STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115712	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seminole Manor Nursing Home	100 Florence Street Donalsonville, GA 39845

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 16683 Based on observation, staff interviews, record review, and review of the facility policie titled Dignity and Routine Resident Checks, the facility failed to provide care in a manner to promote dignity and respect for five of seven residents (R) (R3, R9, R57, R60, and R54) who were noted to have food spills on their clothing or dirty, jagged fingernails. This failure had the potential to diminish R3, R9, R57, R60, and R54's quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life. Findings include: A review of the facility policy titled Dignity, last reviewed and revised on 6/19/2024, revealed the following: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances hir or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. A review of the facility policy titled Routine Resident Checks, last reviewed and revised on 4/2025, revealed the following: Staff shall make routine resident checks to maintain resident safety and well-being . Policy Interpretation and Implementation 1. To ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each unit at least once per each 8-hour shift. 2. Routine resident checks should occur more frequently for residents that are not able to call for assistance based on their individual needs. Residents that are able may call for assistance as needed for any care needs to be performed. This involves entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc. 1. Review of R57's medical record revealed he was admitted to the facility on [DATE], and diagnoses included diabetes mellitus with diabetic neuropathy, age-related nuclear cataract, and bilateral vitreous degeneration. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of his most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/27/2025, R57 achieved a score of 13 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. The assessor also documented on this MDS that R57 had impaired vision and impairments in functional range of motion in both upper and lower extremities. During the seven-day look-back period established by the ARD of 2/27/2025, the resident did not exhibit any rejection of care. Under Section GG (Functional Abilities and Goals), the assessor documented that R57 required set-up or clean-up assistance with eating. (Set-up or clean up assistance was defined as: Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.). The assessor also documented that R57 was dependent with personal hygiene (defined as: The ability to maintain personal hygiene, including combing hair, shaving, applying make-up, washing/drying face and hands (excludes baths, showers, and oral hygiene. Dependent was defined as Helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.) Review of the resident's Comprehensive Care Plan revealed a Problem, dated 12/17/2024, which noted, [Name of R57] requires partial/dependent assistance from staff for ADLS [activities of daily living] R/T [related to] immobility. The goal associated with the problem was: [Name of R57]'s ADLs will be met per staff as needed. Review of a quarterly Registered Dietitian Progress Note recorded, dated 3/5/2025 at 2:05 pm, found: . He [R57] will not sit up to eat but is able to feed himself, using a divided plate. Observation on 4/22/2025 at 11:58 am revealed R57 in his room, wearing a hospital gown while lying in bed. Some food was observed on the front of his hospital gown, although he was not actively eating at the time of observation. No meal tray was present on his overbed table, indicating that someone had removed his meal tray from his room after he finished eating his breakfast that morning. 2. Review of R3's medical record revealed he was readmitted to the facility on [DATE], and diagnoses included: multiple sclerosis, muscle spasms, other specified disorders of muscle, encounter for attention to gastrostomy. Review of his most recent MDS assessment, with an ARD of 2/19/2025, R3 achieved a score of 15 out of 15 on the BIMS, which indicated the resident was cognitively intact. The assessor also documented on this MDS that R3 had impairments in functional range of motion in both upper and lower extremities. During the seven-day look-back period established by the ARD of 2/19/2025, the resident did not exhibit any rejection of care. Under Section GG (Functional Abilities and Goals), the assessor documented that R3 was dependent with eating. The assessor also documented that R3 was dependent with personal hygiene. Review of the resident's Comprehensive Care Plan revealed a Problem, dated 4/2/2019, which noted, [Name of R3] is dependent on staff for ADLs R/T MS (Multiple Sclerosis). He will reject care at times. The goal associated with the problem was: [Name of R3]'s ADLs [sic] will be met per staff. A review of the resident's Physician Orders noted the following active orders: Oral Meals Only When Out Of Bed And Seated At 90 Degrees, Dated 4/9/2025. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regular, Dys Adv [Dysphagia Advanced] Special Instructions: Add Ice Cream To Tray No Liquids, Dated 4/4/2025. May Have Pleasure Snacks By Mouth If Requested, He May Have Sherbert Or Ice cream Along With Solid Snacks Three Times A Day [Sic], Dated 3/20/2025. Observation on 4/22/2025 at 10:17 am revealed R3 in his room, wearing street clothes, seated in his wheelchair beside his overbed table, operating his computer tablet. Some food was observed on the front of his shirt and on his overbed table, although he was not actively eating at the time of observation. No meal tray was present on his overbed table, indicating that someone had removed his meal tray from his room after he finished eating his breakfast that morning. 3. Record review revealed R60 was readmitted to the facility on [DATE], and diagnoses included vascular dementia with behavioral disturbance, disorganized schizophrenia, and moderate intellectual disabilities. Review of his most recent MDS assessment, with an ARD of 4/3/2025, R60 achieved a score of zero out of 15 on the BIMS, which indicated the resident was severely cognitively impaired. During the seven-day look-back period established by the ARD of 4/3/2025, the resident rejected care one to three days during the look-back period. Under Section GG (Functional Abilities and Goals), the assessor documented that R60 required setup or clean-up assistance with both eating and personal hygiene. Review of the resident's Comprehensive Care Plan revealed a Problem, dated 1/17/2025, which noted, [Name of R60] requires assistance with ADLS R/T ID [intellectual disability] & Dementia. The goal associated with the problem was: [Name of R60] will receive adequate assistance with hygiene on a daily basis, AEB [as evidenced by] clean, neat appearance. [sic] Observation on 4/22/2025 at 11:06 am revealed R60 in the lounge area on South Hall, wearing a bright green T-shirt with orange stains down the front. Observation on 4/22/2025 at 11:58 am revealed R60 in the dining room, seated at a table, and wearing a bright green T-shirt with orange stains down the front. Observation on 4/22/2025 at 12:30 pm revealed R60 found him walking independently from the South Hall to the lobby after lunch at 12:30 pm on 4/22/2025, wearing a bright green T-shirt with orange stains down front. Observation at 7:08 am on 4/24/2025 revealed R60 independently propelling himself in a manual wheelchair down South Hall wearing a white T-shirt with orange stains down the front. During an interview at 8:10 am on 4/24/2025, the Activity Director (AD) was asked if R60 dressed himself. The AD replied, Yes and no . He does dress himself. When told he was wearing a white T-shirt with an orange stain on it, the AD stated, That's probably cocoa . He will change it if you ask him to. Observation on 4/24/2025 at 9:22 am revealed R60 standing at the nursing station. He was wearing a bright green T-shirt under a camouflage jacket. The green T-shirt had an orange stain down the front. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 4/24/2025 at 1:14 pm revealed R60 found him sitting in a recliner in the lobby. He was wearing a bright green T-shirt under a camouflage jacket. The green T-shirt had an orange stain down the front. In an interview on 4/24/2025 at 1:15 pm, Certified Nursing Assistant (CNA) EE, who was also in the lobby, stated the stain on R60's shirt was probably from cocoa or a chocolate drink. 4. Record review revealed R9 was readmitted to the facility on [DATE] and was admitted to Hospice services on 9/3/2024 for congestive heart failure. Review of the most recent MDS, with an ARD of 1/30/2025, R9 achieved a score of 14 out of 15 on the BIMS, which indicated the resident was cognitively intact. During the seven-day look-back period established by the ARD of 1/30/2025, the resident had no documented episodes of rejecting care. Under Section GG (Functional Abilities and Goals), the assessor documented that R9 was dependent with personal hygiene. Review of the resident's Comprehensive Care Plan revealed a Problem, dated 3/11/2019, which noted, [Name of R9] requires limited assistance with ADLS R/T debility. The goal associated with the problem was: [Name of R9] will receive adequate assistance with hygiene on a daily basis AEB clean, neat, appearance. [sic] Observation on 4/24/2025 at 7:22 am revealed R9 lying in bed wearing a hospital gown with the covers pulled over his right arm. An observation of his left hand found the fingernails to be dirty and jagged. 5. Record review of R54 showed an admitted [DATE] for hospice care related to a diagnosis of lung cancer. The Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Observation on 4/22/2025 at 2:22 pm revealed R54's fingernails were dirty and untrimmed. Further observation revealed R54 had dried food on her hands, face, and clothing. She did not answer when asked about her fingernails and the dried food. During an interview beginning at 4:38 pm on 4/25/2025, the Administrator was asked about her expectations for staff rounding and providing residents with assistance with personal hygiene. The Administrator stated she would expect that staff would round every two hours. The Administrator also stated that, depending on where the resident was when found soiled, she would expect different staff to assist the resident to clean up. Regarding fingernail care, the Administrator stated each resident's assigned aide was responsible for the care of a resident's fingernails, including cleaning and clipping or shaping them. 45143 46565

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16683 46565 Based on observation, staff interview, record review, and review of the facility policy titled Call System, Resident, the facility failed to ensure one of 41 sampled residents (R) (R9) call devices was within reach. Findings include: Review of the facility policy titled Call System, Resident, last reviewed and revised on 4/22/25, revealed the following: Policy Heading: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed by push button cord, from toileting/bathing facilities and from the floor . 3. The resident call system remains functional at all times . Cords are to be placed easily in reach of resident. 4. If a resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan. [sic] Record review revealed R9 was readmitted to the facility on [DATE] and was admitted to Hospice services on 9/3/2024 for congestive heart failure. Review of the MDS, with an ARD of 1/30/2025, R9 achieved a score of 14 out of 15 on the BIMS, which indicated the resident was cognitively intact. During the seven-day look-back period established by the ARD of 1/30/2025, the resident had no documented episodes of rejecting care. Under Section GG (Functional Abilities and Goals), the assessor documented that R9 required partial to moderate assistance with eating and substantial to moderate assistance with activities of daily living. Review of the resident's Comprehensive Care Plan revealed a Problem, dated 3/11/19, which noted, [Name of R9] requires limited assistance with ADLS R/T debility. The goal associated with the problem was: [Name of R9] will receive adequate assistance with hygiene on a daily basis AEB [as evidenced by] clean, neat appearance. [sic] Observation on 4/24/2025 at 7:22 am revealed R9 lying in bed wearing a hospital gown with the covers pulled up, covering his right hand. The resident's left hand was free. Observation revealed the call bell cord was wrapped around the right upper half bed rail, with the pendant dangling down below the half rail and not within the resident's reach. In an interview on 4/24/2025 at 7:29 am, Licensed practical Nurse (LPN) BB verified that R9's call device was not within his reach and placed it within his reach. During an interview beginning at 4:38 pm on 4/25/2025, the Administrator stated her expectation was that the call light should be readily accessible to the resident at all times.

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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. 45143 Based on observation and staff interview, the facility failed to ensure four of 42 sampled residents (R) diagnoses were kept private and confidential. This failure had the potential to affect all residents with a diagnosis of diabetes living in the facility. Observation on 4/22/2025 at 9:30 am revealed that an undated handwritten list titled Diabetics was seen posted on the wall in the activity room. There was a window between the lobby and the activity room that allowed clear visibility of the list to anyone visiting the facility. The activity room was used daily by residents and staff. During an interview with the Activities Director on 4/24/2025 at 2:35 pm, she stated that the list was used to ensure residents with diabetes received snacks appropriate for them and acknowledged that she was unaware that posting that sign was a privacy and confidentiality issue.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16683 Based on observation, staff interviews, record review, and review of the facility policies titled Nebulizer Equipment and Oxygen Equipment, the facility failed to maintain respiratory equipment in a sanitary manner for four residents (R) (R9, R14, R28, and R37) of 41 sampled residents. Findings include: Review of the facility policy titled Nebulizer Equipment, with a review date of 11/2024, revealed the Purpose section stated, It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using the proper technique and standard precautions. The Procedure section included Care of the Equipment 1. Clean after each use. 2. Wash hands before handling equipment. 3. Disassemble parts after every treatment. 4. Rinse the nebulizer cup and mouthpiece with water. 5. Shake off excess water. 6. Air-dry on an absorbent towel. 7. Once dry, store the nebulizer cup and mouthpiece in provided storage container. 8. Routinely change nebulizer tubing every 14 days, and as needed before. 9. Periodically disinfect the unit per the manufacturer's recommendations. Review of the facility policy titled Oxygen Equipment, with a review date of 11/2024, revealed the Purpose section included, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. The Procedure section included Care of the Equipment 1. Care of the Concentrator: . c. Nurse responsibilities: i. Change oxygen tubing and mask/cannula every 14 days with date label, and as needed if it becomes soiled, contaminated, or damaged. 1. Review of R28's Comprehensive Care Plan revealed a Problem, dated 2/26/2025, which noted: [Name of R28] has scheduled nebulizer treatments R/T [related to] SOB [shortness of breath]. Approaches associated with this problem included: Change tubing and mask as directed by MAR [Medication Administration Record]. Clean Nebulizer mask with water, rinse after each use. Review of R28's Physician Orders revealed an order dated 1/28/2025 for administration of ipratropium-albuterol solution, one three milliliter (ml) vial for inhalation via nebulization twice daily. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R28's MAR dated April 2025 revealed that, between 8:00 am on 4/1/2025 and 8:00 am on 4/24/2025, R28 was to receive a total of 47 doses of the nebulizer treatment. Further review of the MAR revealed she refused 27 nebulizer treatments and accepted and received 20 nebulizer treatments during this same period. The last scheduled nebulizer treatment she received was at 8:00 pm on 4/23/2025. Further review of the MAR revealed no documentation of changing the nebulizer tubing, cup, or mask. Review of R28's Physician Orders revealed no order to change the nebulizer tubing, cup, or mask. Observation on 4/24/2025 at 7:13 am in R28's room revealed a nebulizer compressor on the floor against the wall under the head of R28's bed. The tubing, mask, and nebulizer cup were attached to the compressor. The tubing, nebulizer cup, and mask were not dated. 2. Review of R14's Comprehensive Care Plan revealed a Problem, dated 3/2/2025, which noted: [Name of R14] requires nebulizer treatments 5 [five] times a day R/T COPD [Chronic Obstructive Pulmonary Disease]. Approaches associated with this problem included: Change tubing and mask as directed by MAR. Clean Nebulizer mask with water, rinse after each use. Review of R4's Physician Orders revealed an active order, dated 4/13/2022, for ipratropium-albuterol solution, one three ml vial for inhalation via nebulization to be administered five times per day. The order also contained the following Special Instructions: Clean After Each Use. Rinse With Warm Water & Dry & Store In Container @ [at] Bedside. Review of R14's MAR dated April 2025 revealed the administration times for scheduled doses of ipratropium-albuterol were at 12:00 am, 5:00 am, 9:30 am, 3:30 pm, and 7:30 pm. Further review of the MAR revealed the resident received a dose of ipratropium-albuterol at 5:00 am on 4/24/2025, indicating the nebulizer cup was not disassembled and allowed to air-dry after it was last used. Review of the MAR revealed no documentation of changing the nebulizer tubing, cup, or mask. Review of R28's Physician Orders revealed no order to change the nebulizer tubing, cup, or mask. Observation on 4/24/2025 at 7:16 am of R14's room revealed a nebulizer device in the seat of a chair placed at the bedside. Observation of the nebulizer compressor found tubing connected to the device with the mask connected to an assembled nebulizer cup, both of which were resting on folded white paper towels. Observation of the nebulizer cup revealed droplets of moisture inside the cup, indicating the nebulizer cup had not been disassembled and allowed to air-dry. Further observation revealed no dates on the tubing, cup, or mask. 3. Review of R9's medical record revealed he was readmitted to the facility on [DATE] and was admitted to Hospice services on 9/3/2024 for congestive heart failure. Review Of R9's Comprehensive Care Plan Revealed A Problem, Dated 8/22/2019, Which Noted: [Name Of R9] Requires O2 [Oxygen] @ two lpm [Liters Per Minute] via N/C [Nasal Cannula] As Needed R/T Effects Of COPD With Chronic Bronchitis. Approaches Associated With This Problem Include: Change O2 Tubing Twice Monthly When In Use. Humidify O2 With Sterile Or Distilled Water When In Use And PRN [As Needed] To Prevent Drying Of The Mucous Membranes (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's Physician Orders revealed an order dated 10/1/2024, for O2 at two LPM PRN SOB. Further review revealed there was no order to indicate what days staff should change the oxygen tubing. Observation on 4/24/2025 at 7:16 am revealed R9 receiving O2 at two LPM via a NC, connected to an O2 concentrator. Observation reveled the tubing was undated. During an observation and interview on 4/24/2025 at 7:46 am, Licensed Practical Nurse (LPN) BB confirmed R9's O2 tubing was undated. When asked how often staff were to change the tubing, LPN BB stated, It's set up in the computer for each resident. I think it's weekly. 4. Review of R37's medical record revealed the resident was readmitted to the facility on [DATE], and diagnoses included COPD. Review of R37's Comprehensive Care Plan revealed a Problem, Dated 7/2/2024, which noted: Resident Requires O2 @ 2 Lpm Prn Via N/C R/T Shortness Of Breath And/or Decreased O2 Sats [Oxygen Saturation Levels, Which Refers To The Percentage Of Red Blood Cells That Are Carrying Oxygen In The Blood]. Approaches Associated With This Problem Include: Administer O2 Per MD Order. Change Nasal Canula [Sic] Bubble Humidifier On The 2nd & 4th Wed [Wednesday] Of Each Month When In Use And As Needed. Humidify O2 With Steril [Sic] Or Distilled Water When In Use As Needed To Prevent Drying Of The Mucous Membranes. Review of R37's Physician Orders revealed an order dated 7/2/2024 for O2 at two LPM via NC PRN. Review of R37's MAR for April 2025 revealed the resident had used the O2 14 times in April, with the last use documented as having occurred at 11:17 pm on 4/18/2025. Observation on 4/24/2025 at 7:40 am of R37's room revealed an O2 concentrator set up beside the unoccupied bed next to R37's bed. R37 was not present at the time of the observation. The O2 concentrator was not in use, and the NC tubing, which was connected directly to the O2 concentrator, was rolled up and stuck under the elastic strap intended to secure a bubble humidifier bottle on the front of the concentrator. A section of tubing dangled from the concentrator and was in direct contact with the floor. There was no date on the tubing to indicate when it had been put into service. In an interview on 4/24/2025 at 8:03 am, LPN BB stated R37 normally used his O2 at night, and she would have the tubing changed. In an interview on 4/25/2025 at 4:38 pm, the Administrator stated that after the nebulizer treatments, the nebulizer cup should be taken apart, and the cup and mask were to be rinsed with water and stored on a paper towel inside a plastic container and allowed to air-dry. The Administrator further stated that staff should change the O2 tubing, nebulizer mask, and nebulizer cup every 14 days, and date the tubing when changed. 46565

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 16683 Based on observations, staff interviews, record review, and review of the facility's policies titled Pharmacy Services For Medications and Multi-Dose Vials, the facility failed to ensure routine medications were available for two of four residents (R) (R8 and R62) observed during medication administration. The deficient practice had the potential to place R8 and R62 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: Review of the facility policy titled Pharmacy Services For Medications, review date 4/2025, revealed the Policy Statement included, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. The Policy Interpretation and Implementation section included . 3. Pharmacy services are available to residents 24 hours a day, seven days a week. 4. Residents have a sufficient supply of their prescribed medications and receive medications (routine, emergency, or as needed) in a timely manner. 5. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. Borrowing medications from other residents or from the emergency medication supply because of a failure to order or reorder a medication in time for a resident to receive a scheduled medication is not acceptable practice. 7. Medications are received, labeled, stored, administered and disposed of according to applicable state and federal laws and consistent with standards of practice. Review of the facility policy titled Multi-Dose Vials, review date 8/2024, revealed the Policy section included, It is the policy of [name of facility] to date all vials as they are opened during administration. Medication in multi-dose vials can be used for administration within 28 days of when the vial was opened. 1. Observation on 4/23/2025 at 7:47 am, during medication administration, revealed Licensed Practical Nurse (LPN) DD administering R8's medications. Observation revealed that a scheduled dose of Vitamin D3 1000 units was not in the resident's medication supply. LPN DD checked the medication storage room and stated the medication was not available and she would order it from the pharmacy. 2. Observation on 4/23/2025 at 7:57 am, during medication administration, revealed LPN BB administering R62's medications. Review of R62's Medication Administration Record (MAR) revealed an order for Lantus (insulin glargine) 100 units per milliliter, 15 units subcutaneous once daily at 8:00 am. LPN BB removed a multidose vial of Lantus, which was in its original box. Neither the box nor the vial was labeled with an open date. Observation revealed a pink sticker on the box reading Discard after 28 Days. LPN BB confirmed there was no open date on the insulin, and there was no way to determine the opened date. She checked the medication storage room and confirmed there was no back-up supply of the insulin. LPN BB re-ordered the insulin from the pharmacy. (continued on next page)

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	115712	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seminole Manor Nursing Home	100 Florence Street Donalsonville, GA 39845

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/25/2025 at 4:38 pm, the Administrator stated her expectation was for a back-up container of insulin to be available for each resident prescribed insulin, and for medications to be available as ordered. The Administrator further stated that medications should be reordered prior to the current supply being exhausted.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 16683 Based on observation, staff interviews, record review, and review of the facility's policy titled Pharmacy Services For Medications, the facility failed to ensure the medication error rate was less than 5 percent. A total of 30 opportunities were observed with two errors for two residents (R8 and R62), resulting in an error rate of 6.67 percent. This failure had the potential to place R8 and R62 at risk of medication not being given in accordance with the physician's orders and had the potential to adversely affect the residents' clinical conditions. Findings include: A review of the facility policy titled Pharmacy Services For Medications, reviewed 4/2025, revealed the Policy Statement included, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. The Policy Interpretation and Implementation section included, . 3. Pharmacy services are available to residents 24 hours a day, seven [7] days a week. 4. Residents have a sufficient supply of their prescribed medications and receive medications (routine, emergency, or as needed) in a timely manner. 1. Observation on 4/23/2025 at 7:47 am, during medication administration, revealed Licensed Practical Nurse (LPN) DD administering R8's medications. Observation revealed that a scheduled dose of Vitamin D3 1000 units was not in the resident's medication supply or the back-up medication supply. The medication was not administered. LPN DD verified the medication was not administered and would be an omitted dose. 2. Observation on 4/23/2025 at 7:57 am, during medication administration, revealed LPN BB administering R62's medications. Review of R62's Medication Administration Record (MAR) revealed an order for Lantus (insulin glargine) 100 units per milliliter, 15 units subcutaneous once daily at 8:00 am. LPN BB removed a multidose vial of Lantus, which was in its original box. Neither the box nor the vial was labeled with an open date. Observation revealed a pink sticker on the box reading Discard after 28 Days. LPN BB confirmed there was no open date on the insulin, and there was no way to determine the opened date. There was no back-up or emergency supply of the medication, and the medication was not administered. LPN BB verified the medication was not administered and would be an omitted dose. In an interview on 4/25/2025 at 4:38 pm, the Administrator stated her expectation was for medications to be available for each resident, and medications should be re-ordered before the supply was exhausted.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 16683 Based on observations, staff interviews, and review of the facility's policy titled Medication Storage And Labeling, the facility failed to ensure one of three medication carts was locked and secured when unattended and out of the sight of authorized personnel, failed to ensure expired medications and medical supplies were discarded from the storage room and treatment cart, and failed to ensure a multi-dose vial of insulin was dated when opened. These deficient practices created the potential for residents, unauthorized staff, and visitors to have access to medications and biologicals stored on the medication cart and placed residents at risk of receiving medications with altered effectiveness. The facility's census was 64 residents. Findings include: A review of the facility policy titled Medication Storage And Labeling, review date 4/22/2025, revealed the Policy included, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. The Policy Interpretation and Implementation section included, Medication Storage . 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others . Medication Labeling 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices . 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. 1. Observation on 4/22/2025 at 12:09 pm revealed one medication cart parked in front of the nursing station under a sign delineating the room numbers for South Hall (Rooms 96 through 111). The cart's key lock was popped out, indicating the cart was unlocked, and the surveyor was successful in accessing a drawer full of medications. [NAME] Clerk (WC) CC was sitting at the nursing station and stated Licensed Practical Nurse (LPN) BB was responsible for the unlocked medication cart. Observation revealed LPN BB sitting at a desk behind the nursing station, located in an area without direct line of sight of the cart. At 12:11 pm, LPN BB verified the cart was unlocked, out of her sight, and locked the cart. In an interview on 4/22/2025 at 2:23 pm, the Director of Nursing (DON) stated the medication cart should not be unlocked when out of sight of the nurse. She stated anyone could access its contents, including residents, if left unlocked and unattended. 2. Observation on 4/22/2025 at 11:37 am with the DON of the contents of the storeroom housing central supply revealed the following: One gastrostomy feeding tube - expired 9/23/2022 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One dressing change tray - expired 1/31/2025 One infusion set - expired 9/2016 20 IV [intravenous] start kits - expired 3/1/2023 One box of 50 suction catheters - expired 10/31/2024 two bottles of packing strip dressing - expired 3/20/2025 One box of 10 electrocardiogram tab electrodes - expired 9/2017 One skin staple extractor - expired 3/31/2025 Multiple boxes of absorbent, permeable adhesive film dressings - expired 2/2025 20 male external catheters - expired 3/1/2023 The DON verified the findings. Observation on 4/22/2025 at 1:20 pm with the DON of the treatment cart and supplies stored in the treatment room revealed: One eight-ounce bottle of Hibiclens Chlorhexidine Gluconate - expired 9/2024 One tube of Clotrimazole Cream 1 percent - expired 2/2025 One tube of Clotrimazole Antifungal Cream - expired 9/2024 One bottle of packing strip dressing - expired 3/20/2025 One bottle of packing strip dressing - open with expiration date rubbed off Two multiple-use drawing needles - expired 2/26/2025 Four tuberculin syringes - expired 8/2021 39 packages of skin closures - expired 11/2023 Six occlusive bandage strips - expired 11/30/2024 One 0.9% sodium chloride injection, 20 milliliters (ml) - expired 1/1/2025 One 0.9% sodium chloride injection, 20 ml - expired 11/11/2024 One 12 ml syringe with luer-lock tip - expired 11/16/2024 Six buffered sodium citrate - expired 3/31/2025 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the treatment care revealed the following items were opened, compromising the cleanliness of the items: Two antibacterial foam dressings Two foam dressing One adhesive island dressing One non-adherent pad prepack One wound dressing Three occlusive gauze patch Four occlusive gauze strip One honey impregnated wound dressing Two open packages of non-sterile cotton-tipped applicators, containing a combined total of 84 applicators. The applicators were seen spilling from the open packaging into the cart and would not be considered clean for use in applying anything to an open wound. In an interview on 4/22/2025 at 2:00 pm, the DON confirmed that all items observed were kept past their expiration dates and/or were opened and should not have been available for use. 3. During medication pass observation on 4/23/2025 at 7:47 am, observation revealed LPN DD left a prepared cup of MiraLax on top of the medication cart, parked in the area of a resident's room, when she went to the medication storage room. The medication was left out of her direct line of sight. Upon her return to the medication cart at 7:56 am, LPN DD confirmed she had left the cup of MiraLax unsecured and unattended on top of her cart when she walked to the medication room. 4. During medication pass observation on 4/23/2025 at 7:57 am, observation of LPN BB preparing one resident's (R) (R62) medications revealed one opened multi-use vial of Lantus insulin (a medication used to treat high blood sugar) without an open or discard date. LPN BB confirmed that neither the multi-dose vial nor the box was dated to indicate when the vial was opened. In an interview on 4/23/2025 at 3:24 pm, the DON stated her expectations were for expired medications and medical supplies to be removed from use, and multi-dose vials were to be dated when opened and discarded 28 days after opening. In an interview on 4/25/2025 at 4:38 pm, the Administrator stated her expectations were for medication carts to be locked and secured when unattended, medications to be secured and not left on top of medication carts when unattended, and expired medications and supplies to be discarded upon expiration dates.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 16683 45143 Based on observations, resident interviews, and staff interviews, the facility failed to serve food to residents that was palatable, attractive, and appetizing. This deficient practice had the potential to adversely affect 62 residents who received meals from the kitchen. Findings include: In a Resident Council meeting on 4/23/2025 at 9:30 am, residents expressed dietary concerns, including that meals were often cold and the food was bland and without flavor. On 4/25/2025 at 5:30 pm, the Administrator ordered a test tray to be brought to the Activity Room. The test tray was carried by a staff member from the Kitchen to the Activity Room and was delivered at 5:32 pm. The dinner plate was covered with a dome lid, and an insulated bowl, and all beverage cups were covered with disposable plastic lids. Two surveyors participated with the Administrator in sampling the test tray. The tray contained the following food items: - One prepackaged bag of barbeque potato chips (one and one-half ounces) - One bowl of broccoli and cheese soup - One chicken salad sandwich on white bread and one serving of green pea salad, which were served on the same plate. Observation revealed that the green pea salad was in a liquid that had spread across the plate and came into contact with the bottom slice of the sandwich's bread, causing the bread to become soggy. The sandwich was cut into four quarters and tasted by all three participants. All participants agreed that the chicken salad was bland and lacked salt and/or seasoning. The soup was found to be lumpy. The temperature of the soup was neither hot nor cold. The soup, when tasted, was bland and of the consistency of condensed soup, as if no water had been added to a concentrated pre-packaged product. The pea salad, when sampled, was neither hot nor cold and tasted like peas without any additional seasoning. The sauce also lacked any seasoning. The Administrator speculated that the sauce was mayonnaise-based and remarked that this salad should have been served cold. All three people who sampled the test tray agreed that the pea salad should have been served in a bowl or with a thicker sauce to prevent the sauce from running across the plate into the sandwich. All three people sampling the test tray agreed with the above findings, and the Administrator stated that most of the residents' complaints were about the supper [evening] meal.

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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. 45143 Based on observations, staff interviews, record review, and review of the facility's policy titled Food: Preparation, the facility failed to ensure sanitary practices were followed during food preparation. This deficient practice had the potential to place the 62 residents who received food from the kitchen at risk of foodborne illness. Findings included: Review of the facility's policy titled Food: Preparation, dated 9/2017, revealed the Procedures section included, .2. Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. Observation on 4/22/2055 at 11:50 am revealed the Dietary Manager (DM) measuring food temperatures of 11 food items on the steam table. The DM used a paper napkin to wipe the residue from the probe thermometer between each food item tested without sanitizing the probe. He then used the probe thermometer to measure the temperature of a bowl of fruit and a bowl of applesauce. When asked about sanitizing the temperature probe, the DM placed the probe in a cup of sanitizing solution and said the same solution used in the sanitization buckets was used in the probe thermometer cup. In an interview on 4/23/2025 at 11:55 am, the DM stated he tried to sanitize the food thermometer probe between each food in a sanitizing solution and provided a box of food probe wipes. The box was tattered and had an illegible date ending in 2025. In an interview on 4/23/2025 at 2:15 pm, the District Manager acknowledged that using a paper napkin to wipe the food thermometer probe between food types was not acceptable, and the expectation was that staff should use a clean probe wipe to sanitize the temperature probe between each food type to prevent cross-contamination. In an interview on 4/25/2025 at 3:32 pm, the Registered Dietitian stated there were probe wipes available to sanitize the probe thermometer between food types, and the expectation was for dietary staff to sanitize the probe between each food type with a new wipe.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46565 Based on observation, staff interview, and review of the facility's policy titled Storage of Records, the facility failed to ensure confidential medical, financial, and legal records were stored in a manner to prevent unauthorized access to the records. This deficient practice had the potential to compromise the confidentiality of resident records. Findings include: Review of the facility's policy titled Storage of Records, reviewed 11/2024, revealed the Purpose section included, .Resident-purged paper records are placed in filing cabinets located in the locked [NAME] Hall storage room. Observation on 4/24/2025 at 4:25 pm, in the copy room across from the Nurse's Station, revealed a bin for storage of medical records to be destroyed that was unlocked, and the door to the copy room was unlocked. Observation on 4/24/2025 at 4:24 pm revealed a shred bin behind the Nurse's Station that was unlocked with the door slightly ajar. The Nurse's Station had an open floor plan with no doors or gates to restrict access to the items behind it. At the time of the observation, multiple staff members were both behind and in front of the nursing station. Observation on 4/24/2025 at 7:20 am revealed that the [NAME] Hall Storage Room used the same entry code as the restroom. Observation of the storage room revealed two two-drawer file cabinets and five four-drawer filing cabinets next to a scale for weighing residents. One of the two-drawer filing cabinets had a label that stated Jan - [DATE] Financial. Another drawer was labeled as COVID-19 2020 - 2022. Another drawer was labeled Social Service Files, and another was labeled Business Office Files. Three cabinets were labeled Resident Files and had unlocked hasps attached. In an interview on 4/25/2025 at 4:37 pm, the Administrator stated that medical and financial records should be stored securely to limit access based on a need-to-know. The Administrator confirmed that locks were being ordered and would be installed to secure the records in the [NAME] Hall Storage Room.