STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115642	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azalea Health and Rehabilitation	300 Cedar Road Metter, GA 30439

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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** Based on observations, staff interviews, record review, and review of the facility's policy titled Pharmacy Services, the facility failed to ensure one of 37 sampled residents (R) (R40) did not have unauthorized, unsecured medications at bedside. This deficient practice had the potential to allow unauthorized access to medications to other residents and visitors in the facility. Findings included:A review of the facility policy titled Pharmacy Services: dated 12/31/2024 revealed that the facility will facilitate a process for safe self -administration of medications by patients when appropriate each patient who desires to self administer medication is permitted to do so if the nursing center's interdisciplinary team has determined that the practice would be safe for the patient and other patients of the nursing center and that the patient can accurately self-administer. A review of clinical records for R40 revealed the following diagnoses, but not limited to, vascular dementia, paroxysmal atrial fibrillation, hypertension, and chronic obstructive pulmonary disease. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R40 presented with a Brief Interview Mental Status Score (BIMS) of five, indicating severe cognitive impairments. An observation on 9/9/2025 at 12:28 pm revealed the following over-the-counter medications: a bottle of antacid tablets and a small tube of sterile lubricant eye ointment (style) lying on a nightstand.A review of clinical records for R40 revealed an omission of a completed assessment to determine whether or not the resident was capable of Self-Administration of Medications.During an interview at the time of observation of R40's room on 9/9/2025 at 4:01 pm, with Certified Medical Assistant (CMA) HH, CMA HH reported being unaware of medications in the resident room. She reported receiving prior in-services to monitor for unauthorized medications in resident rooms. CMA described R40 's cognition as having periods of confusion, which would make her incapable of self-administering medications without supervision During an observation of R40's room on 9/9/1025 at 4:13 pm, with Licensed Practical Nurse (LPN) LPN BB, LPN BB confirmed the unauthorized medication in the resident room. She removed the medications from the room. LPN BB reported R40 was not assessed to self-administer medications and described her mental status as being very confused. LPN BB reported that most likely the resident's family brought the meds into the room. She reported that her expectations are for the nursing staff and certified medical assistant (CMA) to monitor the residents' rooms for medications. During an interview on 9/10/2025 at 10:20 am, the Director of Nursing (DON) reported being unaware of medications in R40's room. She reported that the IDT (Interdisciplinary Team) determines the patient's ability to self-administer medications, and at this time, the IDT had not assessed any residents to self-administer medication. The DON reported that after the deficient practice was brought to her attention yesterday, she and her staff did a scan of all residents' rooms for unauthorized meds and conducted an in-service on unauthorized meds with staff.

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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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to ensure vents were free from dust and grime buildup in five resident rooms on one of two halls (Hall B).Findings included:An observation on 9/9/2025 at 12:04 pm revealed that the air vent was covered in dust buildup in Hall B in room [ROOM NUMBER].An observation on 9/9/2025 at 11:32 am revealed that the air vent was covered in dust buildup in Hall B in room [ROOM NUMBER].An observation on 9/9/2025 at 11:11 am revealed that the air vent was covered in dust buildup in Hall B in room [ROOM NUMBER].An observation on 9/9/2025 at 10:16 am observed that the air vent was covered in dust buildup in Hall B in room [ROOM NUMBER].An observation on 9/9/2025 at 10:43 am revealed that the air vent was covered in dust buildup in Hall B in room [ROOM NUMBER].During an interview on 9/10/2025 at 2:02 pm, the Maintenance Director revealed that he is responsible for cleaning the filters. He confirmed that the filters were dirty and possibly last cleaned in August 2025. An additional interview at 2:52 pm with the Maintenance Director revealed that it takes days to clean the filters and that he takes them outside he places a purple cleaning solution on the filters, and then cleans them off with a water hose. He attempts to clean one hall at a time. He reports that the last time they were cleaned was on 8/13/2025.During an interview on 9/10/2025 at 2:02 pm, the Environmental Services Director confirmed that the air filters were dirty. She stated that the cleaning is tracked in Telles' maintenance system. The subsequent interview at 2:52 pm revealed that the facility does not have a policy for the cleaning or maintenance of air filters or air conditioning units. The facility just tracks the information in its maintenance system. During an interview on 9/10/2025 at 2:02 pm, the Administrator confirmed that the observed air filter in room [ROOM NUMBER] was dirty. Subsequent interviews with the Administrator on 9/11/2025 at 10:51 am revealed that he expected that when they are dirty, like the observation of the filter, the filter should be cleaned immediately.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility policy titled Patient's Plan of Care, the facility failed to ensure the care plan was followed for two (R) (R78 and R31) of 37 residents related to Activities of Daily Living Care for R78 and R31 related to medication parameters. Harm was identified to have occurred on 12/13/2024 when Certified Nursing Assistant (CNA) EE was providing ADL care alone, resulting in R78 falling out of bed and sustaining a sub-capital fracture of the femoral neck.Findings included:1. A review of the Patient's Plan of Care dated 12/29/2023, revealed each patient will have a person-centered comprehensive care plan developed and implemented to meet his or her other preferences and goals, and address the patient's medical, physical, mental, and psychosocial needs.A review of the medical record for R78 revealed the resident was initially admitted to the facility on [DATE] with the following diagnosis's not limited to fracture of unspecified part of neck of right femur, initial encounter of closed fracture, Parkinson's disease without dyskinesia without mention of fluctuations, unspecified dementia severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, chronic obstructive pulmonary disease, unspecified, and schizoaffective disorder, unspecified.A review of Quarterly Minimum Data Set (MDS) dated [DATE] (MDS at time of fall) revealed that the resident had a Brief Interview for Mental Health Status (BIMS) of four, indicating severe cognitive impairment. Section GG (functional abilities and goals) revealed the resident was dependent on staff for self-care and mobility (required 2 persons).A review of the care plan dated 6/10/2024 revealed the resident is a fall risk. Interventions included but are not limited to two-person assist with bed mobility.An interview on 9/10/2025 at 8:45 am with the Director of Nursing (DON) revealed that the fall with injury occurred when CNA EE provided care to the residents. The DON confirmed that the resident was a two-person assist for bed mobility and that the CNA was the only staff providing care. The DON stated she expects that staff follow care plans and provide a two-person assist when requiredAn interview with Registered Nurse (RN) MDS Coordinator on 9/11/2025 at 11:37 am revealed that care plans are developed as a team. She is responsible for completing the MDS assessment. She confirmed that the resident was coded as a two-person assist for bed mobility in the MDS and care plan at the time of the fall. She stated the resident should have had two staff assisting her and that the staff are aware of a resident's care level because it is listed in their charting system. 2. A review of the Minimum Data Set (MDS) assessment dated [DATE] revealed that R31 had presented with a Brief Interview for Mental Status (BIMS) score of 00, indicating that R31 was totally dependent on activities of daily living (ADL) care.A review of the care plan dated 8/19/2025 revealed that R31 was at risk for Phenytoin (Dilantin) Toxicity related to Dilantin and Levetiracetam. The goal was for the R31 will be free of any discomfort or adverse side effects and will be injury-free during the review period. The interventions include, but are not limited to, holding g-tube feeding one hour before and one hour after Dilantin administration.A record review for R31 revealed that the resident's tube feeds were to be held one hour before and one hour after the administration of phenytoin (Dilantin).During an interview with RN FF on 9/11/2025 at 1:07 pm revealed that the care plan states to hold tube feeds one hour before and one hour after administration of phenytoin (Dilantin). She admits that she did not hold the medication. She admits that she did not realize that she needed to hold the medication. She states that the parameters should she added to the physician's orders. She admits that she only reviews care plans if there is a change in a resident's condition.An interview with the Minimum Data Set (MDS) coordinator on 9/11/2025 at 1:15 pm states that parameters for medication are found in the medication administration record. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Everyone on the interdisciplinary team is responsible for the care plan. The care plan does include medication parameters. In the electronic record, that is a tab with recommendation parameters for staff to follow.An interview with the Director of Nursing (DON) on 9/11/2025 at 1:25 pm reveals that the expectation is that the nurse follows the care plan. Parameters for medications are in order. The nurses have access to the care plan for review.

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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** Based on record review, staff interviews, and review of policy titled Falls Management, the facility failed to provide care by two staff members for one of two residents (R) (R78) reviewed for falls. Harm was identified on 12/13/2024 when resident R78 fell from bed during care, resulting in a right hip fracture.Findings included: A review of the facility policy dated 12/29/2023 titled Falls Management revealed upon admission/readmission, the nurse will complete the Falls Risk Assessment and address the risk factors related to the patient on the plan of care and implement appropriate interventions as identified.A review of the medical record for R78 revealed the resident was initially admitted to the facility on [DATE] with the following diagnosis's not limited to fracture of unspecified part of neck of right femur, initial encounter of closed fracture, Parkinson's disease without dyskinesia without mention of fluctuations, unspecified dementia severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, chronic obstructive pulmonary disease, unspecified, and schizoaffective disorder, unspecified. A review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] (MDS at time of fall) revealed that the resident had a Brief Interview for Mental Health Status (BIMS) of four, indicating severe cognitive impairment. Section GG (functional abilities and goals) revealed the resident was dependent on staff for self-care and mobility (required two persons). A review of a progress note dated 12/13/2024 at 6:55 am revealed the resident rolled out of the bed onto the floor during patient care. The fall was observed by Certified Nurse Assistant (CNA) EE, the CNA who was assisting the resident with patient care. The resident complained of pain in the right knee. The resident's granddaughter and physician were notified, and the resident was transferred to the emergency room by rescue.A review of the hospital emergency room report on 12/13/2024 revealed an X-ray report that listed a subcapital fracture of the femoral neck. Attempts were made to contact the resident's representative, but were unsuccessful.During an interview on 9/11/2025 at 9:10 am with CNA EE confirmed she was the only CNA providing care to the resident when the resident required a two-person assist. CNA EE revealed she received a corrective action and was given a verbal/written warning. She was provided with education on bed mobility.During an interview on 9/10/2025 at 8:45 am with the Director of Nursing (DON) revealed that the fall with injury occurred when CNA EE provided care to the resident without the assistance of another staff member. The DON confirmed that the resident was a two-person assist for bed mobility and that the CNA was the only staff providing care. The DON revealed CNA EE received a corrective action and revealed CNA EE, along with all clinical staff, including CNA's were provided education on bed mobility. The DON completed nurse aide competency checklists on turning and repositioning a patient in bed, as well as audits/monitoring. A review revealed a facility document titled on-site in-service, dated 12/13/2024, documented that all nursing staff were provided education by the DON. The topic, Subject: adl plan of care/care plan, bed mobility. The fall management policy was attached. Staff signed their name as an acknowledgement of attending the in-service. A review revealed A corrective action that was given to CNA EE on 12/13/2024. She received a verbal and written warning. It was signed by the CNA.A review revealed a written statement by CNA EE on 12/13/2024---I, CNA EE was doing patient care on R78. I was changing her brief and bed. I turned her over to her right side, pointing towards the door. As I rolled the sheet over to the other side of the bed, R78 fell out of the bed to the floor. Immediately, I called for help. If you have any questions, please call me.A review revealed competency checklists on repositioning and bed mobility were completed with staff. Verified by DON on 9/11/2025 at 2:00 pm, and with staff interviewed. During an interview on 9/11/2025 at 11:30 am with Certified Medication Assistant (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(CMA) AA revealed she has been working for one year. She revealed she received training on bed mobility and following care plans. She stated she is aware of what a resident's care level is by looking at the medical chart. She stated that all staff should know a resident's care level before completing care with a resident to ensure safety. During an interview on 9/11/2025 at 11:43 am with CMA GG revealed she has been with the facility for five months. She stated she had training on bed mobility and care plans.During an interview on 9/11/2025 at 11:45 am with Registered Nurse FF, revealed that they have been employed for a year. She confirmed she had training on bed mobility and care plans. She stated that all staff have access to the resident's level of care, and that is how they know if a resident requires a two-person assist. During an interview on 9/11/2025 at 11:48 am with CMA HH revealed she has been employed with the facility for a year. She confirmed she had training on bed mobility and care plans. She stated that the medical chart has the resident care level.

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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. Based on observations, staff interviews, record review, and a review of the facility policies titled Medication Administration-General and Insulin Administration, the facility failed to ensure a medication error rate of less than five percent for three of five residents (R) (R39, R14, and R31). There were three errors from 47 opportunities observed for a medication error rate of 6.38 percent. Findings included:A review of the Medication Administration-General policy revealed that medications are administered as prescribed, in accordance with good nursing principles. Under the guidelines revealed that a joint responsibility of the center and the pharmacy is to facilitate accurate medication administration.A review of the Insulin Administration policy revealed that insulin was to be administered correctly and safely. Under bullet point number five, instruct to prime the pen and clear air from the needle: Turn the dose knob at the end of the pen to 1 or 2 units. Hold the pen with the needle pointing upward Press the dose knob while watching for the insulin drop or stream to appear Repeat, if needed, until insulin is seen at the tip. The dial should be back at zero after priming is complete.Step six states that after priming then turn the dose knob to dial in the insulin dose.A review of the manufacturer's instructions for the use of the Lantus pen revealed that in step three, always perform the safety test before each injection to ensure that the pen and needle work properly and remove air bubbles. The first step is to select a dose of two units by turning the dose selector. The pen is to be held pointing upwards, then tap the insulin reservoir so that any air bubbles rise towards the needle. Finally, press the injection button all the way in, and check if insulin comes out of the needle tip. Check the dose window shows 0 following the safety test, then select the required dose by turning the selector clockwise.A review of the manufacturer's instructions for use revealed that in step seven, the Tresiba FlexTouch pen dose selector is turned to two units. Step eight proceeds to instruct that the pen was to be held with the needle pointing up, then tap the top of the pen gently a few times to let any air bubbles rise to the top. Press and hold the dose button until the dose counter shows zero.A review of physician orders revealed that R 39 was to receive Lantus 20 units subcutaneously every 12 hours.An observation of Licensed Practical Nurse (LPN) BB on 9/10/2025 at 8:26 am revealed that she did not prime the Lantus before administration. During the interview after administration, she states that she primed the pen with 1 unit. She stated that she turned the pen to 20 units, then squirted a little out.A review of the physician orders revealed that R39 was to receive Tresiba FlexTouch 100 units/ml 10 units subcutaneously once a day.An observation and interview with LPN BB on 9/10/2025 at 8:34 am revealed that she did not prime the pen before administration. She turned the pen into 11 units. Observed pen read 11 units. She proceeded to push out one unit, but then she pushed out six units. She stated she pushed too hard. She then turned the dial to 10 units. During the interview, she states that you prime the pen with one unit. An interview with the Director of Nursing on 9/11/2025 at 12:06 pm revealed that insulin should be primed one to two units before administering the dose. The policy says to prime with one to two units before dialing the dose.An observation and concurrent interview with Registered Nurse (RN) FF on 9/10/2025 at 10:36 am revealed that R31 was receiving a continuous tube feed infusion through a gastrostomy tube. RN FF stopped the feeding infusion. She checked placement, then began administering the phenytoin (Dilantin) with a water flush before and after medication. She then reconnected the tube feed infusion to the gastrostomy and then restarted the feeding pump. During an on 9/11/2025 11:54 am, RN FF revealed that she crushed phenytoin (Dilantin) and then administered it between the medications through the tube. She paused the tube feeding and then continued the tube feeding after the medication was administered.During an interview on 9/11/2025 at 11:36 am, the Pharmacist Consultant revealed that the recommendation was to stop tube (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feedings for one hour before and one hour after the administration of phenytoin (Dilantin). She stated that the staff usually sends her an email if they have questions, and she checks the resident's chart and asks questions about the resident. She stated, A resident with tube feeds needs the tube feed stopped before administering phenytoin (Dilantin) or complete frequent labs to make sure that the phenytoin levels are maintained; this is up to the prescriber.An interview with the Director of Nursing (DON) on 9/11/2025 at 12:06 pm revealed that administering phenytoin (Dilantin) is based on whatever the orders say, but usually the nurses should hold the feeding for 30 minutes, then they give based on flush instructions. If a nurse has questions about how to administer medication, they would come to me for assistance. If there are questions about the orders, the nurse would speak with the prescriber. Phenytoin is based on the orders for how often the lab work is checked. If there are continued questions about medication administration, then we reach out to the Pharmacist consultant.

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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 observation, staff interviews, record review, and facility policies titled, Medication Storage in the Care Center and Multi-dose of Medication Storage Conditions and Expiration Date Factsheet, the facility failed to ensure that medications, biologicals, and supplies were stored properly following manufacturers' recommendations or those of the suppliers, including expiration dates for two of two medication carts. This deficient practice has the potential to place residents at high risk for potential clinical, psychosocial, and mental harm.Findings included:A review of policy titled Medication Storage in the Care Center with a last review date of [DATE], revealed that the facility was to facilitate safe, secure, and proper storage of medications and biologicals following the manufacturer's recommendations or those of the supplier. Bullet point 13 revealed that medications requiring refrigeration are kept in a refrigerator with a thermometer to allow for temperature monitoring.An observation and interview with Certified Medication Assistant (CMA) AA on [DATE] at 11:39 AM on B hall medication cart revealed lubricated jelly dated [DATE] and diclofenac sodium topical gel 1% expired in [DATE]. CMA AA admits that the lubricated jelly and diclofenac sodium topical gel 1% had expired. She stated that the lubricated jelly should have been discarded. She states that the lubricated jelly was used for Foley insertion and to check the rectum for impactionAn interview with Licensed Practical Nurse (LPN) BB admits that the diclofenac sodium topical gel 1% had expired in [DATE]. She states the lubricated gel expired in [DATE]. Subsequent interview on [DATE] at 4:29 pm revealed that it is a joint effort with night shift, but night shift was ultimately the one to manage the medication cart.An interview with LPN CC on [DATE] at 4:41 pm revealed that the expectation was that medication carts are clean and everything labeled, and medication is to be discarded timely.An interview with the Assistant Director of Nursing (ADON) revealed that the expectation is that nurses and CMAs must check the cart when coming on and as they give out medications for expiration dates.A review of the factsheet Multi-dose Packages of Medication Storage Conditions and Expiration Dates revealed that Rocklanta unopened should be stored at two to eight degrees or 36-46 degrees Fahrenheit.An observation and interview with Registered Nurse (RN) FF on A hall medication cart on [DATE] at 1:46 pm revealed that the medication eye drops that were unopened required refrigeration before use. There was a label on the box that stated to refrigerate before use. She is unsure how long the box was in the cart. RN FF admits that eye drops were not refrigerated and admits that they should be refrigerated.An interview with the Assistant Director of Nursing (ADON) on [DATE] at 1:46 pm revealed that the eye drops were not open and required refrigeration.An interview with the Director of Nursing (DON) and the Facility Regional nurse on [DATE] at 2:50 pm revealed that the eye drop medication should be refrigerated until it opens. An interview with a Pharmacy Consultant on [DATE] at 11:36 am revealed that the Rocklanta eye drops are to be refrigerated until opened.