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	08/07/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, resident and staff interviews, and review of the facility's policy titled Grievance Policy, the facility failed to ensure information about the grievance process was posted and made available in visible areas of the facility. In addition, the facility failed to ensure three of 20 sampled residents (R) (R1, R38, and R3) were informed of the grievance process. The deficient practices had the potential to place the 44 residents residing in the facility at risk of not having the knowledge to file a grievance. Findings include:Review of the facility's undated policy titled Grievance Policy revealed the Procedure section included, 1. We will notify residents individually or through posting in prominent location throughout the facility of the right to file a grievance orally (spoken) or in writing: the right to file grievance anonymously; the contact information of the grievance official with whom a grievance can be filed, his or her grievances; and the contact information of the independent entities with whom grievances may be filed, that the pertinent State agency, Quality improvement Organization, State Survey Agency and the state Ombudsman program and advocacy system included. 3. If the grievance is anonymous; a written grievance; to the resident and coordinating with state and federal agencies is necessary of special allegations.1. An initial tour of the facility on 8/5/2025 at 9:00 am revealed no visible posting of information on how to file a grievance, information on who the Grievance Official was, or accessible grievance forms. 2. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 6/20/2025, for R1 revealed a Brief Interview of Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment). During an interview on 8/7/2025 at 10:00 am, R1 stated she was unaware of who the Grievance Official was, the facility had not explained how to file a grievance, and she was not familiar with a grievance form. Review of the Quarterly MDS assessment, dated 5/10/2025, for R38 revealed a BIMS score of 14 (indicating little to no cognitive impairment). During an interview on 8/7/2025 at 10:05 am, R38 stated she was unaware of who the Grievance Official was, the facility had not explained how to file a grievance, and she was not familiar with a grievance form. Review of the Significant Change MDS assessment, dated 5/13/2025, for R3 revealed a BIMS score of 14 (indicating little to no cognitive impairment). During an interview on 8/7/2025 at 10:05 am, R3 stated she was unaware of who the Grievance Official was, the facility had not explained how to file a grievance, and she was not familiar with a grievance form. During an interview on 8/7/2025 at 10:21 am, Certified Nurse Assistant (CNA) AA stated she was aware of what grievances are, but she did not know who the Grievance Official was for the facility or how the process works. She stated that if a resident had a complaint, she would inform the Director of Nursing (DON).During an interview on 8/7/2025 at 10:24 am, Charge Nurse (CN) HH stated that if a resident had a grievance, she would go to the DON because she was the Grievance Official. She further stated she was unaware of the process for filing a grievance for the residents and was unaware of a grievance form.During an interview on 8/7/2025 at 10:31 am, the DON stated the Administrator was the Grievance Official and she handled and processed all the reports. She stated that if a resident wanted to file a grievance anonymously, she would not disclose the resident's name to the Administrator. She confirmed the grievance forms were not available to the residents, and there were no postings in the facility with grievance information or the name of the (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Grievance Official.During an interview on 8/7/2025 at 10:45 am, the Administrator stated she was the Grievance Official and completed the forms for the residents. The Administrator stated she completed the grievance form when a resident wanted to file a complaint. The Administrator further stated that the facility previously had an area with grievance forms available to the residents, but the forms were no longer available to residents. She confirmed there were no postings in the facility to provide residents with information on grievances.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on staff interviews and record review, the facility failed to ensure 14 of 14 Certified Nurse Aides (CNA) reviewed received an annual performance evaluation. This deficient practice had the potential to place the 44 residents residing in the facility at risk of receiving care from incompetent staff. Findings include: Review of the facility's education and training records dated 8/23/2024 through 7/17/2025 revealed no record of annual performance review for CNAs.During an interview on 8/7/25 at 9:45 am, CNA AA stated evaluations were done verbally and with observations, and she cannot recall having a written evaluation since her hire date of 3/29/2024.During an interview on 8/7/2025 at 10:06 am, CNA KK reports not having had a written performance evaluation since her start date of 10/23/2023, and that the Director of Nursing (DON) observes her and gives feedback while she is completing care for a resident.During an interview on 8/7/2025 at 10:03 am, Charge Nurse (CN) HH reported having completed training courses since she had been on staff, but could not say when she had received a formal evaluation, but thought she had.During an interview on 8/6/2025 at 4:45 pm, the DON stated that the facility does not do yearly CNA performance reviews or skills check-offs. She reports that annual performance reviews were not done prior to her employment, and she planned to implement the practice going forward.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, the facility failed to ensure expired medications and medical supplies were not stored in the medication storage room. This deficient practice had the potential to place the 44 residents residing in the facility at risk of receiving expired medications or having expired medical supplies being used for them. Findings Include:Observation of the medication storage room on 8/6/2025 at 10:45 am with the Office Manager and Licensed Practical Nurse (LPN) JJ revealed the room contained supplies sitting on the floor and included: One box of 10 cubic centimeters (cc) syringes with expiration date 11/03/2024. Three boxes of skin prep with expiration date 4/1/2025. Two bottles of bisacodyl 5 milligram (mg) with expiration date of 8/2024. Bisacodyl suppositories with an expiration date of 6/2025. One box of Metamucil with an expiration date of 1/2025. Three bottles of Hibiclens with an expiration date of 10/2024. Intermittent male catheters with expiration dates of 7/24/2025 and 3/31/2025.In an interview, the Office Manager confirmed the identified expired medications and medical supplies. In an interview on 8/6/2025 at 11:00 am, the Office Manager revealed that she was responsible for managing the stock medications and supply room. She said that some of the items in the room were no longer in use. In an interview on 8/7/2025 at 11:41 am, the Director of Nursing (DON) revealed the Office Manager was responsible for the medication storage room. She stated that the Office Manager and the Administrator were the only ones with a key to the room. She further stated that if the medication cart was low in stock of an item, either the Administrator or the Office Manager would retrieve the items from the medication storage room. In an interview on 8/7/2025 at 11:58 am, LPN DD revealed that if they run out of a floor stock medication, the DON will get the key and retrieve the item for them.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to ensure kitchen equipment was stored in a sanitary manner and failed to ensure the ice machine was clean and free from residue. These deficient practices had the potential to place the 44 residents who received hydration from the kitchen at increased risk of illness. Findings include:The initial walk-through observation of the kitchen on 8/5/2025 at 9:15 am, with the Dietary Manager (DM), revealed one slicer sitting on a prep table, and located near the hand-washing sink without a cover. Further observation revealed one industrial-sized mixer sitting on a prep table without a cover.Observation and interview on 8/5/2025 at 9:15 am with the Dietary Manager (DM) in the Dining Hall, of the industrial ice machine, revealed a red-brown residue on the interior of the ice machine when wiped with a paper towel. The DM confirmed the findings. Observation on 8/7/2025 at 10:30 am in the kitchen revealed that the industrial-sized mixer and slicer remained uncovered. Interview with the DM on 8/5/2025 at 9:15 am revealed that the ice machine was cleaned daily by the dietary staff, and Maintenance oversaw the overall upkeep of the ice machine.Interview with the DM on 8/7/2025 at 10:30 am revealed that neither the slicer nor the mixer had had a cover on them since she had worked there.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough outside ventilation via a window or mechanical ventilation, or both. Based on observations, staff interviews, and review of the facility's policy titled Smoking Policy, the facility failed to ensure proper and effective ventilation, specifically in the indoor designated smoking area and hallways near the area. This deficient practice had the potential to place the 44 residents residing in the facility at risk of medical complications related to exposure to poor air quality. Findings include:Review of the facility's undated policy titled Smoking Policy revealed the Procedure section included, . 6. Smoking occurs in designated locations that are environmentally separate from all residents' care areas. These designated locations may be outdoors. The Documentation section included, .3. Smoking will occur in a designated area at a designated time only. Currently, the area is the back porch and the front area outside area. Times and location are subject to change.During the initial tour of the facility on 8/5/2025 at 9:00 am, the smell of cigarette smoke was noted in the hallway that was connected to the designated indoor smoking area. Observations on 8/5/2025 at 2:00 pm and 8/7/2025 at 9:29 am revealed the smell of cigarette smoke lingering in the hallways connected to the designated indoor smoking area.During an interview on 8/6/2025 at 4:00 pm, Certified Nurse Assistant (CNA) CC revealed there was an air filter in the indoor smoking room to help keep the smoke down, but she was unsure who was responsible for maintaining the air filter. She continued to state that when the residents were finished with smoking, the smoke and the smell of cigarette smoke lingered into the hallways, and could be smelled at the end of the hall.During an interview on 8/7/2025 at 9:30 am, CNA AA confirmed she smelled cigarette smoke in that hallway, and stated it usually smelled like that because they open the door from the indoor smoking area, and the smell gets out.During an interview on 8/7/2025 at 10:34 am, the Director of Nursing (DON) confirmed she noticed the smell of cigarette smoke and stated this could be an issue for other residents who don't smoke. She continued to state that the residents who smoke would leave the designated smoking area, and the smoke would linger in the hallways. The DON further stated that they try to get the residents who smoke out fast to help with the smell, but there was no ventilation system in the designated smoking area.During an interview on 8/7/2025 at 10:41 am, the Administrator stated that the closed indoor designated smoking areas have an air purifier, fans, and windows open to help reduce smoke. She continued to state she expected the staff to leave the door closed during the smoking time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, record review, and review of the facility's policy titled Medication Administration General Guidelines, the facility failed to ensure a significant medication error did not occur for one of 20 sampled residents (R) (R32). This deficient practice had the potential to place R32 at risk of medical complications and a reduced quality of life. Findings include:Review of the facility policy titled Medication Administration General Guidelines, dated 2007, revealed the Procedures: Medication Preparation section included, . 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record [MAR]. Compare the medication and dosage schedule on the resident's MAR with the medication label. The Medication Administration section included, . 9. Verify medication is correct three (3) times before administering the medication. a. When pulling the medication package from the med cart. b. When dose is prepared. c. Before dose is administered. 10. Residents are identified before medication is administered using at least two resident identifiers.Review of the clinical record for R32 revealed diagnoses including, but not limited to, hypertension, brainstem stroke, dysphagia, and [NAME] syndrome.Further review of the clinical record revealed that R32 was allergic to penicillin.Review of the facility-provided document titled Incident/Accident Report for R32 revealed an entry dated 4/6/2025 at 10:00 pm and signed by Registered Nurse (RN) GG, documented medication error; pt. [patient] given oral dose Amoxil [amoxicillin, a penicillin-type of antibiotic]. No signs/symptoms of reaction. No actual physical injury. Pt. notified and RP [responsible part] notified. Administration notified. The physician was notified, and the physician, Director of Nursing, and Administrator signed the document. Review of Nurses Notes for R32 revealed: 4/7/2025 at 2:20 am, documented no rash or signs of adverse reactions. 4/72025 at 4:00 am, documented no signs of a reaction. 4/7/2025 at 6:00 am, documented R32 denied having any symptoms during the night. 4/7/2025 at 1:40 am, documented R32 in his room, sitting in his wheelchair, and no reaction noted. 4/7/2025 for 7:00 pm to 7:00 am, documented no visible signs of reaction or rash. 4/8/2025 at 2:20 pm, documented no adverse reaction. 4/9/2025 for 7:00 am to 7:00 pm, documented no signs of rash, hives, itching, or swelling. 4/10/2025 for 7:00 am to 7:00 pm, documented no skin rashes noticed, and no difficulty breathing. In an interview on 8/7/2025 at 10:03 am, Charge Nurse (CN) HH stated new medication orders were documented on a 24-hour report and communicated at shift change. She further stated physician orders were placed on the MAR, and if the medication was not on the MAR, the nurse should not administer it. In a telephone interview on 8/7/2025 at 1:23 pm, Registered Nurse (RN) GG stated that on 4/6/2025, he prepared medication for R32 and R2 before administering the medications. He stated he always prepared medications for both residents residing in the same room at the same time. He further stated that after he administered medication to R32, he realized he had administered Amoxil, which was ordered for R2, to R32 in error. He stated that after review of the MAR for R32, he verified that R32 was allergic to penicillin, and he notified the physician, received an order to administer Benadryl, and to monitor R32. In an interview on 8/7/2025 at 1:10 pm, the Director of Nursing (DON) stated RN GG realized the medication error as soon as it occurred, notified the physician, administered the prescribed Benadryl, and staff monitored R32 accordingly. She confirmed that an incident report was filed, but there was no re-education with RN GG after the incident.