STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115692	A. Building B. Wing	04/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medical Management Health and Rehab Center	1509 Cedar Ave Macon, GA 31204

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and facility policies Resident Rights and Smoking Policy-Residents the facility failed to protect and promote the rights of one of 11 resident (R) (R28) related to smoking. The facility census 71.A review of the facility's policy titled Resident Rights (revised 02/2021) documented under Policy Interpretation and Implementation stated that residents were to be free from corporal punishment or involuntary seclusion, and from physical or chemical restraints not required to treat the resident's symptoms. It further stated that residents had the right to exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.A review of the facility's policy titled Smoking Policy - Residents (dated 2001) documented under Policy Interpretation and Implementation stated that any smokingˆrelated privileges, restrictions, and concerns (e.g., need for close monitoring) were to be noted on the care plan, and all personnel caring for the resident were to be alerted to these issues. Under Progressive Disciplinary Action, the policy stated that due to the danger posed by violations, a progressive disciplinary format would be strictly enforced: first offense - verbal warning; second offense - suspension of privileges for 24 hours; third offense - termination of smoking privileges.A review of the clinical record for R28 revealed that the resident was admitted on [DATE] with diagnoses including, but not limited to: Schizophrenia, Anxiety Disorder, Nicotine Dependence (Cigarettes) With Unspecified Nicotineˆinduced Disorders, Major Depressive Disorder, Antisocial Personality Disorder, Unsteadiness on Feet, Other Abnormalities of Gait and Mobility, and Need for Assistance With Personal Care.The resident's most recent Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively alert and oriented. Section E (Behavior) documented behaviors not exhibited. Section GG (Functional Abilities) documented no impairment in upperˆextremity range of motion and impairment on both sides in lowerˆextremity range of motion. Under Mobility Devices, wheelchair was documented. Under Selfˆcare, supervision or touching assistance was documented for eating.A review of the Care Plan for R28, initiated 06/18/2025, documented the Focus: I have had an actual fall related to poor balance. The Goal (target date 06/11/2026) stated the resident would resume usual activities without further incident. Interventions included referral to therapy for evaluation and possible reacher. A revised Focus dated 04/18/2026 documented Tobacco Usage: Resident is a smoker. Residents deemed it unsafe to smoke. Interventions included the resident require supervision while smoking.Smoking observations on 04/18/2026 and 04/19/2026 at 9:30 AM revealed that R28 was not present.A review of a witness fall report dated 04/03/2026 documented under Immediate Action Taken: MD notified, reevaluation of smoking completed, reeducation on fall prevention provided, and resident would no longer be a smoker but would be allowed chewing tobacco.A Progress Note dated 02/10/2026 by LPN JJ documented a witnessed fall: Nurse was informed by staff that resident was being pushed up ramp and resident was leaning over in wheelchair holding smoke box and fell coming into doorway. staff verbalized and reeducated resident on proper body positioning.On 04/18/2026 at 10:00 AM, during the Resident Council meeting, R28 stated three times that his smoking privilege had been taken away and (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expressed a desire to smoke again. The Activities Director was present.An interview on 04/19/2026 at 9:10 AM with the Director of Nursing (DON) revealed that residents displaying unsafe behaviors-such as not sitting upright or experiencing falls-would have their smoking privileges revoked. The DON confirmed that R28 was assessed upon admission and was to be evaluated every three months. The DON stated that R28 was admitted with an unsteady gait and was often observed bent over throughout the day. The DON further stated that following the fall on 04/03/2026, R28 was deemed unsafe to smoke, and his smoking rights were revoked without prior discussion in the IDT team, and disciplinary action was documented per policy. The DON reported that interventions included verbal prompts to maintain an upright position and a referral to therapy.An interview on 04/19/2026 at 10:09 AM with the Administrator revealed that she had not discussed R28's smoking privileges with her team in any meetings. She stated she expected a smoking assessment to be completed and any violations addressed. The Administrator noted that R28 used a wheelchair throughout the day, particularly during meals, and staff ensured he was seated closer to the table. She stated that his smoking rights should not have been revoked, and that he should instead have been positioned nearer to the ashtray.An interview on 04/19/2026 at 10:19 AM with the Staff Scheduler/Certified Medication Assistant (HH) revealed she was present during the fall on 04/03/2026. She stated that R28 was attempting to reach the ashtray and was seated at the end/corner of the table.An interview on 04/19/2026 at 10:35 AM with Licensed Practical Nurse (LPN) JJ revealed that she performed a smoking evaluation after being informed that R28 had fallen while attempting to stand and reach for the ashtray located in the center of the adjacent table. LPN JJ stated she assessed R28 on 04/03/2026 following the fall and determined that he was not safe to smoke.