STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115265	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Satilla	1600 Riverside Ave Waycross, GA 31501

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 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. Based on staff interviews, record review, and review of the facility's policy titled, Comprehensive Care Plans, Facility A failed to implement the comprehensive care plan for one of 63 sampled Residents (R) (R112). Actual harm occurred on 12/5/2025 when Certified Nurse Assistant (CNA) LL failed to transfer R112 using two people to assist, which resulted in a left humerus fracture.Findings include:Review of the facility's policy titled, Comprehensive Care Plans, dated 1/1/2023 under the Policy section revealed, It is the policy of this facility to develop and implement comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a residents' medical, nursing, mental, and psychosocial needs and all services that are identified in the residents' assessment.Review of the quarterly Minimum Data Set (MDS) assessment for R112, dated 11/29/2025, revealed that Section C (Cognitive Patterns) documented that R112 had a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented that a chair-to-bed-to-chair transfer and a tub or shower transfer were not attempted due to medical condition or safety concerns. Section I (Active Diagnoses) documented diagnoses of, but not all inclusive, dementia, muscle weakness, congestive heart failure, osteoarthritis, and hypertension.Review of the care plan for R122, date initiated 6/8/2022 and revised 2/7/2024, revealed that R112 needed assistance with grooming, bathing, and personal hygiene related to mobility impairment and self-care impairment, and required two people at all times when giving care. Interventions included bathing assistance of two people, must have two people for all care provided, and transfer assistance of two people with a mechanical lift.Review of a Facility Incident Report Form, dated 12/7/2025, revealed R112 complained of pain to left shoulder post transfer to the shower chair. Resident noted to have bruising under left axilla and left arm. X-ray results showed fractured left proximal humerus.In an interview on 2/12/2026 at 5:15 PM, Certified Nurse Aide (CNA) LL confirmed that R112 required a mechanical lift transfer with two people. She reported that on 12/5/2025, she transferred R112 without assistance. She reported that R112 complained of pain during the last round at approximately 12/5/2025 at 5:30 PM. In an interview on 2/12/2026 at 4:59 PM, the National Director of Risk Management confirmed that the care plan interventions for R112 documented the resident required two-person assistance with a mechanical lift for transfers.In an interview on 2/12/2026 at 5:02 PM, the Administrator confirmed the care plan documented R112 required two persons assistance with a mechanical lift for transfers. Cross-Reference F-689

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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on staff interviews, record review, and review of the facility's policy titled, Safe Resident Handling/Transfer, Facility A failed to ensure safe transfer to a shower chair for one of 68 sampled residents (R) (R112). Actual harm occurred on 12/5/2025 when Certified Nurse Assistant (CNA) LL failed to transfer R112 using two people to assist, which resulted in a left humerus fracture.Review of the facility's policy titled, Safe Resident Handling/Transfer, dated 1/1/2026, under the Policy section stated, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risk of injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines.Review of the quarterly Minimum Data Set (MDS) assessment for R112, dated 11/29/2025, revealed that Section C (Cognitive Patterns) documented that R112 had a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive impairment). Section GG (Functional Abilities and Goals) documented that a chair-to-bed-to-chair transfer and a tub or shower transfer were not attempted due to medical condition or safety concerns. Section I (Active Diagnoses) documented diagnoses of, but not all inclusive, dementia, muscle weakness, congestive heart failure, osteoarthritis, and hypertension.Review of the Progress Notes for R112 revealed an entry dated 12/7/2025 of Bruising observed under resident's left axilla. Resident reported tenderness to the affected area. MD [medical doctor] notified; received order to obtain an X-ray.Review of a Radiology Results Report, dated 12/7/2025, for R112 revealed that the procedure was left humerus, 2+ views, and the findings were a fracture of the proximal humerus (upper bone of the arm).Review of a Facility Incident Report Form, dated 12/7/2025, revealed R112 complained of pain to left shoulder post transfer to the shower chair. Resident noted to have bruising under left axilla and left arm. X-ray results showed fractured left proximal humerus.In an interview on 2/12/2026 at 5:15 PM, Certified Nurse Aide (CNA) LL confirmed that R112 required a mechanical lift transfer with two people. She reported that on 12/5/2025, R112 was insistent on getting a shower to wash her hair, but all the mechanical lift pads were in use. She confirmed that she transferred R112 without assistance. CNA LL stated that another CNA was there to hold the shower chair during the transfer, but did not touch R112. She reported that R112 complained of pain during the last round at approximately 12/5/2025 at 5:30 PM. She states she reported it to the nurse.In an interview on 2/12/2026 at 5:29 PM, CNA MM confirmed that she held the shower chair while CNA LL transferred R112 without using the mechanical lift. She confirmed that R112 required two staff during transferring with the Hoyer lift. CNA MM stated that she did not physically transfer the resident, and that CNA LL picked the resident up under the resident's arms for the transfer.In an interview on 2/12/2026 at 4:53 PM, the Administrator revealed that the incident happened on 12/5/2025, and on 12/7/2025, the Director of Nursing (DON) notified the Administrator when bruising was identified under R112's left axilla.In an interview on 2/12/2026 at 4:59 PM, the National Director of Risk Management confirmed that R112 was a two-person assist for transfer using a mechanical lift. He stated he was unsure who the other person was who assisted the CNA.In an interview on 2/12/2026 at 5:02 PM, the Administrator confirmed that there should have been a second CNA. She confirmed that R112 required two-person assistance with transfers.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, record review, and review of facility's policy titled, Date Marketing for Food Safety Policy, Facility A failed to ensure food was stored, sealed, and labeled correctly. This deficient practice affected the facility kitchen and had the potential to cause food contamination and foodborne illness among all residents consuming facility-prepared food. Facility A had 75 sampled residents that received an oral diet from the kitchen.Findings include:A review of the facility's policy titled, Date Marketing for Food Safety Policy, dated 1/1/2026, revealed that the facility adheres to a date marketing system to ensure the safety of ready-to-eat, time/temperature control for safety food.During an observation and walk through of the kitchen on 2/10/2026 at 10:20 AM with the Dietary Manager (DM) revealed the following:1. In the walk-in freezer a bag of filet fish was observed freezer burned, undated, and unlabeled.2. In the walk-in freezer sweet potato waffle fries were observed unsealed and unlabeled. 3. In the walk-in freezer a bag of chicken fingers was observed opened, unsealed, and undated. 4. In the walk-in freezer a bag of chicken fingers was observed opened, unsealed, and undated.Interview on 2/10/2026 at 1:50 PM with the DM confirmed the findings and stated that moving forward he and the kitchen staff would routinely monitor the dates and labels of all foods stored in the walk-in freezer.-in freezer.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, record review, and review of the facility's policy titled, Disposal of Garbage and Refuse, Facility A failed to ensure trash and garbage refuse for one of two dumpsters was maintained in a sanitary manner, creating a potential of harboring pest and insects. The facility's census was 75 residents. Findings include:Review of the facility's policy titled, [Name of Facility] Disposal of Garbage and Refuse Procedure revealed containers shall be durable, cleanable, and free from cracks or leaks and covered when not in use.Observation on 2/12/2026 at 2:15 PM with the Dietary Manager revealed that the dumpster lid was open with no staff observed in the area.Interview on 2/12/2026 at 2:25 PM with the Dietary Manager confirmed the findings and acknowledged that the dumpster lid should be closed when not in use.Interview on 2/12/2026 at 5:50 PM with the Administrator confirmed the findings and acknowledged that the dumpster lid should be closed when not in use.