STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115728	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archway Transitional Care Center	4373 Houston Avenue Macon, GA 31206

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, staff interviews, and record review, the facility failed to ensure that furniture in resident rooms and the day room on one of four halls, and in the dining room, were maintained in good repair. These deficient practices had the potential to place residents at risk of living in an unsanitary and unsafe living environment and a diminished quality of life.Findings include: Observations on 12/9/2025 at 10:30 am on the 300 Hall revealed seven armchairs in use in resident rooms and the day room with missing and torn upholstery. Cushion material was visible on the chairs' seats, arms, and backs. Further observations revealed dressers in resident rooms had broken handles and missing drawer fronts. Observations on 12/9/2025 at 11:54 am in the dining room revealed 55 of 55 chairs in disrepair, with torn or missing upholstery and exposed or missing cushioning on the arms, seats, and backs of chairs. Four of the 55 chairs were missing arm padding/cushioning, leaving sharp metal corners exposed.Review of the email correspondence dated 9/6/2023 between the Central Division [NAME] President and the Administrator revealed a request for new furniture, including bedside tables, dressers, and overbed tables. Review of an email correspondence dated 10/1/2025 revealed a request for estimates for 12 pairs of armchair rests for replacement. A follow-up email to the Administrator provided the estimated price. Review of an email correspondence dated 10/2/2025 revealed the Administrator requested the armchair rests to be ordered. Review of an email correspondence dated 10/7/2025 revealed that a corporate representative clarified the items requested for the order, sent a Purchase Order, and the Administrator signed the order. Review of the facility records titled [Electronic System Name] Tasks in Use revealed no evidence of requests for furniture repair or inspections. During concurrent observations and an interview on 12/11/2025 at 11:55 am, the Administrator and Maintenance Supervisor confirmed the armchairs and dressers were in need of repair. The Maintenance Supervisor stated parts had been ordered and had not been delivered. He further stated that all staff could enter a work order, not the electronic notification system, and stated he had not received any work orders for the furniture. The Administrator stated the chairs with missing armrests had been removed from the building, but kept reappearing. The Administrator stated it was her expectation to have resident furnishings and dining chairs in good repair for the facility.In an interview on 12/11/25 at 2:00 pm, the Administrator stated she had spoken with the corporate office over the course of two years to request new furniture.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115728	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archway Transitional Care Center	4373 Houston Avenue Macon, GA 31206

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interviews, record review, and review of the facility's policies titled Medication Administration-General and Medication Errors, the facility failed to ensure the medication error rate was less than five percent. There were three medication administration errors with 35 opportunities for two of six residents (R) (R37 and R96) observed for a medication error rate of 8.57 percent. This deficient practice had the potential to place R37 and R96 at risk of avoidable medical complications.Findings include:Review of the facility policy titled Medication Administration-General, revised 4/15/2025, revealed the Guideline section included, Associates authorized to administer medications do so only after they have familiarized themselves with the medications. The joint responsibility of the center and the pharmacy is to facilitate accurate medication administration. Prior to medication administration, the Nurse or Certified Medication Aide (CMA): . Reads the administration directions on the MAR [Medication Administration Record] and verifies correct medication, dose, and directions for use. Checks the expiration date of the medication. Expired medications are not administered to a patient.Review of the facility policy titled Medication Errors, revised 4/15/2025, revealed the Definition section stated, Medication Error is defined as the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services.1. Review of the electronic medical record (EMR) for R37 revealed diagnoses including, but not limited to, hypertensive heart disease with heart failure, pulmonary hypertension, and unspecified dementia.Review of the Med Aid MAR for R37, dated 12/1/2025 to 12/13/2025, revealed an order dated 5/16/2025 for Anoro Ellipta 62.5 micrograms (mcg)-25 mcg/actuation powder for inhalation, one puff inhalation, one time per day for dependence on supplemental oxygen. Observation on 12/10/2025 at 9:55 am revealed Certified Medication Aide (CMA) GG, administered Anoro Ellipta powder inhaler, two puffs to R37.In an interview on 12/10/2025 at 10:10 am, CMA GG confirmed the medication Anoro Ellipta powder inhaler was not administered as ordered. CMA GG confirmed that administering two puffs instead of one puff was an error and stated it would be reported to the charge nurse.2. Review of the EMR for R96 revealed diagnoses including, but not limited to, Guillain-Barre syndrome, chronic respiratory failure, and chronic obstructive pulmonary disease.Review of the Med Aid MAR for R37, dated 12/1/2025 to 12/13/2025, revealed an order dated 9/23/2025 for loratadine 10 milligrams (mg) one tablet by mouth, one time per day for seasonal allergic rhinitis. Further observation revealed an order dated 3/3/2025 for olanzapine five mg, one tablet, disintegrating by mouth one time per day for schizophrenia. Observation on 12/11/2025 at 9:07 am revealed during medication preparation for R96, CMA II prepared loratadine 10 mg, one tablet from a container with an expiration date of 10/27/2025. The surveyor intervened, and the medication was not administered. CMA II confirmed they were preparing to administer the loratadine to R96, and this would have been a medication error. Continued observation revealed CMA II administered an olanzapine five mg oral disintegrating tablet, by mouth to R96, and did not instruct the resident to allow the medication to dissolve in his mouth. R96 swallowed the medication without allowing it to dissolve. In an interview on 12/11/2025 at 9:12 am, CMA II confirmed the olanzapine five mg disintegrating tablet was not administered as ordered. CMA II confirmed the medication was given by oral ingestion and confirmed it should have been allowed to dissolve in the resident's mouth. In an interview on 12/11/2025 at 9:33 am, Charge Nurse Licensed Practical Nurse (LPN) BB and Unit Manager Registered Nurse (RN) HH confirmed the administration route for olanzapine was incorrect, and the date for the loratadine had expired. Medication error protocols were initiated at this time.