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	04/30/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and review of the facility's policy titled Discharge Planning, the facility failed to ensure a safe and appropriate discharge for one of one sampled (R)(R113). The facility discharged R113 to an environment that was not safe, placing R113 at risk for psychosocial and physical harm.Findings Include:A review of the facility's policy titled, Discharge Planning last revised on 02/24/2025, documented, .The Discharge Summary provides the necessary information to continuing care providers pertaining to the course of treatment while the resident was in the facility and the patient/resident's plan for care after discharge, including but not limited to the following: Discharge Recapitulation of Stay Form. Notice of Discharge will be issued 1 day prior to the discharge date , Matrix Care Continuity of Care Document (CCD)- Reconciliation of all pre-discharge with post discharge medications.Procedure:.7. The Discharge Summary includes the Discharge Recapitulation of Stay Form, CCD, Discharge Summary and a copy of the face sheet. The policy also revealed, the Senior Care Partner, SSD, or Administrators designee provides oversight for the completion of this process and reviews all aspects of care with the patient /resident and patient representative.A review of R113 admissions records revealed that the resident was admitted to the facility on [DATE] and discharged on 12/02/2025 with diagnoses that included: Chronic obstructive pulmonary disease with (acute) exacerbation, essential hypertension and muscle generalized weakness.Review of the most recent Quarterly Minimum Data Set (MDS) dated [DATE] documented that R113 had a Brief Interview for Mental Status (BIMS) of 0 indicating severe cognitive impairment.A review of the care plan for R113 revealed the facility failed to identify and address discharge planning needs, including coordination of community resources (services and agencies) necessary to support a safe transition and promote quality of life in the community.A review of the resident notes report for R113 dated 12/02/2025 revealed that the Notice of Medicare Non-Coverage (NOMNC) was received on 11/26/2025 after the Minimum Data Set (MDS) Coordinator had left for the day. The MDS Coordinator was off for the holiday, and the resident was not informed of the last covered day (LCD). On 12/01/2025, R113 left the building at 8:50AM before MDS Coordinator was made aware that he did not receive the NOMNC. MDS Coordinator left the NOMNC in room R113 as he did not return until 11:00PM.Further review of the resident notes report revealed that the patient never received a timely NOMNC prior to discharge.A review of the NOMNC revealed that the coverage ended on 11/28/2025.Review of financial records for R113 revealed that insurance coverage ended on 11/28/2025; however, services continued through 12/02/2025. Charges for 11/29/2025 through 12/01/2025 were written off, indicating a lack of coordination related to coverage status and discharge planning.A telephone interview on 04/29/2026 at 12:04 PM with resident representative (RR) of R113 who stated she was unsure of the circumstances surrounding R113's discharge from the nursing facility. She provided a contact telephone number for R113.A telephone interview on 04/29/2026 at 12:08 PM with R113 revealed he felt he was discharged inappropriately. He reported that he was sitting at the dining table eating breakfast when staff informed him he was being discharged after he finished his meal. He stated he was not aware of the discharge, as no notice had (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been provided. The resident further reported that he attempted to speak with the Director of Nursing (DON) but was refused a meeting. He stated he then contacted his brother to pick him up, packed his belongings, and waited outside the facility for transportation.Interview on 04/29/2026 at 1:35 PM with the Social Services Director (SSD) revealed she had been employed at the facility for approximately four months. The SSD stated the resident was admitted for rehabilitation services and that the length of stay is determined by the resident's insurance coverage. She further stated that the MDS Coordinator is responsible for completing the NOMNC. The SSD indicated that residents are notified of discharge, and if the resident is difficult to understand, the family is notified instead. She acknowledged that there have been occasions when residents were provided only a oneˆ to twoˆday notice of discharge when a fiveˆday notice is required. She further stated there have also been instances in which residents were not prepared for discharge due to late notification and therefore remained in the facility past the intended discharge date .Interview on 04/29/2026 at 1:55 PM with MDS Coordinator revealed that R113 was admitted to the facility from the hospital for therapy services. She provided a copy of the NOMNC, which had not been uploaded into the Electronic Health Records (EHR). The document did not contain the resident's signature. She stated it was difficult to locate the resident due to his frequent sign-in and sign-out from the facility. She reported that she left a copy of the NOMNC at the nursing station for staff to obtain the resident's signature; however, the document was not signed. She further stated that upon returning from the holidays on 12/01/2025, she personally presented the NOMNC to the resident; however, no signature was obtained. She confirmed that she did not notify R113 of the NOMNC or provide the discharge notice within the required timeframe to ensure appropriate and timely discharge planning.Interview on 04/29/2026 at 1:55 PM with MDS Coordinator revealed that R113 was admitted to the facility from the hospital for therapy services. She provided a copy of the NOMNC, which had not been uploaded into the EHR. The document did not contain the resident's signature. She stated it was difficult to locate the resident due to his frequent sign-in and sign-out from the facility. She reported that she left a copy of the NOMNC at the nursing station for staff to obtain the resident's signature; however, the document was not signed. She further stated that upon returning from the holidays on 12/01/2025, she personally presented the NOMNC to the resident; however, no signature was obtained. She confirmed that she did not notify R113 of the NOMNC or provide the discharge notice within the required timeframe to ensure appropriate and timely discharge planning.Interview on 04/30/2026 at 1:48 PM with the East Wing Unit Manager revealed that the NOMNC is received by the MDS Coordinator, who is responsible for notifying the resident of the anticipated discharge and obtaining the required resident signature. The MDS Coordinator then forwards the NOMNC to the Social Services Director (SSD), who initiates the discharge process. The East Wing Unit Manager stated she was not aware of the specific incident involving R113. She confirmed that residents should receive a notice of discharge prior to the discharge date to ensure an appropriate and safe discharge process. She further stated that discharge planning includes arrangements such as medications, home health services, or family support, and that failure to complete a proper discharge process may result in residents not receiving necessary services.Interview on 04/30/2026 at 5:42 PM with the Administrator confirmed that the discharge of R113 was inappropriate. She stated it is her expectation that the MDS Coordinator and SSD ensure all residents receive an appropriate discharge that meets facility and state requirements, including a safe discharge to the community or an alternate plan of the resident's choice. She further stated she plans to provide training to staff related to weekend discharge processes to ensure compliance with required discharge planning procedures.

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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, interviews, and review of the facility's policy titled, Oxygen Safety and Storage, it was determined that the facility failed to ensure there were no freeˆstanding oxygen cylinder tanks in one of 13 rooms (room [ROOM NUMBER]) on East Hall. This deficient practice has the potential to place residents at risk for accident or injury. Findings Include:A review of the facility policy titled Oxygen Safety and Storage revealed that it is the policy of [Facility Name] to assure that oxygen is administered and stored safely within the healthcare centers or outside storage areas.The Storage section further revealed: 1. Assure that oxygen tanks kept in storage rooms are either chained to the wall or installed on a stable, wheeled dolly or floor stand.Record review of R7 's electronic health record revealed the following diagnoses but not limited to chronic pulmonary obstructive disease and history of pneumonia.Review of R7's admission Minimum Data Set (MDS), dated [DATE], for Section C (Cognitive Patterns) revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating cognitive awareness with little to no periods of confusion. Review of Section O (Special Treatments, Procedures, and Programs) for R7 did not reflect oxygen therapy.Review of R7's physician order does not reflect oxygen therapy.Observations on 04/28/2026 at 4:46 PM, 04/29/2026 at 8:55 AM, and 04/29/2026 at 2:19 PM in room [ROOM NUMBER] East B revealed that a portable oxygen tank was on the floor in the corner of the room next to the bathroom on all three occasions. Interview on 04/30/2026 at 10:12 AM with Assistant Director of Nursing confirmed that oxygen tank was on the floor. She confirmed that she moved the tank because oxygen tanks should not sit on the floor.Interview on 04/30/2026 at 4:33 PM with Director of Health Services revealed that portable oxygen has to be in a holder at all times. Holders are available on back of wheelchairs and with wheels. She admits that therapy was educated about storage of oxygen.Interview on 04/30/2026 at 5:06 PM with Administrator revealed that portable oxygen tanks in a resident's room should be kept in holders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of the facility policy titled Medication Storage in the Healthcare Centers, the facility failed to ensure a medication cart was locked or under direct supervision of authorized staff in an area accessible to residents for one of two wound care carts (West Unit). This deficient practice had the potential to allow resident access to unsecured medications.Findings Include:A review of the facilities policy titled, Medication Storage in Healthcare Centers, revealed that medications and biologicals are stored safely, securely, and properly following manufacturer recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, Certified Medication Assistants, and pharmacy personnel. Under step three procedure the policy reflects that nursing staff and medication aids who administer medications are responsible for the cleaning and organization of medication carts and storage areas.Observation on 04/29/2026 at 11:39 AM revealed that the treatment cart located on the [NAME] One unit was positioned in front of room [ROOM NUMBER] West, unlocked, with the bottom drawer open.Interview with Licensed Practical Nurse (LPN) DD on 04/29/2026 at 11:39 AM revealed that she had been behind the curtain and could not see the cart. She confirmed that the treatment cart was unlocked and the bottom drawer was open. She admitted that the drawer should have been closed and the cart locked.Observation and interview on 04/29/2026 at 2:39 PM of the East Two-unit medication cart with LPN CC revealed that the third and fourth drawers contained a dirtˆlike substance in the back of the cart. One packet of Zofran (nausea medication) was observed loose in the middle drawer and did not have a label with a resident's name. During interview, LPN CC stated she was unsure whom the Zofran belonged to. She admitted that nurses were responsible for cleaning the medication carts.Interview on 04/30/2026 at 4:00 PM with the Pharmacy Consultant revealed that he evaluated the cleanliness of the carts monthly. He stated he wrote a monthly report and informed the nurse when a medication cart needed attention.Interview on 04/30/2026 at 5:59 PM with the Director of Health Services (DHS) revealed that medication carts, including medication and wound carts, were to remain locked at all times when not in use. She stated the carts were to be locked so they were not accessible to unauthorized individuals. She confirmed that nurses were responsible for keeping medication carts clean and free of expired medications.