Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/08/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115676	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of South Georgia	2002 Tift Avenue North Tifton, GA 31794

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, staff interviews, record review, and review of the facility's policies titled Self-Administration of Medications and Storage of Medications, the facility failed to ensure three of 36 sampled residents (R), (R88, R95, R41) did not have unauthorized, unsecured medications at bedside. This deficient practice had the potential to allow unauthorized access to medications to R88, R95, and R41, other residents, unauthorized staff, and visitors. Findings include:Review of the facility policy titled Self-Administration of Medications, dated 2/8/2021, revealed the Policy Statement stated, Resident in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. The Policy Interpretation and Implementation section included, . 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of the resident permitted to self-administer will be stored in a central medication cart or in the resident's medication room. Nursing will transfer the unopened medication to the resident when the resident requests them. The nurse will have a key to the storage container.Record review of the facility policy titled Storage of Medications, dated 2/8/2022, revealed the Policy Statement stated, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The Policy Interpretation and Implementation section included, . 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.1. Observation on 12/1/2025 at 1:34 pm of R88's room revealed a tube of zinc oxide cream on the overhead bedside table, within open view of residents and visitors.Review of the electronic health record (EHR) for R88 revealed diagnoses including, but not limited to, unspecified dementia, cerebral palsy, and chronic pulmonary disorder disease. Review of the Quarterly Minimum Data Set (MDS) assessment for R88, dated 9/10/2025, revealed that Section C (Cognitive Patterns) assessed a Brief Interview Mental Status (BIMS) score of six, indicating moderate cognitive impairment.Review of the care plan for R88 revealed no focus area for self-administering medications.Review of the Physician Order Form for R88 revealed no order for zinc oxide or for self-administration of medication.Record review of the clinical record for R88 revealed that a medication self-administration assessment was not completed.During an observation and interview on 12/3/2025 at 2:24 pm in R88's room, with the Director of Nursing (DON), the DON confirmed the zinc oxide cream in R88's room and removed it. The DON stated that staff used the zinc oxide cream for preventative care. 2. Observation on 12/1/2025 at 10:56 pm and 11:05 pm of R95's room revealed a tube of zinc oxide cream sitting on the rolling bedside table, within open view of residents and visitors.Review of the EHR for R95 revealed diagnoses including, but not limited to, dementia, Alzheimer's, atrial fibrillation, and chronic kidney disease. Review of the Quarterly MDS for R95, dated 11/18/2025, revealed that Section C (Cognitive Patterns) assessed a BIMS score of 00, indicating severe cognitive impairments.Review of the Physician Order Form for R95 revealed no order for zinc oxide or for self-administration of medication.Record review of the clinical record for R95 (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed that a medication self-administration assessment was not completed.During an interview and observation on 12/3/2025 at 11:53 am in R95's room, with the DON, the DON confirmed cream zinc oxide ointment in the resident room. She stated that the cream was a topical cream and should be stored on a treatment cart. She reported that the risk was that the cream would be accessible to a wandering resident with low cognition, and that a resident could possibly eat or rub the product in his/her eyes. The DON stated she would provide in-services to the nursing staff regarding leaving medication products in resident rooms.3. Observations on 12/1/2025 at 10:56 pm and 11:05 pm of R41's room revealed a tube of zinc oxide cream on R41's bedside stand, within open view of residents and visitors.Review of the EHR for R41 revealed diagnoses including, but not limited to, unspecified dementia, unspecified severity with other behavioral disturbances, heart failure, and type 2 diabetes with diabetic neuropathy.Record review of the Quarterly MDS assessment for R41, dated 10/8/2025, revealed Section C (Cognitive Patterns) assessed a BIMS score of 13, indicating little to no cognitive impairment.Review of the care plan for R41 revealed no focus area for self-administering medications.Review of the Physician Order Form for R41 revealed no order for zinc oxide or for self-administration of medication.Record review of the clinical record for R41 revealed that a medication self-administration assessment was not completed.During an observation and interview on 12/3/2025 at 2:24 pm, the DON confirmed the zinc oxide cream in the resident room and removed it. The DON reported that R41 did not have a current wound or skin condition that required application of the cream.

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F 0656 Level of Harm - Minimal harm or potential for 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. Based on observations, staff interviews, record review, and review of the facility policy titled Care Plans-Comprehensive, the facility failed to follow care plans for one of 36 sampled residents (R) (R77). This deficient practice had the potential to place R77 at risk of not receiving treatment and/or care in accordance with their needs. Findings include:Record review of the facility policy titled Care Plans-Comprehensive, dated 2/2/2025, revealed the Policy Statement stated An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident 's medical, nursing, mental, and psychological needs is developed for each resident. The Policy Interpretation and Implementation section included, . 3. Each resident's comprehensive care plan is designed to: . (e) Reflect treatment goals, timetables, and objectives in measurable outcomes; (f) identify the professional services that are responsible for each element of care.Review of the electronic health record (EHR) for R77 revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, emphysema, cardiomegaly, and hypertension. Review of the Quarterly Minimum Data Set (MDS) for R77, dated 9/30/2025, revealed that Section O (Special Treatment Procedures, Program) revealed the resident received oxygen therapy.Record review of the care plan for R77 revealed a Focus area, last revised 5/19/2021, of the resident has altered respiratory status/difficulty breathing related to anxiety, asthma, and COPD. The Goal was for the resident to have no complications related to shortness of breath. The Interventions included, but were not limited to, oxygen via nasal cannula as ordered. Review of the physician orders for R77 revealed an order dated 1/11/2024 for oxygen at two liters per minute (LPM) via (by) nasal cannula continuous as the resident will allow. Observations on 12/2/2025 at 12:23 pm, 2:20 pm, and 4:15 pm revealed R77 lying in bed receiving oxygen by an oxygen concentration via a nasal cannula with the flow rate set to four LPM.During an observation on 12/2/2025 at 4:15 pm with the Assistant Director of Nursing (ADON), the ADON confirmed that the oxygen was set to four LPM and adjusted it to two LPM.In an interview on 12/4/2025 at 1:16 pm, the MDS Coordinator reported that her expectation was for staff to review the care plan to ensure it was followed. Cross-Reference F695

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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, and record review, the facility failed to ensure that one of six residents (R) (R84) receiving nourishment via a tube feeding received water flushes as ordered by the physician. This deficient practice had the potential to place R84 at increased risk of medical complications.Findings include: Review of the admission Record for R84 revealed diagnoses including, but not limited to, adult failure to thrive, dysphagia, chronic kidney disease, stage four, and type 2 diabetes mellitus. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed that Section GG (Functional Abilities and Goals) documented that the resident was dependent with eating. Section K (Swallowing/Nutritional Status) documented that the resident had a feeding tube while a resident and received two to 501 cubic centimeters (cc) of fluid intake per day via the feeding tube. Review of the physician's orders for R84 revealed an order dated 7/25/2025 for Glucerna 1.5 at 40 cubic centimeters (cc) per hour and purified water flush of 50 cc per hour via pump. Review of the Medication Administration Record (MAR), dated 12/1/2025 through 12/31/2025, for R84 revealed an order dated 7/25/2025 for Glucerna 1.5 at 40 cubic centimeters (cc) per hour and purified water flush of 50 cc per hour via pump. The MAR was marked as the ordered feeding and flushes were administered as ordered. Observations on 12/2/2025 at 1:16 pm, 12/3/2025 at 11:26 am, and 12/4/2026 at 10:08 am revealed R84 receiving Glucerna 1.5 tube feeding at 40 cc per hour and water flush at 40 cc per hour via a feeding pump. In an interview on 12/04/2025 at 11:00 am, Licensed Practical Nurse (LPN) DD confirmed that the feeding pump for R84 was set to 40 cc per hour for the water flush. She confirmed the physician's order for the water flush was 50 cc per hour and changed the setting on the feeding pump. LPN DD stated the rate should have been updated when the order was changed. She stated that if the resident doesn't receive the appropriate amounts of fluids, it could lead to dehydration. In an interview on 12/4/2025 at 12:04 pm, the Director of Nursing (DON) stated that she expected the nurse to check tube feeding and flush rates every shift. She stated that there was an order that staff sign off on each shift that they had assessed the tube feeding. She further stated that incorrect rates of feeding tube flushes could lead to dehydration or fluid overload. In an interview on 12/4/2025 at 12:26 pm, the Administrator stated that she expected nurses to follow the physician's orders when setting rates for tube feedings and flushes. She stated that if the rates were lower than ordered, it could lead to dehydration.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, staff interviews, record review, and review of the facility's policy titled Oxygen Administration, the facility failed to ensure that one of 19 residents (R) (R77) receiving oxygen was administered oxygen therapy in accordance with the physician orders. This deficient practice had the potential to place R77 at risk for respiratory complications and a diminished quality of life.Findings include:Review of the facility policy titled Oxygen Administration, dated 2/25/2024, revealed the Policy Statement was, The purpose of this procedure is to provide guidelines for safe oxygen administration. The Policy Interpretations and Implementation section included, 1. Verify that there is a physician's order for this procedure. Review the physician 's orders or facility protocol for oxygen administration.Review of the electronic health record (EHR) for R77 revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, emphysema, cardiomegaly, and hypertension. Review of the Quarterly Minimum Data Set (MDS) for R77, dated 9/30/2025, revealed that Section O (Special Treatment Procedures, Program) revealed the resident received oxygen therapy. Review of the physician orders for R77 revealed an order dated 1/11/2024 for oxygen at 2 liters per minute (LPM) via (by) nasal cannula continuous as the resident will allow. Observations on 12/2/2025 at 12:23 pm, 2:20 pm, and 4:15 pm revealed R77 lying in bed receiving oxygen by an oxygen concentration via a nasal cannula with the flow rate set to four LPM.During an observation on 12/2/2025 at 4:15 pm, with the Assistant Director of Nursing (ADON), the ADON confirmed that the oxygen was set to four LPM and adjusted it to two LPM. The ADON stated that if a resident with a diagnosis of COPD received too much oxygen, it placed them at risk for adverse effects, including hypercapnia.