assessment Form, dated 4/14/2024, indicated R3 had a total score of 15, which indicated the resident was at risk for falls. Review of a Fall Risk Assessment Form, dated 7/13/2024, indicated R3 had a total score of 15, which indicated the resident was at risk for falls. The Fall Risk Assessment Form indicated R3 experienced no falls in the prior three months. Review of the Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/13/2024, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 5 (indicating severe cognitive impairment). Section GG (Functional Abilities and Goals) documented R3 had impairment on both sides of the lower extremities and required substantial to maximal assistance with walking. Section I (Active Diagnoses) documented diagnoses including dementia, arthritis, and hypertension. Section J (Health Conditions) documented R3 had one fall since admission with no injury. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's Care Plan revealed a problem area for falls, revised 3/5/2025, that indicated that the resident was at risk for falls related to a diagnosis of dementia, multiple sclerosis (MS), degenerative joint disease of the spine, a shuffling gait, and psychotropic medication use. Interventions directed to staff to Provide safe, clutter free environment/uncluttered pathways and Safety training and education as needed for staff. The care plan indicated that, for 5/3/2024 and 8/3/2024, there were No falls this review period. Review of a Nursing Notes For Heavy Nursing Care Except Medication note, dated 5/22/2024 at 5:45 pm, indicated that while R3 was ambulating to the dining room, the resident was noted to start sliding to the floor. The note indicated, lowered resident [R3] to the floor, then assisted to chair, and started to slide out of the chair. Writer assisted resident to floor. Review of the hospital General Instructions, dated 5/22/2024, indicated R3 was admitted on [DATE] at 6:45 am and was evaluated for acute bilateral sacral pain. The General Instructions indicated R3 was discharged to a nursing home with fall prevention warnings. Review of R3's Falls Intervention Plan (FIP), dated from the timeframe of 2017 through 2025, revealed no dated entry for an intervention related to the resident's fall on 5/22/2024. During an interview on 3/19/2025 at 10:45 am, the DON stated she was not aware R3 experienced a fall in May of the prior year, as she did not have an incident report for a fall in May of 2024. The DON reviewed the nurse's note dated 5/22/2024 and confirmed that she did not have an incident report for the 5/22/2024 incident. The DON stated perhaps the nurse did not consider the incident to be a fall, as R3 was assisted to the ground. The DON stated that if the resident did not fall to the ground, she would not consider that a fall. The DON further stated the team did not review R3 for a fall on 5/22/2024. The DON stated she expected an incident report be completed for all falls and the care plan and fall interventions to be updated after a resident had a fall. During an interview on 3/19/2025 at 10:55 am, the Administrator stated when a resident fell , she expected staff to ensure the resident was safe and that there were no injuries. The Administrator stated she expected the nurses to do assessments, call the doctor, call the family, notify the DON, notify the Administrator, and fill out an incident report for the fall. The Administrator further stated that she expected the DON to investigate the fall, get staff statements, do a timeline, and complete a root cause analysis to find out why the resident fell and how they could prevent another fall. The Administrator stated she was aware of the 5/22/2024 incident where staff lowered R3 to the ground. The Administrator stated R3 did not fall because staff caught the resident and lowered the resident to the floor. The Administrator stated she was not aware that easing a resident to the ground (an episode where a resident lost their balance and would have fallen, if not for another person or if they had not caught themselves) was considered a fall. The Administrator stated she expected when there was a fall, an incident report and an investigation were completed that would show how and why the resident fell so that new interventions could be put in place to prevent future falls.