STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115715	A. Building B. Wing	01/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oaks Health Ctr at the Marshes of Skidaway Island	95 Skidaway Island Park Road Savannah, GA 31411

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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 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** 36200 Based on observations, staff and resident interviews, record review, and review of the facility policies titled Administering Medications and Self-Administration of Medications, the facility failed to ensure medications were not left at the bedside of two of 14 sampled residents (R) (R7 and R215) who were not assessed for medication self-administration. This deficient practice had the potential to place R7 and R215 at risk for the unsafe use of medications. Findings: Review of the facility policy titled Administering Medications, dated 2001, revealed the Policy Statement was Medications are administered in a safe and timely manner, and as prescribed. The Policy Interpretation and Implementation section included 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Review of the facility policy titled Self-Administration of Medications, dated 2001, revealed the Policy Statement was Resident have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 1. Review of the medical record for R7 revealed diagnoses that included, but not limited to, anxiety, constipation, and atrial fibrillation. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed R7 had highly impaired vision and a Brief Interview of Mental Status score (BIMS) of 15 (indicating little to no cognitive impairment). Review of the Physician's Orders for R7 revealed no order for over-the-counter medication for stomach relief or diclofenac sodium gel (a topical medication used to treat pain). There also was no order for self-administration of medication for R7. During an observation and interview on 1/18/2025 at 4:57 pm in R7's room, stomach relief pills were found sitting in the window seal, and diclofenac sodium topical gel was found on the overbed table. The Administrator confirmed the medications in the room and informed R7 that the items would have to be removed. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for R215 revealed diagnoses that included, but not limited to, a personal history of transient ischemic attack (TIA), cerebral infarction without residual deficits, unspecified dementia, mild without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the Physician's Orders for R215 revealed no order for medication to treat fever blisters or Voltaren (a topical medication used to treat pain). There also was no order for R215 to self-administer medications. During an observation and interview on 1/18/2025 at 10:40 am with R215, a bottle of pills used to treat fever blisters was observed on the floor by R215's chair, and a tube of Voltaren was observed on the nightstand beside the bed. The Director of Nursing (DON) confirmed that the medications were in the room. The DON expressed that she was unaware the resident had the medications and stated there were no residents in the facility who had been assessed to self-administer medications at this time. The DON informed R215 that she would need to remove the medications because there was no order for them, and the resident reported that she had been taking the medications for years. During an interview on 1/19/2025 at 5:41 am, Licensed Practical Nurse (LPN) DD reported if residents had an order for medication self-administration, they were able to keep medications at their bedside and self-administer.

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F 0656 Level of Harm - 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. 41165 Based on interviews and record reviews, the facility failed to ensure that the care plan was followed for Activities of Daily Living (ADL) ensuring that care was provided by the appropriate number of staff, to prevent accidents, for one of 14 residents (R) (R115), sampled for care plans. Harm was identified to have occurred on 12/16/2024 when R115 fell while receiving ADL care, resulting in bilateral femoral fractures and a right humeral fracture. Findings include: A review of the undated facility policy titled Care Plans, Comprehensive Person-Centered revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. A review of the care plan for R115 date initiated 9/20/2024, revised 12/24/2024, revealed that R115 requires staff assistance for ADLs. Requires maximum to total assistance with ADL care, including but not limited to bed mobility, transfers, locomotion, and toileting. Two persons assistance for ADL care. A review of the Fall Incident Report for R115 dated 12/16/2024 at 7:37 am revealed that the Certified Nursing Assistant (CNA) BB stated she was changing R115's bed linen when she rolled out of bed and hit her head on the floor. The CNA was unable to catch her, so she rolled off the bed onto the floor. Interview on 1/19/2025 at 5:58 am with CNA BB revealed that management normally tells staff what assistance is needed. She reported that she does not remember how many people were needed to provide care for R115 but remembered that when she was in training (day shift), sometimes one person was caring for R115, and there were other times that there were two persons providing care. CNA BB further revealed that it depended on how busy the CNAs were to determine if a second CNA would be available to offer assistance. A nurse is not always available on the night shift due to performing other tasks. She stated that the Director of Nursing (DON) provided a list of residents who were two-person assistance, and the nurse came to help whenever needed. She stated that the Assistant Director of Nursing (ADON) has watched her do a bed change with a resident in bed and signed off on it. Interview with Licensed Practical Nurse (LPN) CC on 1/19/25 at 1:17 pm revealed that she was unaware that R115 was a two- person assistance while she was in bed. LPN CC stated that she rarely needs assistance with R115, and she and CNA BB had just finished repositioning the resident on the bed before the incident. She stated that after the incident, she received education on two-person assistance. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Post survey interview with the Assistant Director of Nursing (ADON) on 1/31/2025 at 1:50 pm revealed the cardex comes from the electronic medical record and staff should print the cardex each shift. The ADON stated care plans are communicated by walking rounds each shift between the CNAs about their residents, and staff should have the cardex on hand. The nurses also do walking rounds each shift. The ADON further revealed that the cardex is specific to each resident showing their activities, bowel and bladder, behavior, nutrition, and precautions. Staff should communicate to each other whether a resident is a one- or two-person assistance with ADLs. Cross reference F689

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45811 Based on observation, staff interviews, record review, and review of the facility policy titled Administering Medications, the facility failed to ensure a medication order was clarified with the physician prior to administering the medication to one of five residents (R) (R12) observed for medication pass. This deficient practice had the potential to place R12 at risk of avoidable medical complications due to a medication dosage order not being clarified prior to administration. Findings included: Review of the facility policy titled Administering Medications, dated 2001, revealed the Policy Statement was Medications are administered in a safe and timely manner, and as prescribed. The Policy Interpretation and Implementation section included 10. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Review of the medical record for R12 revealed diagnoses included, but not limited to, spinal stenosis in cervical region, polyarthritis, polyneuropathy, idiopathic gout, osteoporosis, and sacrococcygeal disorders. Review of R12s Physicians Orders revealed an order dated 9/21/2024 for celecoxib (a medication used to treat mild to moderate pain), one capsule by mouth one time a day. During observation of medication administration by Registered Nurse (RN) AA on 1/18/2025 at 8:45 am, R12 was administered celecoxib 200mg. In an interview on 1/18/2025 at 2:00 pm, RN AA confirmed celecoxib 200 mg was administered to R12 and confirmed the physician's order did not specify the dosage to be administered. In an interview on 1/19/2025 at 9:00 am, the Assistant Director of Nursing (ADON) stated all nurses can transcribe physician orders. She verified that R12's order for celecoxib was not transcribed accurately and should specify a dosage. In an interview on 1/19/2025 at 10:00 am, the Director of Nursing (DON) stated nursing staff was responsible for transcribing physician orders. The DON further stated the consulting pharmacist normally reviewed physician orders when ordered and monthly.

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F 0689 Level of Harm - 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** 41165 Based on record review and staff interviews, the facility failed to protect one of two residents (R) (R115) sampled for falls during Activities of Daily Living (ADL) care. Harm was identified to have occurred on 12/16/2024 when R115 fell while receiving ADL care, resulting in bilateral femoral fractures and a right humeral fracture. Findings include: Review of the Electronic Medical Records (EMR) revealed an admitted [DATE] with a diagnosis of post-polio syndrome, cognitive impairment of unknown etiology, abnormal gait and mobility, hypertensive heart disease without heart failure, contracture right and left foot, and muscle weakness. Record review of the most recent quarterly Minimum Data Set (MDS) for R115 dated 11/12/2024 revealed a Brief Interview for Mental Status (BIMS) score of 05, indicating severe cognitive impairment. Section GG (Functional Abilities and Goals) documented that R115 was dependent on staff for self-care and mobility requires two persons assistance for ADL care. The helper does all of the effort. The resident does none of the effort to complete the activity. A review of the Fall Incident Report for R115 dated 12/16/2024 at 7:37 am revealed at approximately 6:19 am, nursing was alerted to the room by Certified Nursing Assistant (CNA) BB. The CNA BB stated she was changing R115's bed linen when she rolled out of bed and hit her head on the floor. The CNA was unable to catch her, so she rolled off the bed onto the floor. Resident noted to have a hematoma to the right side of her head as well as skin tear to lower right extremity. Both areas were bleeding, and pressure was applied and bleeding controlled. R115 was helped back to bed. Resident was alert and oriented with in her base line. Hospice was notified at 6:27 am and recommend sending resident out to hospital. R115's family member was notified. A report was given to the local hospital at 6:40 am. R115 left the facility via Emergency Medical Services (EMS) at 7:25 am. A review of the hospital Discharge Plan dated 12/16/2024 revealed a disposition of 1. Bilateral femoral fractures, 2. Right humeral fracture. Patient is a Do Not Resuscitate (DNR) and under hospice care at nursing home facility. Interview with the Director of Nursing (DON) on 1/18/2025 at 11:48 am revealed she got a call from the nurse that R115 fell out of bed while CNA BB was putting clean linen on the bed. She stated R115 had a skin tear and a hematoma to her head. DON stated that the doctor gave an order to send R115 to the emergency room (ER) for evaluation. DON stated R115 had injuries of bilateral broken femurs. She stated that a CNA provided care, and R115 rolled out the bed, but CNA BB could not catch the resident. She stated that R115 was on Hospice prior to the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the Medical Director (MD) on 1/18/2025 at 4:17 pm revealed he is familiar with R115 and her care; he stated that she had a fall about a year and a half ago prior to this fall. The MD stated that when R115 was in the hospital, the doctor, along with her family, wished to not repair her femurs due to the risk of surgery being too high. The MD further revealed that the death certificate listed atherosclerotic heart disease (plague builds up and hardens inside arteries) as the immediate cause of death and that R115 also had osteoporosis. He stated that she was under hospice services, had declined prior to her death, and had other natural comorbidities. Interview with CNA BB on 1/19/2025 at 5:58 am revealed she confirmed that she was providing care for R115 on the day of her fall. CNA BB explained that it was towards the end of the shift. She stated that the nurse told her that R115 had a soiled brief. CNA BB reported that she had changed R115 before by herself. She reported that she cleaned R115 up well first and then began changing the linens on the bed. CNA BB stated that the fitted sheet was on the bed, and she instructed R115 to turn on her side and hold on to the bed rail. She further revealed that R115 began moving forward, and she tried to catch her from falling, but she slipped out of her hands and fell . CNA BB reported that R115 seemed to have increased confusion on that day and tried getting out of bed multiple times during her shift. Interview with a Licensed Practical Nurse (LPN) CC on 1/19/2025 at 1:17 pm during the morning medication pass revealed that R115's legs were hanging out of the bed. She asked CNA BB to help her straighten R115 up in bed, and that she was soiled. She stated that she asked CNA BB if help was needed, and CNA BB said no, she had changed her by herself. LPN CC revealed she was later called by CNA BB to R115's, and she saw the resident on the floor in a sitting position with a pool of blood on the floor and a small hematoma on her head, to which she applied pressure and called 911. She stated that R115 never lost consciousness. She revealed that she got help from the upstairs nurse. She further revealed that she noticed a skin tear on the lower right leg, and the LPN CC contacted the hospice nurse, who recommended that she be sent to the ER. She further revealed that the DON was contacted through phone text message. She stated the DON did not come to the facility at that time. A review of the death certificate signed date of 1/31/2025 revealed the cause of death as atherosclerosis heart disease. Further review revealed that R115 was admitted to hospice care on 10/2/2024.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914 Based on observation, staff interview, record review, and review of the facility policies titled Standard Precautions, Dressings, Dry/Clean, and Laundry Services, the facility failed to ensure infection control practices were adhered to during wound care for one of three residents (R) (R12) reviewed for wound care. The facility also failed to ensure laundry practices were conducted so as not to cause cross-contamination of clean linen with soiled linen. The deficient practices had the potential to increase R12's risk of infections due to cross-contamination during wound care and had the potential to place all residents residing in the facility at risk of infections due to cross-contamination due to inappropriate handling of linen. Findings include: Review of the facility's undated policy titled Standard Precautions revealed the Policy Interpretation and Implementation section included 1. Standard precautions apply to the care of all residents regardless of suspected or confirmed presence of infectious disease. The Hand Hygiene section included b. Hand hygiene is performed with alcohol-based hand rub (ABHR), or soap and water (1) before and after contact with the resident; (2) before performing an aseptic task; (3)before moving from work on a soiled body site to a clean body site on the same resident ; (4)after contact with items in the resident's room; and after removing gloves. Review of the facility's undated policy titled Dressing, Dry/Clean revealed the Steps in the Procedure section included 1. Clean bedside stand, establish a clean field. 2. Place the clean equipment on the clean field, arrange supplies so they can be easily reached. 5. Wash and dry your hands thoroughly. 6. Put on clean gloves, loosen tape and remove soiled dressing. 8. Wash and dry your hands thoroughly. Record review revealed R12 had diagnoses of, but not limited to, pressure ulcer of sacral region and pressure-induced deep tissue damage of sacral region. Review of R12's Admission Minimum Data Set (MDS) dated [DATE] revealed Section M (Skin) documented the resident had an unhealed stage four pressure ulcer/injury over the bony prominence. Review of R12's Physician Orders revealed an order dated 12/31/2024 to cleanse the sacral wound with wound cleaner, apply Medihoney (a product used to treat wounds and burns) to wound bed only and cover with foam dressings one time daily. Review of R12's care plan revealed the resident had altered skin integrity related to a pressure wound to the sacral area. The goal indicated skin areas will not worsen through the next review date. Interventions, dated 9/21/2024, included observing for signs and symptoms of infection and notifying the physician if present. Roho cushion in place. Resident states a pillow on top of the cushion is most comfortable. Treatments per physician orders. Air Mattress in place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During wound care observation on 1/18/2025 at 10:15 am conducted by Registered Nurse (RN) AA revealed RN AA came to the conference room to get the surveyor for wound care observation for R12 with the wound care supplies in her ungloved hands that included a tube of Medihoney, dry gauze, Opti foam dressing, and wound cleanser. Observation revealed RN AA took the supplies into the resident's room and placed them on the overbed table that was located against the wall on the left side of the room. Once RN AA donned gloves and a gown, she then placed the supplies on the bedside table by the resident's bed without cleaning or disinfecting the area or placing a barrier on the table to place the supplies on. Continued observation revealed no wound dressing on the area of R12's wound, and the resident was sitting on the side of the bed. RN AA cleaned the wound with the wound cleanser and wiped the area with the dry gauze on the resident's table. After cleaning the wound, the nurse did not remove her gloves to wash or sanitize her hands before applying the Medihoney to the wound bed. Further observation revealed RN AA squeezed an undisclosed amount of Medihoney onto her right index finger, applied it directly to the resident's wound bed with her finger, and applied the Opti foam dressing. In an interview on 1/18/2025 at 10:30 am, RN AA confirmed that she did not provide a clean surface to place the wound care supplies on during R12's wound care. Further interview revealed RN AA confirmed that she did not wash or sanitize her hands at any time during the wound care treatment. RN AA revealed that she was unaware that she should wash her hands and change her gloves during the wound care procedure. In an interview on 1/18/2025 at 11:00 am, the Director of Nursing (DON) revealed that when completing wound care, the nurse should first check the order to ensure that the proper treatment was being completed. Once the order has been verified, the nurse should gather supplies and ensure the area where the supplies will be resting is cleaned and sanitized and a barrier placed on the table. Further interview revealed the expectation was that during wound care, the nurse should change gloves between dirty and clean process during wound care and wash and sanitize hands during those glove changes. In an interview on 1/18/2025 at 2:00 pm, the Administrator revealed that the staff should follow infection control practices when completing wound care and other tasks with residents. 36200 2. Review of the facility policy titled Laundry Services, dated 2014, revealed . 6. Laundry Handling: The community must implement procedures that prescribe how clean laundry and soiled laundry is to be handled. Proper linen handling according to a written procedure will help avoid cross-contamination of clean and soiled laundry. This is an important infection control consideration. Use of universal precautions will reduce the risk of exposure to laundry staff to pathogenic microorganisms. During the initial laundry tour on 1/18/2025 at 10:12 am with the Executive Director, observation revealed no laundry staff present at that time. Observation in the dirty laundry area revealed two clear trash bags with housekeeping cleaning towels and tablecloths in them, sitting on top of full containers of laundry detergent and on the floor next to the laundry detergent. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation and interview on 1/18/2025 at 10:15 am, Housekeeper/Laundry Staff EE reported that she placed the towels in the plastic bags and put them in the soiled room because she had to work in housekeeping as well and had to put them somewhere until she was able to come back to the laundry room to finish processing them. During an interview on 1/18/2025 at 11:42 am, the Director of Nursing (DON) stated that best practice would be for cleaned items to not be stored in the soiled laundry area, even if they were in bags. She stated the clean items would have to be relaundered.