STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115577	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altamaha Healthcare Center	1311 West Cherry Street Jesup, GA 31545

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 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. Based on observation, interview, record review, and review of the facility's policies titled Safe Smoking Standard and Fall Management, the facility failed to ensure an environment free from accident hazards for two of 42 sampled residents (R) (R51 and R6). Harm was identified to have occurred on 7/30/2025, when Certified Nursing Assistant (CNA)12 was independently providing a bed bath for R51, and the resident fell from the bed. It was determined that R51 required two-person assistance for bed mobility (turning from left to right in the bed). Findings included:A review of the facility's policy titled Fall Management, dated January 2025, indicated, The facility strives to reduce the risk of falls and injuries by promoting the implementation of the Risk Reduction: Falls and Injuries Program. Residents are assessed for the fall risk factors. The interdisciplinary team works with the residents and family to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. A review of the facility's policy titled Safe Smoking Standard, revised December 2022, indicated, No staff member, visitor, or resident is permitted to smoke inside the building at any time, this includes e-cigarettes and smokeless products such as chewing tobacco. The policy specified, Oxygen use is prohibited in the smoking area.1. A review of R51's admission Record revealed the facility admitted R51 on 7/3/2025. According to the admission Record, the resident had a medical history that included diagnoses of generalized muscle weakness and a need for assistance with personal care. A review of R51's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 7/9/2025, revealed R51 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was dependent on the staff for bathing. A review of R51's Care Plan Report included a focus area initiated 7/28/2025 that indicated the resident required assistance with activities of daily living (ADL) care related to activity intolerance, confusion, fatigue, impaired balance, and limited mobility. Interventions directed the staff to provide the resident with extensive assistance from one staff member with bathing/showering per schedule and as necessary, and that the resident required extensive assistance of two staff members to turn and reposition in bed as necessary. A review of R51's progress note dated 7/30/2025, during the provision of a bed bath by CNA12, when the resident was rolled, the resident's leg went off the side of the bed, which caused the resident to roll off the bed onto the floor. Per the progress note, the resident hit their head, which caused a laceration. The progress note indicated the resident was assessed by the Nurse Practitioner and subsequently transferred to the emergency room for further evaluation and treatment. A review of R51's hospital Visit Record dated 7/30/2025, indicated the resident fell out of the bed and hit their head while getting a bed bath. The record indicated the resident had a laceration to the scalp, a four-centimeter (cm) linear which was closed with skin glue and an adhesive. During an interview on 8/8/2025 at 2:49 pm, CNA12 stated she was told in the report when she started her shift for work about the needs of the residents, such as whether they needed one or two people for (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 0689 Level of Harm - Actual harm Residents Affected - Few	assistance. CNA12 stated she took care of R51 on 7/26/2025 before the fall, and the resident did not require two-person assistance, so she thought it was okay to give the resident a bed bath by herself. She stated the resident turned over onto their right side and just kept going. CNA12 stated that when the resident's leg went off the side of the bed, the resident slid off the bed. She stated the Director of Nursing (DON) and Administrator educated her to use two people with R51. CNA12 stated she did not mean for it to happen. During an interview on 8/8/2025 at 9:39 am, the Licensed Practical Nurse Unit Manager (LPN UM) stated that two people should be used for a bed bath if the resident required two people for bed mobility. The LPN UM stated that on 7/30/2025, when she entered R51's room, the resident was wrapped up in the covers and lying on the floor with the covers draped off the bed. The LPN UM stated the resident had a bleeding laceration to their forehead. During an interview on 8/8/2025 at 11:03 am, the DON stated the CNA should have two people for a bed bath if two people were needed for bed mobility. The DON stated the CNA was giving R51 a bath, unassisted, and when she turned the resident over, the resident just kept going off the side of the bed. She stated the resident got a laceration on their forehead, first aid was rendered, and the resident was transferred to the emergency room for further evaluation and treatment. According to the DON, CNA12 was in-serviced one-to-one to make sure she used two people when giving care. During an interview on 8/8/2025 at 11:30 am, the Administrator stated the staff should use two people for a bed bath if the resident required two persons to assist with bed mobility. The Administrator stated she was told the CNA was giving R51 a bed bath, and the resident rolled and fell out of the bed that was in a high position. She stated the CNA worked as needed, and she did not look for or ask how much assistance the resident needed. The Administrator stated she filed a state report, the CNA was educated, and an in-service was done. 2. A review of R6's admission Record revealed that the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease (COPD).A review of R6's Annual MDS assessment, with an ARD of 4/1/2025, revealed R6 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident used oxygen therapy.A review of R6's Order Summary Report that contained active orders as of 8/5/2025, revealed an order dated 7/18/2024 for supplemental oxygen at three liters per minute by way of a nasal canula as tolerated every shift. A review of records revealed a Facility Incident Report Form, dated 11/19/2024, indicated residents reported today [11/19/2024] that [R6] was smoking in the smoking area with [his/her] oxygen on. Resident states that [his/her] oxygen was turned off. No one was hurt.A review of records revealed an Employee Interview Form, signed by the Activities Director (AD) and dated 11/19/2024, indicated, On smoke break today at 11:00 am the smokers reported to me that [R6] was outside on last night's smoke break with [his/her] oxygen on smoking. A review of records revealed a Witness Statement Form, signed by R6 and dated 11/19/2024, indicated the resident admitted they had one cigarette, they turned their supplemental oxygen off, CNA15 lit their cigarette, and once they finished their cigarette, they turned their supplemental oxygen back on. A review of records revealed, CNA15's Witness Statement Form, dated11/19/2024, indicated, I took [R6] out to smoke and forgot to leave the [his/her O2 [oxygen] tank inside, even still I turned it off, asked my nurse what should have been the best thing to do the next day and he said I should have left it by the door my mistake.A review of records revealed that CNA15's Separation Notice, signed by the Administrator and dated 11/21/2024, indicated CNA15's employment with the facility was terminated on 11/22/2024 for a violation of company policy. Per the Separation Notice, CNA15 placed residents in danger by allowing a resident to smoke with a supplemental oxygen tank. During an interview on 8/7/2025 at 2:15 pm, R6 stated they went out one time to smoke with their supplemental oxygen, and the CNA who let them go out lost their job. R6 stated that after (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that incident, they began to vape. Review of R6's progress note dated 5/20/2025 revealed that the CNAs approached R6 in the DON's office and informed nursing that a vape was found in the resident's room. Per the progress note, staff saw smoke in the resident's room and walked in and saw the vape. A review of R6's social service progress note dated 5/21/2025, indicated a vape device was found in the resident's possession after the resident was reportedly caught smoking. During an interview on 8/7/2025 at 9:10 am, the AD stated CNA15 let R6 go out during a smoke break with a supplemental oxygen tank on the back of the resident's wheelchair. During an interview on 8/7/2025 at 10:33 am, the DON stated she believed staff knew it was not okay to have supplemental oxygen outside for a smoke break. During a follow-up interview on 8/7/2025 at 3:57 pm, the DON stated that 5/20/2025 was the first time R6 was found with a vape in their room. The DON stated the vape was removed, and the resident was caught again with a vape on 5/24/2025 in their room. The DON stated that the risk of vaping in a resident's room was that it could potentially start a fire. During an interview on 8/7/2025 at 4:13 pm, the Administrator stated she thought she had heard a while ago that R6 was vaping in their room. She did not recall what was done after the incident and did not know how many times the resident was caught with a vape. The Administrator stated the resident was not allowed to vape in their room because the resident was on supplemental oxygen, and it was flammable. During a telephone interview on 8/9/2025 at 9:18 am, the former DON stated she was the DON at the time when CNA15 allowed R6 to go outside with a supplemental oxygen tank to smoke. According to the former DON, R6 wanted to go outside with the group, and CNA15 told the resident it was okay to go outside with the supplemental oxygen tank because he had turned it off. The former DON stated it scared the other residents, and they reported it the next day. Per the former DON, CNA15 admitted he made a mistake. During a telephone interview on 8/9/2025 at 10:18 am, the former Administrator stated he was the Administrator when CNA15 allowed R6 to go outside with a supplemental oxygen tank to smoke. The former Administrator stated that CNA15 was suspended, and then their employment was terminated. During an interview on 8/9/2025 at 1:54 pm, the DON stated her expectation was that all smoking materials were to be kept with the staff and no residents could have smoking materials in their room. The DON stated that staff were expected to report any found smoking materials to anyone in charge. During an interview on 8/9/2025 at 2:44 pm, the Administrator stated her expectation for vapes in a resident's room was that they were not allowed, and she expected them to be stored with cigarettes. The Administrator stated she expected staff to report to her, the DON, or a nurse if they found a resident with a vape. During an interview on 8/9/2025 at 2:46 pm, the Administrator stated her expectation was that there were to be no supplemental oxygen tanks outside while residents were smoking.