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 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, staff interviews, and a review of the facility's policy titled Food Storage Guideline, the facility failed to discard expired food items and failed to properly label, and date food products as required. The facility also failed to maintain sanitary practices during the handling of dishware and utensils, resulting in wet nesting and crossˆcontamination risks. These deficient practices had the potential to place 69 residents who received an oral diet from the kitchen at risk for contracting a foodborne illness.Findings Include:A review of the facility's policy titled Food Storage Guideline dated 03/2024 documented that nonˆperishable food was required to have a delivery date and once opened, an open date. Items were to be discarded by the expiration or useˆby date listed on the product. The policy stated that prepared foods received upon delivery, such as cheese, salads, and luncheon meats, were required to have a delivery date and once opened, an open date and discard date. Food prepared in the facility was required to have a prepared date and a discard date.During the initial tour on 04/17/2026 at 7:43 AM with the Administrator, the kitchen inspection revealed food stored in the dry storage area designated for emergency preparedness. The dry storage area contained five 46ˆounce nectarˆconsistency items with an expiration date of 01/27/2026. One open 10ˆcount package of hamburger buns was observed without proper storage, labeling, or dating. The reachˆin freezer contained one twoˆgallon bag of preˆpackaged food that lacked required labels and dates. The Administrator verified that the beef patties inside the bag were prepared on 04/15/2026, but no expiration or discard date had been provided. The walkˆin refrigerator contained one oneˆgallon bag holding a cut onion dated 04/14/2026, but no expiration or discard date was documented. Additionally, a twoˆgallon bag containing preˆpackaged ham was observed, and the Administrator confirmed that the expiration date appeared to be either 04/06/2026 or 04/16/2026, but the date was difficult to read due to blurriness caused by moisture.An observation and interview on 04/18/2026 at 1:00 PM with Dietary Aide (DA) II revealed that dirty dishes were transported to the dishwashing area through a square opening in the wall. As dishes moved from the washing machine to the drying area, wet nesting was observed on plates and serving domes. DA II operated a lowˆtemperature dish machine and demonstrated unsanitary hand hygiene practices by using the same gloves to retrieve dirty dishes and to handle, prepare, and store clean dishes. DA II explained that he retrieved dirty dishes from the window, scraped food from the plates, sprayed them on a rack, ran them through the dishwasher, removed them, and stacked them to dry, repeating this process until all dishes were completed. He confirmed that he did not have a drying rack or any method to allow dishes to airˆdry properly and that he had never changed his gloves or washed his hands between handling clean and soiled dishware and utensils. The Dietary Manager confirmed the observation and instructed DA II to rewash the dishes and change gloves.An interview on 04/18/2026 at 1:11 PM with the Dietary Manager confirmed that all dietary staff had been inˆserviced on labeling and dating requirements as well as the dishwasher procedure. The Dietary Manager stated that DA II was in a hurry and had limited workspace. She acknowledged that food items in the walkˆin refrigerator and reachˆin freezer had preparation dates but lacked required useˆby dates. She also stated that moisture on the ham packaging caused the date to blur and that she planned to implement a new (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	labeling process. The Dietary Manager further stated that the Registered Dietitian had indicated the thickener stored in the dry storage area was still acceptable to keep, explaining that the use˜by date referred to freshness; however, she confirmed that the product was not to be used past that date.

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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 Nicotineˆ Induced 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 Selfˆ Care, 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 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 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations and staff interviews, the facility failed to ensure the confidentiality of resident medical records for one of 71 sampled resident (R) (R 67).Findings include:Observation on 04/18/2026 at 10:57 AM, Licensed Practical Nurse (LPN) AA locked the medication cart and walked away from the medication cart leaving the computer screen open and with the R67's medication list and information exposed. LPN AA entered R67's room and placed the glucometer on R67 bedside table without a barrier. LPN AA dropped the test strip on the floor and left the room to retrieve another test strip. LPN AA returned to the medication cart, unlocked the cart and retrieved a test strip. LPN AA again walked away from the med cart then turned around and looked at the computer screen and closed the screen.Interview on 04/18/2026 at 11:15 AM with LPN AA revealed that she should have locked the computer screen before she walked away from the med cart. She stated that when she came back to the cart it was too late.Interview on 04/19/2026 at 2:30 pm with Registered Nurse (RN) KK revealed that her expectation is for nurses to lock or cover the computer screen when they walk away from the medication cart.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the facility policy titled Resident Assessment - Coordination with PASARR Program, the facility failed to conduct a Preadmission Screening and Resident Review (PASARR) Level II assessment for one of 24 sampled residents (R28). This deficient practice had the potential to affect residents who required Level II PASARR specialized services.Findings include:A review of the facility policy dated 12/19/2022 titled Resident Assessment-Coordination with PASARR Program revealed:Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority.Record review revealed R28 was admitted to the facility on [DATE] with diagnoses including, but not limited to: Bipolar disorder, Anxiety disorder, Schizophrenia, Psychotic disorder (other than schizophrenia), and Depression (other than bipolar). Medications listed included but were not limited to: Ativan 1 mg three times a day, Haloperidol 10 mg two times a day, Depakote 500 mg two times a day, and Olanzapine 20 mg at bedtime.Review of the PASRR Level I application Resident Identification Screening Instrument revealed R28 had Schizophrenia and another mental disorder; however, no date was documented.Review of R28's Quarterly Minimum Data Set (MDS) dated [DATE] revealed in Section A (Identification Information) that the Preadmission Screening and Resident Review (PASARR) Level II assessment was not selected. Review of Section C (Cognitive Patterns) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Section I (Active Diagnoses) documented diagnoses including, but not limited to, anxiety disorder, depression, bipolar disorder, and psychotic disorder.Review of R28's Care Plan Report revealed a Focus indicating R28 was at risk for adverse effects of antipsychotic medication. R28 used antipsychotic medications related to behavior management, disease process, schizophrenia, dementia, and major depressive disorder.Review of R28's clinical record revealed no PASRR Level II.Interview on 04/18/2026 at 9:37 AM with the Social Services Director (SSD) revealed the SSD stated that on R28's initial application he had a diagnosis of Alzheimer's. She stated he also had diagnoses of another mental disorder and schizophrenia. The SSD stated she realized this past Wednesday that R28 did not have a Level II PASRR. She stated she spoke with the Administrator and the Business Office Manager (BOM), and they were in agreement that he should have a Level II. She stated she had not submitted for a Level II yet because she needed the Medical Director to complete another DMAˆ6. She stated the MD was available by phone, and she planned to try to reach him on Monday. The SSD stated she was responsible for PASRRs and acknowledged it was an oversight on her part.Interview on 04/18/2026 at 9:51 AM with the Business Office Manager (BOM) revealed the BOM stated the SSD told her on Wednesday that R28's diagnoses on his DMAˆ6 might trigger a Level II PASRR. The BOM stated the SSD told her she would resubmit. The BOM stated she had not seen R28 or noticed any behaviors because her office was located in the front of the building.Interview on 04/18/2026 at 9:55 AM with the Administrator revealed that R28 should have Level II PASARR. She stated they had their mock survey on Wednesday, and it was discovered at that time that he did not have Level II. She stated they were cited on PASRRs a couple of years ago. The Administrator stated she did not have an excuse for R28 not having a PASRR Level II.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews, the facility failed to provide effective infection control practices related to fingerstick blood sugar checks for one of 24 sampled resident(R) (R67).During medication administration on 04/19/2026 at 10:57 AM, Licensed Practical Nurse (LPN) AA removed the glucometer from the medication cart, sanitized her hands, cleaned the glucometer, and placed it in her gloved hand. LPN AA entered R 67 room and placed the glucometer directly on the resident's bedside table without a barrier. LPN AA wiped R67's right index finger with an alcohol pad and performed the blood glucose fingerstick. After completing the procedure, LPN AA cleaned the glucometer with a disinfectant wipe and placed the wet glucometer directly on top of the medication cart to dry without a barrier.An interview conducted on 04/18/2026 at 11:15 AM with LPN AA revealed she had no explanation for why she did not place a barrier between the resident's bedside table and the glucometer.An interview conducted on 04/19/2026 at 2:30 PM with Registered Nurse (RN) KK revealed that her expectation was for nurses to use a barrier between the glucometer and the resident's bedside table during blood glucose testing.