STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115778	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
4angels of Byromville Healthcare Center	712 Patterson Street Byromville, GA 31007

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review and review of the facility's policy titled Enteral Nutrition, the facility failed to ensure appropriate treatment and services were provided by not checking placement and residual per physician's orders for one of one resident (R) R6 receiving tube feed. This deficient practice had the potential to cause feeding intolerance, aspiration and worsening of R6's medical conditions.Findings include:Review of the facility's policy titled Enteral Nutrition revised November 2018 documented Policy Interpretation and Implementation:. 11. The nurse confirms that orders for enteral nutrition are complete. Complete orders include: a. the enteral nutrition product; b. the specific enteral access device (nasogastric, gastric, jejunostomy tube, etc.; c. administration method (continuous, bolus, intermittent); d. volume and rate of administration; e. the volume/rate goals and recommendations for advancement toward these; and f. instructions for flushing (solution, volume, frequency, timing and 24-hour volume). 13. Staff caring for residents with feeding tubes are trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube, such as: a. aspiration; b. tube misplacement or migration; c. skin breakdown around insertion site; d. perforation of the stomach or small intestine leading to peritonitis; e esophageal swelling, strictures, fistulas; and f. clogging of the tube. Review of the facility's Electronic Medical Records (EMR) revealed R6 was readmitted to the facility on [DATE] with diagnosis included but not limited to dysphasia (difficulty swallowing). Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview for Mental Status (BIMS) of R6 was rarely/never understood, Section K (Swallowing/Nutritional Status) R6 had feeding tube. Review of care plan dated 02/05/2026 documented Focus: R6 was on tube feedings with interventions to: Observe/document/report as needed (PRN) any signs and symptoms (s/sx) of: aspiration- fever, shortness of breath (SOB), tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration. Review of Physician's Orders dated 07/24/2025 documented included but not limited to Enteral Feed Order five times a day Enteral: Give Jevity 1.5 240 milliliter (Ml) every four hours (q4hr) and Flush before and after feeding 100 ml no feeding after midnight Verbal Active. Enteral Feed Order five times a day Flush Peg-tube with 100 ml water (H2O) before and after each feeding Verbal Active 07/24/2025. Check and record residual every (q) shift notify medical doctor (MD) if exceeds 50 ml and hold feeding every day and night shift verbal active 03/26/2025. Check tube placement before initiation of formula, medication administration, and flushing. If abnormal results, call medical doctor (MD), responsible party (RP), and enter a progress note. every day and night shift Verbal Active 03/26/2025. Observation on 04/08/2026 at 02:11 PM during R6's gastrostomy tube feed/care revealed Licensed Practical Nurse (LPN) BB did not check for placement of the gastrostomy tube and she did not check for residual before she administered medication and feed to R6. LPN BB flushed R6's gastrostomy tube with 100 mls of water, administered Jevity feed 233 mls, then administered 100 mls water without checking residual and placement of the gastrostomy tube. Interview on 04/08/2026 at 02:15 (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM with Licensed Practical Nurse (LPN) BB revealed she confirmed she did not check for placement of the gastrostomy tube and she did not check for residual before she administered flushes, medication and feed to R6. She stated there were physician's orders to check for placement of the tube and to check for residual, but she did not. She stated she should have checked the placement of the tube to ensure the tube was in the stomach because the tube could dislodge and the feed would go R6's abdominal cavity and cause infection and worsening of her medical condition. LPN BB further stated that she should have checked the residual to see how much feed was left in the stomach before giving her more feed, because R6 could get too much feed and aspirate. Interview on 04/09/2026 at 10:19 AM with the Director of Nursing (DON) revealed she stated her expectations were for the nurses to check residual and placement of the gastrostomy tube before administering feedings, medications and flushes. She stated the nurses should check for residual because the resident could have too much residual and the nurses should hold the feed. The DON stated that if the nurses did not check for residual and they fed the resident or administered medication or flushes, the resident could get too much fluid and aspirate. The DON further stated that the nurses should check for placement of the gastrostomy tube because the tube could be out of place and not be in the stomach, so if the nurses administer feeds, medications or flushes, it would go straight to the lungs and the resident could aspirate.

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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 observations, staff interviews and review of the facility's policy titled, Medication Labeling and Storage, the facility failed to remove expired medications from one of one medication room reviewed. This deficient practice had the potential to cause decline in the residents' medical conditions.Findings include:Review of the facility's policy titled Medication Labeling and Storage revised February 2023 documented Policy Interpretation and Implementation: 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. Observation on 04/08/2026 at 12:23 PM during review of the medication room on the100 Hall revealed there were expired medications in the medication room. Observations revealed: 1 bottle [NAME]-Vite tablets had expiration date 07/2025, 1 bottle bisacodyl 5 milligram (mg) tablets had expiration date 03/2026, one bottle Acetaminophen 325 mg tablets (1000 tablets) had expiration date 02/2026 and 2 bottles Zinc 50 mg tablets had expiration date 01/2026. Interview on 04/08/2026 at 12:26 PM with Licensed Practical Nurse (LPN) BB revealed she confirmed there were expired medications in the medication room. She stated the bottles of [NAME]-Vite, bisacodyl, acetaminophen and Zinc tablets were expired, and the medications should not be in the medication room because they were expired. She stated that a negative outcome for the residents would be there was a possibility the residents could get the expired medications and the expired medications would not help the residents' conditions. She further stated the residents would not get the full potential of the medications since they were expired. LPN BB further stated there was the possibility that the residents' conditions could worsen. Interview on 04/09/2026 at 10:19 AM with the Director of Nursing (DON) revealed she stated her expectations were for no expired medications to be in the medication room. She stated that the nurses were responsible for removing expired medications from the medication room. The DON stated if the expired medications were given to the residents, a negative outcome would be that the residents could have allergic reactions, and the medications would not work.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and a review of the facility's policies titled Handwashing/Hand Hygiene, Personal Protective Equipment - Gloves, and Laundry and Bedding, Soiled, the facility failed to implement infection control protocols. Staff did not sanitize their hands between glove changes, carried unbagged soiled linen down the 100 hallway, and wore gloves in the hallway. This deficient practice had the potential to increase the risk of infection for residents.Findings include: Review of the facility's policy titled Handwashing/Hand Hygiene revised August 2019 documented This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation:. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: m. After removing gloves. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Procedure:. Applying and Removing Gloves: 1. Perform hand hygiene before applying non-sterile gloves. Review of the facility's policy titled Personal Protective Equipment-Gloves revised July 2009 documented 2. Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed. 8. Wash your hands after removing gloves. Review of the facility's policy titled Laundry and Bedding, Soiled revised September 2022 documented Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. Policy Interpretation and Implementation: Handling1. All used laundry is handled as potentially contaminated using standard precautions (e.g., gloves and gowns when sorting). a. Contaminated laundry is bagged or contained at the point of collection (i.e., location where it was used). Observation on 04/08/2026 at 8:55 AM revealed the Director of Nursing (DON) came out of a resident's room, removed her gloves, and donned a new pair of gloves without sanitizing her hands. Further observation at 9:14 AM revealed the DON removed a pair of gloves in the 100 hallway, rolled them in her hands, walked down the hallway with the gloves in her hands, returned to the medication cart, disposed of the gloves in the garbage bin on the medication cart, and donned a new pair of gloves without sanitizing her hands. Observation on 04/08/2026 at 10:38 AM revealed Certified Nursing Assistant (CNA) AA walked out of a resident's room wearing gloves and proceeded along the 100 hallway into a shower room next to the nurse's station. CNA AA was observed opening the shower room door with her gloved hand, then leaving the shower room with the gloves still on, closing the shower room door with her gloved hand, and walking back to a resident's room. CNA AA opened the resident's room door with her gloved hand and entered the room. Further observation at 10:40 AM revealed CNA AA took linen that was not bagged from a resident's room and walked along the hallway to another shower room. Observation on 04/08/2026 at 03:58 PM revealed Licensed Practical Nurse (LPN) BB came out of a resident's room in front of the nurses' station wearing gloves. She removed the gloves, disposed of them in the garbage bin on the medication cart, and then put on a new pair of gloves without sanitizing her hands. LPN BB cleaned the blood sugar machine on the medication cart, removed her gloves, disposed of them in the garbage bin on the medication cart, and then put on a new pair of gloves without sanitizing her hands before attending to a resident sitting in the hallway near the nurses' station. LPN BB did not sanitize her hands between glove changes. Interview on 04/08/2026 at 11:05 AM with CNA AA revealed she confirmed she walked out of a resident's room wearing gloves, went along the 100 hallway into the shower room, opened the shower room door with her gloved hand, left the shower room, closed the shower room door with the same gloves, and walked back to the resident's room. CNA AA stated she opened the resident's room door with her gloved hand and entered the room. She also confirmed she took soiled linen that was not bagged from a resident's room and walked along the hallway to a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower room. She stated she should not have worn gloves out of the resident's room because she could spread germs to other areas, and residents could get infections when gloves were worn outside of residents' rooms. She stated that when soiled or used linen was taken outside of residents' rooms without being bagged, germs from the linen could spread to other residents, and residents could get infections. Interview on 04/08/2026 at 4:30 PM with Licensed Practical Nurse (LPN) BB revealed she confirmed she did not sanitize her hands between glove changes when she left a resident's room wearing gloves, cleaned the blood sugar machine, and before attending to a resident in the hallway. LPN BB stated she should have sanitized her hands between glove changes because failing to do so could spread germs to residents, and residents could get infections. LPN BB further stated staff were not supposed to keep gloves on when leaving a resident's room and going into the hallway or from room to room. She stated it was an infection control issue and could spread germs to residents. LPN BB stated soiled laundry should not be transferred without being in a bag because it could transfer germs to residents, and residents could get infections. Interview on 04/09/2026 at 10:19 AM with the Director of Nursing (DON) revealed she confirmed she did not sanitize her hands between glove changes. She stated her expectation was for staff to wash their hands or sanitize their hands after removing gloves and between glove changes because residents could get infections. The DON further stated her expectation was for staff not to wear gloves in the hallways. She stated gloves were not to be worn out of residents' rooms and into the hallways because the gloves were contaminated and should be placed in the trash before exiting the rooms. She stated it was an infection control issue and that whatever the residents had could be passed on to other residents when gloves encountered other residents or surrounding areas. The DON stated linen/laundry used by residents was considered soiled and should be bagged before being taken out of residents' rooms because if it was not bagged, it could encounter other residents or surrounding areas touched by residents, and residents could get infections.