STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115705	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks - Bethany Skilled Nursing, The	1305 East North Street Vidalia, GA 30475

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, and record review, the facility failed to ensure one out of 20 sampled Residents (R) (RA) was assessed to safely self-administer medications and that unauthorized and unsecured medications were not left at the bedside. This deficient practice placed RA at risk for unsafe medication use and allowed unsecured medications to be accessible to other residents and visitors.Findings include:Review of clinical records revealed RA was admitted to the facility with diagnoses that included, but were not limited to, gastroesophageal reflux disease (GERD), oropharyngeal phase dysphagia, chronic kidney disease, diabetes, hypertension, and atrial fibrillation. Review of the Quarterly MDS assessment dated [DATE] for R14 revealed Section C (Cognitive Patterns), a BIMS score of 12 out of 15 which indicated moderate cognitive impairment.During observations on 7/30/2025 at 10:33 am, 8/6/2025 at 10:46 am and on 8/19/2025 at 12:00 pm, two thick white tablets were observed sitting on RA's overbed table, which was positioned in front of her, while she was lying in bed, in her room. During the observations, RA stated the tablets were for gas relief, and that the nurses had given them to her, and she took them after meals. Review of RA's clinical record revealed a physician's order, dated 6/7/2025, for two, 80 milligram (mg) chewable Gas Relief tablets to be administered four times a day as needed for a diagnosis of GERD.Review of the care plan for RA revealed no evidence that RA was care planned for self-administration of medication or for medications to be kept at bedside.Review of the Self-Administration of Medication evaluation form dated 6/10/2025 revealed that RA was assessed as not wanting to self-administer medications and that staff would give medications.Following the observation on 8/19/2025 at 12:00 pm of medication in RA's room, Licensed Practical Nurse (LPN) BB was interviewed and observed the medication in RA's room at 12:10 pm. She confirmed the medication was Gas Relief tablets and stated that she had not given any Gas Relief tablets to RA that day. LPN BB stated that she only gave them to RA when she asked, and that she did not ever leave any medication in the room.During an interview on 8/19/2025 at 3:00 pm the Director of Health Services (DHS) confirmed that the medication should not have been left in RA's room.

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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	115705	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks - Bethany Skilled Nursing, The	1305 East North Street Vidalia, GA 30475

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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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record reviews, the facility failed to ensure that the care plan intervention of a floor mat at bedside was implemented for one out of 20 sampled residents (R) (R8). The deficient practice placed R8 at risk for safety and injury.Findings include:Review of clinical records revealed R8 was admitted to the facility with diagnoses that included dementia, chronic obstructive pulmonary disease, polyneuropathy, generalized anxiety disorder, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for R8 revealed Section B (Hearing, Speech, Vision) indicated highly impaired vision, Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated severe cognitive impairment and Section GG (Functional Abilities and Goals) indicated the need for assistance with Activities of Daily Living (ADL) care.Review of progress notes for R8 dated 6/25/2025 at 2:43 pm revealed, a nurse note entry that documented R8's roommate reported that the resident was on the floor. R8 was observed lying on her back on the right side of the bed, near the air conditioner unit. An abrasion was noted to her forehead. The nurse note entry also documented that neurological checks were initiated and were within normal limits, with R8 being alert, oriented to person and confused as per usual for the resident. A floor mat was placed on the floor at bedside to prevent further occurrences.Review of the care plan with problem start date of 4/7/2020 revealed R8 was at risk for falls related to impaired mobility, weakness, cognitive deficits, impaired vision, and psychotropic medication use. Following the fall on 6/25/2025, the fall risk care plan was updated to include an intervention of a fall mat to bedside, dated 6/25/2025.During observations on 8/14/2025 at 2:27 pm, 8/18/2025 at 1:18 pm, and 8/19/2025 at 12:15 pm, R8 was lying in bed, in her room. There was no fall mat on the floor on either side of her bed, as care planned.During an interview on 8/19/2025 at 2:10 pm, when questioned about whose responsibility it was to implement a new intervention following a fall, the Administrator responded that it could be any one of the staff, but it would be the unit manager's responsibility. Cross reference to F689

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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	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** Based on observations, staff and resident interviews, and record review, the facility failed to ensure that a floor mat was in place for one out of 20 sampled Residents (R) (R8), as a fall intervention. The deficient practice created a potential risk for safety and injury for the resident. Findings include:Review of clinical records revealed R8 was admitted to the facility with diagnoses that included dementia, chronic obstructive pulmonary disease, polyneuropathy, generalized anxiety disorder, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for R8 revealed Section B (Hearing, Speech, Vision) indicated highly impaired vision, Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 2 out of 15 which indicated severe cognitive impairment and Section GG (Functional Abilities and Goals) indicated the need for assistance with Activities of Daily Living (ADL) care.Review of progress notes for R8 dated 6/25/2025 at 2:43 pm revealed, a nurse note entry that documented R8's roommate reported that the resident was on the floor. R8 was observed lying on her back on the right side of the bed, near the air conditioner unit. An abrasion was noted to her forehead. The nurse note entry also documented that neurological checks were initiated and were within normal limits, with R8 being alert, oriented to person and confused as per usual for the resident. A floor mat was placed on the floor at bedside to prevent further occurrences.Further review of progress notes for R8 dated 6/26/2025 revealed, a Patient at Risk (PAR) note entry that documented the interdisciplinary team (IDT) met and reviewed R8's recent fall. The PAR note included that a fall mat was placed at the bedside to reduce the risk of injury related to falls. However, during observations on 8/14/2025 at 2:27 pm, 8/18/2025 at 1:18 pm, and 8/19/2025 at 12:15 pm, R8 was lying in bed, in her room, with no fall mats on the floor on either side of her bed.During an interview on 8/19/2025 at 2:33 pm, the Director of Health Services (DHS) stated that R8's fall mat was in her room, but it was behind the chair. The DHS stated that the housekeeper may have forgotten to put it back down after she cleaned the room. Cross Reference to F656