STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115145	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anderson Mill Center for Nursing and Healing LLC	2130 Anderson Mill Rd Austell, GA 30106

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled, Transfer and Discharge (including AMA [Against Medical Advice], the facility failed to ensure six of 41 sampled residents (Resident (R) 3, R7, R149, R4, R15, and R72) and their resident representatives (RR) reviewed for emergency hospital transfer, were provided with a written transfer/discharge notice which contained the appeal process. This failure had the potential to affect the residents and their RR by not having the knowledge of how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following hospitalization for residents transferred to the hospital. Findings include: 1. Review of R149's electronic medical record (EMR) admission Record located under the Profile tab indicated that the facility admitted the resident on 03/06/2026. Review of a document provided by the facility titled Acute Care Transfer Document Checklist dated 03/07/2026 indicated that R149 sustained a change in his condition and was transported to the hospital for evaluation and treatment. Review of R149's EMR revealed no evidence that the resident and/or her RR were provided with a written emergency transfer notice which included the appeal rights to the transfer/discharge. 2. Review of R3's Face Sheet located under the Profile tab of the EMR revealed R3 was admitted to the facility on [DATE] with the diagnoses of UTI (urinary tract infection), malnutrition and type II diabetes. Review of the Progress Notes located in the Progress Notes tab of the EMR revealed R3 was sent to the hospital on [DATE]. Review of R3 's EMR revealed no evidence that written notification regarding R3's transfer to the hospital was sent to R3's responsible party. 3. Review of R7's Face Sheet located under the Profile tab of the EMR revealed R7 was admitted to the facility on [DATE] with the diagnoses of amputation of left leg below the knee, malnutrition, peripheral vascular disease, functional quadriplegia, heart failure and type one diabetes. Review of the Progress Notes located in the Progress Notes tab of the EMR revealed R7 was sent to the hospital on [DATE]. Review of R7 's EMR revealed no evidence that written notification regarding R7's transfer to the hospital was sent to R7's responsible party. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of R15's Face Sheet located under the Profile tab of the EMR revealed R15 was admitted to the facility on [DATE] with the diagnoses of cerebral infarction, type II diabetes, and aphasia. Review of the Progress Notes located in the Progress Notes tab of the EMR revealed R15 was sent to the hospital on [DATE]. Review of R15 's EMR revealed no evidence that written notification regarding R15's transfer to the hospital was sent to R15's responsible party. 5. Review of R72's Face Sheet located under the Profile tab of the EMR revealed R72 was admitted to the facility on [DATE] with the diagnoses of cellulitis left lower limb and heart failure with a pacemaker. Review of the Progress Notes located in the Progress Notes tab of the EMR revealed R72 was sent to the hospital on [DATE]. Review of R72 's EMR revealed no evidence that written notification regarding R72's transfer to the hospital was sent to R72's responsible party. 6. Review of R4's admission Record, located under the Profile tab in the EMR, revealed R4 was admitted on [DATE] with diagnoses including morbid obesity, chronic obstructive pulmonary disease (COPD), depression, acute kidney failure, and acute respiratory failure with hypoxia. Review of R4's quarterly MDS, with an ARD of 03/01/2026 revealed a BIMS score of 14 out of 15, indicating intact cognition. Review of R4's Progress Note, dated 02/16/2026 at 19:30 [7:30] PM and located under the Progress Notes tab of the EMR, revealed R4 was diaphoretic with increased confusion and altered mental status. Report was given to the emergency medical technician, and the resident was transferred to the hospital. Review of R4's EMR revealed no evidence that the resident and/or her RR were provided with a written emergency transfer notice which included the appeal rights to the transfer/discharge During an interview on 05/13/2026 at 3:25 PM, Registered Nurse (RN) 1 stated a transfer/discharge notice was sent with residents when they were transferred to the hospital. She showed this surveyor the e-interact form which was provided to the emergency medical technician (EMT) staff. She stated no other forms were provided to the resident or the resident representative (RR) in a language the resident or representative could understand regarding the rights to appeal the transfer/discharge or that indicated where they were going and why. During an interview on 05/14/2026 at 10:10 AM, the Director of Nursing (DON) stated she was not aware of a separate transfer/discharge form that should be provided to the resident and/or the RR. Review of the facility policy titled, Transfer and Discharge (including AMA [Against Medical Advice], revised March 2025, revealed, . It is the policy of this facility to permit each resident to remain in the facility, [sic] and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source. Emergency Transfers to Acute Care. (g.) Provide a notice of transfer and the facility's bed hold notice policy to the resident and resident representative as indicated.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on resident and staff interviews, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure one of two residents (Resident (R) 31) out of 41 sampled residents had an accurate Minimum Data Set (MDS) assessment. Failure to code the MDS correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the residents. (Cross Reference F656) Findings include: Review of R31's electronic medical record (EMR) admission Record located under the Profile tab indicated that the facility admitted the resident on 03/24/2026. Review of R31's EMR titled, Orders located under the Orders tab dated 03/29/2026 indicated that the psychiatrist ordered Mirtazapine 15 milligrams (mg) to be administered at bedtime to treat the resident's diagnosis of PTSD (post-traumatic stress disorder) and depression. Review of R31's EMR titled, admission MDS with an Assessment Reference Date (ARD) of 03/29/2026, located under the MDS tab indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which revealed the resident was cognitively intact. The assessment failed to indicate that the resident had a diagnosis of Post Traumatic Stress Disorder (PTSD). During an interview conducted on 05/13/2026 at 2:43 PM, R31 confirmed she had a diagnosis of PTSD. During an interview conducted on 05/15/2026 at 10:10 AM, MDS Coordinator (MDSC)2 stated that when she completed the MDS assessment she looked at the hospital records, consulted with the Nurse Practitioner, and would look through the physician orders. MDSC2 stated that the facility was not notified by the psychiatrist of R31's new diagnosis of PTSD. Review of the RAI manual, dated October 2025 and located in the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual by CMS, revealed, .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment .

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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 resident and staff interviews, record review, and review of the facility policy titled, Comprehensive Care Plans, the facility failed to develop a person-centered comprehensive plan of care with measurable goals and interventions for one of one resident (Resident (R) 31) reviewed for mental health, specifically for post-traumatic stress disorder (PTSD). This failure had the potential for staff to provide inconsistent and incomplete care related to the resident's PTSD.Findings include: Review of R31's electronic medical record (EMR) admission Record located under the Profile tab indicated that the facility admitted the resident on 03/24/2026. Review of R31's EMR titled Orders located under the Orders tab dated 03/29/2026 indicated that the psychiatrist ordered Mirtazapine 15 milligrams (mg) to be administered at bedtime to treat the resident's diagnosis of PTSD and depression. Review of R31's EMR titled, admission MDS with an Assessment Reference Date (ARD) of 03/29/2026 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which revealed the resident was cognitively intact. Review of R31's EMR tiled, Care Plan located under the Care Plan tab did not contain evidence that the resident's diagnosis of PTSD had corresponding goals and interventions. A request was made to speak to the psychiatrist, and she was not available to be interviewed by the end of the survey to clarify the diagnosis in the physician orders dated 03/29/2026. During an interview with R31 on 05/13/2026 at 2:43 PM, she confirmed that she had a diagnosis of PTSD. During an interview conducted on 05/13/2026 at 3:53 PM, Licensed Practical Nurse (LPN) 2/Unit Manager stated that the psychiatrist had placed the diagnosis of PTSD in the original order for R31 and the use of the antidepressant. During an interview conducted on 05/13/2026 at 4:15 PM, the Social Services Director (SSD) stated that she read the psychiatrist's notes and would discuss the resident during the morning clinical meeting. The SSD confirmed she was not aware of the resident's diagnosis, Review of a facility policy titled, Comprehensive Care Plans dated October 2025 indicated . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality.'Trauma-informed care' is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, staff interviews, record review, and review of the facility policy titled, Weight Monitoring, the facility failed to ensure weekly weights were implemented for one of one resident (Resident (R) 59) reviewed for nutrition out of a survey sample of 41. This lack of monitoring of residents' weight loss/gain can delay in identifying potential nutritional problems. Findings include: Review of R59's electronic medical record (EMR) admission Record located under the Profile tab indicated that the facility admitted the resident on 04/03/2026 with diagnoses that included stroke and acute kidney failure. Review of R59's EMR titled, Care Plan, located under the Care Plan tab dated 04/03/2026, indicated that the resident had a nutritional problem related to his right sided stroke. The care plan reflected that the resident's diet was upgraded to regular. Review of R59's EMR titled, Physician Orders, located under the Orders tab dated 04/04/2026, revealed the resident was to be weighed once a week for four weeks and then monthly after. Review of R59's EMR titled, Nutritional Assessment, dated 04/07/2026 at 12:36 PM located under the Assemts (Assessment) tab and completed by the Registered Dietician (RD) indicated admission height/weight are pending. The nutritional assessment indicated that the resident was independent with eating with some staff assistance. Review of R59's EMR titled, Weight located under the Weights & Vitals tab indicated that the facility weighed the resident on 04/07/2026 at 2:16 PM and the resident weighed 220.6 pounds. This was a four-day delay in obtaining the resident's initial weight upon admission. There was no documentation in the medical record that the resident was weighed on a weekly basis after the initial weights. Review of R59's EMR titled, admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/09/2026 indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which revealed the resident was cognitively intact. The assessment indicated that the resident had no weight loss/gain during the assessment period. The assessment indicated that the resident weighed 221 pounds. Review of R59's EMR titled, Nutritional Assessment, dated 05/02/2026, located under the Weights & Vitals tab indicated the resident's weight was now 216.4 pounds. During an observation conducted on 05/14/2026 at 1:26 PM, R59 was able to feed himself with his left hand and stated the food was good. The resident stated that he was aware that he had lost some weight while in the hospital and was not able to eat well at that time. During an interview conducted on 05/14/2026 at 2:54 PM, the RD stated residents were to be weighed weekly for the first four weeks due to having a close eye on the resident who came from the hospital since they were considered high-risk with a disease process. The RD stated the facility had identified the lack of initial admission weights and weekly weights for the first four weeks as an issue and were in the process of correcting this as an issue. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Weight Monitoring dated January 2024 indicated .Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable weight or desirable body weight range.A weight monitoring schedule will be developed upon admission for all residents.Newly admitted residents with weight loss-monitor weight weekly for 4 weeks.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on staff interview and review of the facility policy titled, Infection Preventionist, the facility failed to ensure the designated Infection Preventionist (IP) (IP6) completed specialized training in infection prevention and control. This failure had the potential to affect the well-being of any of the 138 residents and/or the staff by not ensuring all current infection prevention and control measures were being instituted. Findings include: 1. Review of a document provided by the facility titled, Timecard for IP6 (employment dates of 06/25/2025-08/30/2025) indicated that she was hired as the Staff Development Coordinator who was also the facility's IP on 06/24/2025. The facility provided no evidence of IP6's specialized training in infection and prevention. 2. Review of a document provided by the facility titled, Timecard for IP5 (employment date 09/09/2025-10/01/2025) indicated that she was hired as the Staff Development Coordinator who was also the facility's IP on 09/09/2025. The facility document failed to indicate when IP5 was no longer employed at the facility. The facility provided no evidence of IP5's specialized training in infection and prevention. 3. Review of a document provided by the facility titled, Timecard for IP4 (employment date 10/16/2025-04/04/2026) indicated that she was hired as the Staff Development Coordinator who was also the facility's IP on 10/16/2025. The document failed to indicate when IP4 was no longer employed at the facility. The facility provided no evidence of IP4's specialized training in infection and prevention. There was no documentation the facility had a quailed IP from 06/24/2025-11/28/2025. During an interview conducted on 05/15/2026 at 2:30 PM, the Director of Regulatory Compliance stated that it was the facility's process to have a full-time Staff Development Coordinator/IP in each of their buildings. The Director of Regulatory Compliance stated that the IP training should be incorporated into each employee file, and it was not. Review of the facility policy titled, Infection Preventionist dated 10/01/2022 indicated . The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program. The IP must have obtained specialized IPC training beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certificate(s) of completion or equivalent documentation.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, review of the facility policy titled, Pneumococcal Vaccine (Series), and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer one of seven residents (Residents (R) 74) reviewed for flu/pneumonia vaccinations and/or their representatives, the opportunity for the residents to be vaccinated in accordance with nationally recognized standards. This deficient practice had the potential to increase the risk for residents to contract pneumonia. Findings include: Review of R74's electronic medical record admission Record indicated that the facility admitted the resident on 08/14/2022. Review of R74's EMR titled, annual Minimum Data Set (MDS) with an Assessment reference date of 04/07/2026, located under the MDS tab indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15, which revealed the resident was cognitively impaired. Review of R74's EMR titled, Immunizations located under the Immun (Immunizations) tab, dated 01/08/2018 indicated, the resident had the Prevnar (PCV)13 vaccination and received the Pneumovax (PPSV23) on 01/30/2019. Review of a document provided by the facility for titled, Georgia Registry of Immunization Transactions and Services, dated 05/15/2026, indicated that R74 was up to date on her pneumococcal vaccines. There was no evidence in this document that reflected that the resident was offered the current CDC recommendations of the PCV20 or PCV21 vaccines. During an interview conducted on 05/15/2026 at 9:27 AM, Infection Preventionist (IP) 1, who was being trained by the Director of Nursing (DON) since the DON was the current IP at the facility, confirmed the vaccination status of R74 and the resident was [AGE] years of age at the time of her admission. Both IP1 and the DON confirmed the resident should have been offered the PCV20 or the PCV21 vaccination based on CDC recommendations. Review of the CDC website titled, PneumoRecs VaxAdvisor App (Application) for Vaccine Providers, dated 02/25/2026, indicated . Based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Regardless of whether PCV20 or PCV21 is administered, their pneumococcal vaccinations are complete. Review of a facility's policy titled, Pneumococcal Vaccine (Series) dated December 2023 indicated .It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines.