STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115308	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Place at Martinez, The	409 Pleasant Home Road Augusta, GA 30907

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on document review and staff interviews, the facility failed to ensure that the arbitration agreement provided to all facility residents, with a current census of 79 residents, was not required to sign an arbitration agreement as a condition of admission to, or as a requirement to continue to, receive care at the facility. Specifically, the facility failed to ensure the arbitration agreement was not mandatory for all residents admitted to the facility. Findings include: Review of the facility provided admissions pack revealed under I. Dispute Resolution Procedure: that 3. Arbitration: This arbitration provision (Provision) is executed in conjunction with an agreement for admission and for the provision of nursing facility services (the admission Agreement) by the Center to (the Patient and/or Guarantor). The parties to the admission Agreement acknowledge that this Provision is part of the admission Agreement. This Provision is binding on and benefits the Center and Patient and their successors, heirs, executors, administrators, or assigns, and survives the lives or existence of the parties hereto. During an interview on 11/18/25 at 10:38 AM, the Administrator stated that the facility's arbitration agreement was within the facility's admission contract. The Administrator stated that all facility residents had signed the arbitration agreement form. During an additional interview on 11/21/25 at 2:30 PM, the Administrator stated that she had been the staff member discussing the facility's admission packet with new residents and families while the admission staff member was not available. She stated that she would answer questions to the residents and families. She said that she was not aware that the arbitration contract within the admission packet stated that the acceptance of the arbitration agreement was contingent on admissions. She stated that she did not believe that was the intent. She confirmed that the arbitration agreement was signed by all the residents in the facility, and that it was not designated separately from the admission agreement.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115308	A. Building B. Wing	11/21/2025

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on document review and staff interviews, the facility failed to ensure that the arbitration agreement signed by all facility residents, with a current census of 79 residents, provided for the selection of a venue that was convenient to both parties. Specifically, the facility failed to ensure that a neutral venue available to both parties was documented within the arbitration agreement. This exclusion places facility residents and families at an unknown disadvantage in potential future disputes.Findings include: Review of the facility provided admissions pack revealed under I. Dispute Resolution Procedure: that it failed to include a clause to allow for any arbitration to be conducted at a site which was convenient to both parties signing the form. No statement or clause identified the process of determining a venue for a dispute to ensure a neutral location. During an interview on 11/18/25 at 10:38 AM, the Administrator stated that the facility's arbitration agreement was within the facility's admission contract. The Nursing Home Administrator stated that all facility residents had signed the arbitration agreement form. During an additional interview on 11/21/25 at 2:30 PM, the Administrator stated that she had been the staff member discussing the facility's admission packet with new residents and families while the admission staff member was not available. She confirmed that the arbitration agreement was signed by all the residents in the facility, and that it was not designated separately from the admission agreement. The Administrator was not aware that the requirement for a venue location agreed on by both parties was not included in the arbitration contract.

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	115308	A. Building B. Wing	11/21/2025

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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. Based on observations, staff interviews, and policy review, the facility failed to maintain a safe, functional, and sanitary environment in the main dining room where 14 out of a total of 85 residents ate their meals. This failure had the potential to lead to the spread of infection or feelings of discomfort and dissatisfaction among residents. Findings include: Review of the undated policy titled, The Place Facilities Safe and Homelike Environment, revealed, Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. During initial observations of the main dining room on 11/18/25 at 9:11 AM, four of five observed ceiling vents were covered with fuzzy dust and dirt. These vents were located above residents' dining tables. The wall below the pass-through window to the kitchen had spilled liquid or food debris running down the length of the wall and onto the floor below. During observation of lunch in the main dining room on 11/18/25 beginning at 12:07 PM, 14 residents were seated at the tables eating lunch. The ceiling vents above the residents were observed with caked-on fuzzy dust and dirt. The wall and floor below the pass-through window continued to have the same liquid spills and food debris. During a concurrent observation and interview on 11/21/25 at 9:50 AM, the Director of Maintenance (DOM), who also served as the Director of Housekeeping, observed the ceiling vents caked with dust and dirt and stated they were dirty and needed to be cleaned. The DOM stated the dust was a concern because it was directly above where residents ate. The DOM stated the housekeeping department was responsible for cleaning the ceiling vents and stated they should be cleaned about every two weeks, but did not have documentation of the cleaning. He stated the vents needed to be cleaned immediately. The DOM also observed the wall and floor under the pass-through window to the kitchen and agreed it was soiled with food or liquid spills. The DOM stated the housekeeping staff cleaned the floor in that area, but he felt the kitchen staff should be responsible for cleaning the wall under the pass-through window. The DOM stated the wall needed to be cleaned.

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	115308	A. Building B. Wing	11/21/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, staff interviews, and document review, the facility failed to ensure that eight of the eight residents who received pureed diets out of a total of 85 residents received the foods as called for in the menus. These failures placed the eight residents at risk for weight loss, malnutrition, or dissatisfaction with their meals.Findings include: Review of a handwritten, undated document titled Texture Count, provided by the Dietary Manager (DM), revealed the facility had eight residents who received a pureed diet. 1. During interview and concurrent observation of breakfast service in the kitchen on 11/20/25 at 7:34 AM, Dietary Aide (DA) 2 stated she prepared pureed eggs, pureed waffles, and cream of wheat for the pureed meals. She was observed serving pureed meals consisting of pureed eggs, waffles, and cream of wheat. Review of the Diet Extensions: Thursday, Week 1, Menu, provided on paper by the Dietary Manager (DM), revealed that the pureed breakfast meal should have consisted of pureed oatmeal, pureed banana, pureed sausage patty, and pureed waffle. During an interview on 11/21/25 at 1:47 PM, the DM stated she had never prepared pureed oatmeal before and had never heard of it being done. She stated she did not know the menu called for pureed oatmeal. The DM stated she did not know why pureed eggs were served instead of pureed sausage or why cream of wheat was served instead of pureed oatmeal. The DM stated she did not know why the pureed banana was not served. The DM stated DA2 probably overlooked it on the menu. The DM placed a call to DA2 for an interview; however, there was no response prior to survey exit. The DM stated she expected staff to serve food as called for on the menu. 2. During interview and concurrent observation of breakfast service in the kitchen on 11/21/25 at 7:35 AM, DA1 stated she had prepared pureed eggs, cream of wheat, and pureed oatmeal for the pureed meals. She was observed serving pureed meals consisting of pureed eggs, cream of wheat, and pureed oatmeal. Review of the Diet Extensions: Friday, Week 1, Menu, provided on paper by the DM, revealed the pureed breakfast meal should have consisted of pureed banana, pureed eggs, pureed diced potatoes, and pureed wheat bread. During an interview on 11/21/25 at 1:47 PM, the DM stated she was unaware that the menu was not followed at breakfast. She stated she did not know why pureed banana was not served, or why pureed oatmeal was served in place of pureed diced potatoes. During an interview on 11/21/25 at 1:50 PM, DA1 stated she did not puree potatoes as the shipment had not come in. She confirmed she did not serve pureed banana.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, document review, policy review, and review of McGeer's criteria, the facility failed to have an Antibiotic Stewardship Program that followed current standards of practice for prescribing an antibiotic for five of five residents (Resident (R) 25, R62, R63, R46, and R50) reviewed for antibiotic stewardship out of total sample of 27 residents. This failure had the potential for residents to be prescribed unnecessary antibiotics.Findings include: Review of the undated facility's policy titled, The Place Antibiotic Stewardship Program indicated, The program includes antibiotic use protocols and a system to monitor antibiotic use. The facility uses the (CDC [Centers for Disease Control] NHSN [National Healthcare Safety Network] Surveillance Definitions, updated McGeer's criteria, or other surveillance tool) to define infections. Review of McGeer's Criteria dated 11/05/24 revealed, . Table 2. Urinary Tract Infection (UTI) Surveillance Definitions Syndrome: UTI without indwelling catheter Criteria: 1. At least one of the following sign or symptom: Acute dysuria or pain, swelling, ., Fever or leukocytosis, and one or more of the following: acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency. If no fever or leukocytosis, then greater than 2 of the following: suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency 2. At least one of the following microbiologic criteria greater than or equal to 100,000 Colony Forming Units (CFU) per milliliter (mL) of no more than 2 species of organisms in a voided urine sample greater than or equal to 100 of any organism(s) in a specimen collected by an in-and-out catheter . 1. Review of R25's undated Face Sheet, located under the Profile tab in the electronic medical record (EMR), indicated R25 was admitted to the facility on [DATE] with the diagnosis of renal insufficiency and diabetes mellitus. Review of R25's Physician Orders, located in the hard copy of R25's medical record, indicated an order dated 01/19/25 to obtain UA [urinalysis] C&S [culture and sensitivity]. Review of the Nursing Progress Notes, located under the Progress Note tab in the EMR, revealed there was no documentation to indicate R25 signs and symptoms to warrant a UA and C&S to be ordered. During an interview on 11/21/25 at 2:15 PM, the Infection Preventionist/Wound Care Nurse (IP/WCN) reviewed the Infection Control Report for R25. In this report, the IP/WCN confirmed there was no documentation to indicate any signs and symptoms R25 was experiencing at the time the UA C&S was ordered. This report also indicated that the Nurse Practitioner ordered Omnicef (an antibiotic) 300 mg (milligrams) by mouth two times a day for 10 days on 01/21/25 for R25. The C&S report was reviewed by the IP/WCN, and she confirmed the results of 10,000 – 49,000 CFU/ml (colony-forming units per milliliter) Proteus mirabilis. The IP/WCN confirmed this result did not meet McGeer's criteria of At least 100,000 cfu/ml or no more than 2 organisms or microorganisms in a voided urine sample, even though the IP/WCN documented on the Infection Control Report the infection did meet criteria for a UTI (Urinary Tract Infection). Copies of the physician's orders for the antibiotic and nursing documentation to reflect the signs and (continued on next page)

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	115308	A. Building B. Wing	11/21/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	symptoms that R25 was experiencing prior to the order of the UA C&S on 01/19/25 were requested. No further documentation was received prior to the exit conference on 11/21/25. 2. Review of R62's Face Sheet, located under the Profile tab in the EMR, indicated R62 was admitted to the facility on [DATE] with the diagnosis of coronary artery disease and renal insufficiency. Review of R62's Physician Orders, provided by the facility, indicated an order dated 08/19/25 for Doxycycline Hyclate (antibiotic) 100 mg by mouth two times a day for 10 days for infection. Review of R62's Progress Note, provided by the facility, revealed the Nurse Practitioner documented, Chief Complaint: cough. Patient [R62] states that her cough today seems worse. She [R62] denies fever, sore throat, runny nose, body aches/chills. chest pain, shortness of breath. Today Oxygen [sic] saturations noted to be 95% on room air. Vital signs noted to be stable. Review of R62's Chest X-Ray Results dated 08/19/25 and provided by the facility indicated No pleural effusion. No acute cardiopulmonary process. During an interview on 11/21/25 at 2:25 PM, the IP/WCN reviewed the Infection Control Report for R62 and confirmed that this did not meet McGeer's criteria due to R62 not having a fever, and the x-ray results on 08/19/25 did not reveal pleural effusion or any acute cardiopulmonary processes, and R62's oxygen saturations were 95% on room air. 3. Review of R63's Face Sheet, located under the Profile tab in the EMR, indicated R63 was originally admitted to the facility on [DATE] with the diagnosis of Alzheimer's Disease and traumatic brain injury. Review of R63's Physician Orders, provided by the facility and dated 04/23/25, indicated Zithromax Z-Pak [antibiotic] 250 mg [milligram] po [by mouth] give 500 mg on day 1 [sic], then 250 mg po on day 2-5 [sic] then stop for cough/congestion. During an interview on 11/21/25 at 2:35 PM, the IP/WCN confirmed that R63 did not meet McGeer's criteria for the diagnosis of congestion. The IP/WCN confirmed the Infection Control Report was not filled out completely to reflect any signs and symptoms the resident was experiencing at the time the antibiotic was ordered on 04/22/25. Nursing progress notes for R63 were requested regarding what signs and symptoms R63 was experiencing prior to the order of the Azithromycin on 04/22/25. No further information was provided by the IP/WCN prior to the exit conference on 11/21/25. During an interview on 11/21/25 at 4:55 PM, the Director of Nursing (DON) stated, [IP/WCN] went over this. We review it together. [IP/WCN] fills out the form, then we bring it to a clinical meeting to discuss with the team. Our NP [nurse practitioner] is also involved in this process. Our biggest thing is to make sure we follow and meet McGeer's criteria for antibiotic use. 4. Review of R46's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE]. (continued on next page)

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	115308	A. Building B. Wing	11/21/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R46's Acute Care Note, dated 11/05/25 and located under the Progress Notes tab of the EMR, revealed, Staff states that resident is noted with some increased confusion . Assessment/Plan: R41.0 - Disorientation, unspecified - New order: UA/CS [urine analysis with culture and sensitivity]. Review of R46's Order Note, dated 11/05/25 and located under the Progress Notes tab of the EMR, documented that a new order was received for a UA/CS due to confusion. Review of R46's EMR under the Orders tab revealed a physician's order, dated 11/10/25, for Macrobid (an antibiotic), 100 milligrams (mg) twice daily for 10 days for a urinary tract infection (UTI). Review of R46's Lab Report, dated 11/06/25 and located under the Miscellaneous tab of the EMR, revealed a result of 40,000 - 50,000 colony-forming units per milliliter (cfu/mL) of Enterococcus faecalis was reported, which was susceptible to Macrobid. Review of R46's paper Infection Report Form, dated 11/11/25 and provided by the IP/WCN, revealed that none of the criteria listed to determine if a UTI was present were checked, but confusion was written in. The form instructed that acute dysuria, fever or leukocytosis, and/or symptoms of suprapubic pain, hematuria, new or increased incontinence, urgency, or frequency must be noted along with at least 1,000,000 cfu/mL of microorganisms detected. The form documenting R46's symptoms did not meet the criteria of a UTI. The form also documented that Macrobid was prescribed. Review of R46's Acute Care Note, dated 11/12/25 and located under the Progress Notes tab of the EMR, revealed, Patient seen today due to being place [sic] on ABT [antibiotic] r/t [related to] UTI. Patient placed on Macrobid 100mg po [orally] BID [twice a day] x10 days. She is tolerating well with no adverse reactions noted. Vital signs [were] noted to be stable. She remains afebrile. She denies chest pain, shortness of breath, headaches, lightheadedness, nausea, vomiting and dizziness. Patient denies urgency, back pain, frequency, and dysuria. 11/5 UA: 40,000 - 50,000 enterococcus faecalis, susceptible nitrofurantoin [Macrobid]. Review of R46's EMR and hard chart did not reveal any documentation that the physician was notified that the infection did not meet criteria for antibiotic use. There was no documented rationale for the continuation of the antibiotic without meeting criteria for a UTI. During an interview on 11/21/25 at 1:29 PM, the IP/WCN stated that if a resident's symptoms and lab values did not meet the criteria of a true infection, she would speak to the physician and try to get the antibiotic discontinued, as it was not necessary. The IP/WCN was unable to provide evidence that the physician was contacted to discuss the findings and the appropriate course of treatment. During an interview on 11/20/25 at 6:31 PM, the Medical Director stated his expectation was to determine whether symptoms and lab values met the criteria of an actual infection prior to treatment with antibiotics or for the discontinuation of an antibiotic if already started when the lab results were received, and the facility determined the criteria were not met. The Medical Director stated there should be a discussion with the physician to determine the proper course of treatment. 5. Review of R50's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE]. Review of R50's Order Note, dated 10/13/25 and located under the Progress Notes tab of the EMR, revealed, Macrobid Oral Capsule, Give 100 mg by mouth two times a day for dysuria [pain on urination] for 10 days. Review of R50's EMR did not reveal any documentation prior to the above Order Note regarding dysuria or any other symptoms. (continued on next page)

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	115308	A. Building B. Wing	11/21/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R50's 10/14/25 Infection Note, dated 10/14/25 and located under the Progress Notes tab of the EMR, revealed, Resident remains on abt [antibiotic] Macrobid. Resident remains afebrile. Review of R50's EMR and hard chart revealed no order for a UA/CS or lab results related to administration of Macrobid. Review of R50's Infection Report Form, provided on paper by the IP/WCN, revealed that none of the criteria listed to determine if a UTI was present were checked. The form instructed that acute dysuria must be accompanied by at least 1,000,000 cfu/mL of microorganisms detected. The form documenting R50's symptoms did not meet the criteria of a UTI. The form also documented that Macrobid was prescribed. Review of R50's EMR and hard chart did not reveal any documentation that the physician was notified that there was no criteria documented for antibiotic use. There was no documented rationale for the continuation of the antibiotic without meeting criteria for a UTI. During an interview on 11/20/25 at 6:19 PM, the IP/WCN stated that to determine whether a UTI met criteria for treatment, there must be a UA/CS performed. She stated R50 did not have a UA/CS ordered or performed because she was on hospice, and the hospice physician initiated the Macrobid order as a prophylactic. The IP/WCN stated, Hospice does that a lot. The IP/WCN was unsure if she provided any education to the hospice physician regarding antibiotic stewardship and the criteria to meet before initiation of antibiotic treatment. The IP/WCN stated the Medical Director was aware of this issue, but the Hospice had its own Medical Director who took care of all the residents in hospice. She stated she did not know if the facility's Medical Director provided any education to the hospice staff. During an interview on 11/20/25 at 6:31 PM, the Medical Director stated the hospice physician managed care for residents on hospice. He stated the hospice takes the patients as their own, they do what they want to do. The Medical Director stated the hospice did not allow a facility physician to oversee medical care for the residents on hospice. The Medical Director stated his expectation was to typically perform a UA/CS, even for his patients on hospice, prior to treatment with antibiotics. He stated there could be instances where it was impossible to get a urine sample, and treatment would be initiated without a UA/CS; however, this was rare. The Medical Director stated the hospice physician typically treated residents on hospice with antibiotics without first ordering a UA/CS. The Medical Director stated this was the way the hospice physician practiced, but he did not practice that way, and it was not the way it should be done.

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	115308	A. Building B. Wing	11/21/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, record review, and review of the facility assessment, the facility failed to ensure one of 27 sampled residents (Resident (R) 107) had the needed adaptive equipment for meals. This deficient practice had the potential to place the resident at risk for an undignified existence. Findings include: Review of [The Facility Name] Facility Assessment, last updated 02/28/24 and provided by the facility, revealed .Services and Care We Offer Based on our Residents' Needs.These are the services we offer our residents.Nutrition-Individualized dietary requirements.assistive devices. Review of R107's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic inflammatory demyelinating polyneuritis (CIDP). Review of R107's admission Minimum Data Set (MDS), with an assessment reference date (ARD) of 11/13/25 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was fully cognitively intact. The MDS also revealed that the facility assessed the resident to need setup or clean-up assistance for eating. The MDS revealed the facility assessed the resident did not have any upper extremity (shoulder, elbow, wrist, hand) range of motion (ROM) impairment. Review of R107's Diet Order & Communication form dated 11/06/25 and provided by the facility revealed the resident was ordered a regular textured diet with no added salt. The adaptive equipment section was not completed. Review of R107's Nutrition/Dietary Note, dated 11/10/25 and located in the resident's EMR under the Progress Notes tab revealed Note Text: RD [Registered Dietitian] review re: new admit to facility for respite care.visited resident, able to make needs known.resident requested built up utensils as she used at home, will notify nursing of resident request. Review of R107's Health Status Note, dated 11/20/25 and located in the resident's EMR under the Progress Notes tab revealed Resident requesting special utensils from home, residents [sic] daughter notified and stated will be bringing them up to the facility at 11 AM. During an interview on 11/18/25 at 12:00 PM, R107 stated she used built-up utensils when she was at home and while she was admitted to the prior nursing facility; however, the staff have not asked her any questions about adaptive equipment, nor have they observed her eating. During an observation and interview on 11/20/25 at 8:40 AM, R107 was eating her cereal using regular dining utensils. The resident appeared to be having difficulty holding the spoon. The resident stated she told a staff member this morning, and he stated he would ask about it. During an interview on 11/20/25 at 10:03 AM, the Director of Therapy (DOT) stated R107 was admitted to the facility for a respite stay and received a therapy screening; however, she would not receive any type of therapy services. The DOT stated she completed the occupational therapy screening, which included asking the resident to raise and lower her upper extremities. When asked if (continued on next page)

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	115308	A. Building B. Wing	11/21/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the screening included assessing if the resident needed any adaptive mealtime equipment, such as built-up utensils, the DOT stated that it would be a nursing recommendation. The DOT stated she did not ask the resident about needing adaptive equipment, and the resident did not bring it up to her. The DOT stated that therapies would not observe R107 eating a meal unless it was just by coincidence at the time of the screening. During an observation and interview on 11/20/25 at 10:42 AM, Licensed Practical Nurse (LPN) 4, who was the Unit Manager, observed the resident who now had a built-up spoon and a built-up fork. The LPN stated the facility got the resident some to use until her family brought the resident's in from home. When asked if therapy had evaluated the resident for the use of the adaptive equipment that was loaned to the resident to ensure it was the most appropriate, LPN4 stated since R107 was there on respite, therapy was not allowed to evaluate nor make recommendations. During an interview on 11/21/25 at 5:00 PM, the Director of Nursing (DON) stated it was her expectation that R107's family would have brought the resident's adaptive equipment to the facility if the resident needed it. During an interview on 11/21/25 at 5:54 PM, the Administrator stated it was her expectation that when the DOT completed the screening on R107, she would have operated within the parameters of her discipline and observed the resident eating a meal as part of the screening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115308	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Place at Martinez, The	409 Pleasant Home Road Augusta, GA 30907

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, text revision (DSM-5-TR), the facility failed to ensure one of five residents (Resident (R) 107) reviewed for unnecessary medications had an adequate indication for its use out of 27 sampled residents. This failure had the potential to place the resident at risk of receiving unnecessary medications.Findings include: Review of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, text revision (DSM-5-TR) revealed .Cultural Concepts of Distress. Relevance for Diagnostic Assessment. The term cultural concepts of distress refers to ways that individuals experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions. Three main types of cultural concepts of distress may be distinguished. Cultural idioms of distress are ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns. For example, everyday talk about 'nerves' .may refer to widely varying forms of suffering withoutmapping onto a discrete set of symptoms, syndrome, or disorder. Cultural explanations or perceived causes are labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress.Examples of Cultural Concepts of Distress.Nervios ('nerves') is a common cultural idiom of distress and causal explanation in Latinx cultural contexts in the United States and Latin America. Nervios refers to a general state of vulnerability to stressful life experiences and to difficult life circumstances. The term nervios includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. Nervios is a broad cultural idiom of distress that spans the range of severity from cases with no mental disorder to presentations resembling adjustment, anxiety, depressive, dissociative, somatic symptom, or psychotic disorders. Review of the DSM-5-TR revealed nerves is a symptom associated with many different mental health diagnoses and not a diagnosis. Review of R107's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included post-traumatic stress disorder (PTSD) and bipolar disorder. There were no anxiety-related disorders identified. Review of R107's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/13/25 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was fully cognitively intact. The Active Diagnoses section of the MDS did not identify the resident to have an active anxiety disorder diagnosis. Review of R107's physician Order Summary Report, located in the resident's EMR under the Orders tab, revealed an order dated 04/06/25 for buspirone Oral Table 15 mg [milligram] give 1 tablet by mouth two times a day for nerves. The Order Summary Report listed the facility's Medical Director as the ordering physician. During an interview on 11/21/25 at 5:00 PM, the Director of Nursing (DON) verified R107's order for buspirone, documented for nerves as the indication for use. The DON stated the resident's Veterans (continued on next page)

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	115308	A. Building B. Wing	11/21/2025

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Place at Martinez, The	409 Pleasant Home Road Augusta, GA 30907

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administration (VA) hospital discharge orders reflected nerves for the diagnosis. The DON stated it was her expectation that the nurse who reconciled the medications would enter the order as it was shown on the discharge orders received. The DON stated the facility's physician(s) did not have any involvement with respite residents' medications, as they brought the medications from home with the indication of use.

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	115308	A. Building B. Wing	11/21/2025

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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 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 record review, staff interviews, policy review, and the review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer or provide documentation of consent or refusal for pneumonia vaccines for two of five residents (Residents (R)25 and R63) and/or their resident representatives (RR) out of 27 sampled residents. This failure had the potential to put these residents at increased risk of developing pneumonia.Findings include: Review of the CDC website page titled Pneumococcal Vaccine Timing for Adults, dated March 2025 and located at https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf, revealed the CDC recommended pneumococcal vaccination for all adults [AGE] years of age or older. A PCV20 or PCV21 (types of pneumonia vaccines) should be administered greater to or equal to one year after PPSV23 given at any age. 1. Review of R25's Face Sheet, located under the Profile tab in the electronic medical record (EMR) indicated R25 was admitted to the facility on [DATE] with the diagnosis of diabetes mellitus and was [AGE] years old upon admission. Review of R25's Immunizations, located under the Immunization tab in the EMR, indicated R25 received Pneumovax 23 on 05/21/22. There was no documentation of R25 receiving or refusing any pneumococcal vaccinations that were recommended a year after the initial Pneumovax vaccine was given to R25. 2. Review of R63's Face Sheet, located under the Profile tab in the EMR, indicated R63 was originally admitted to the facility on [DATE] and was currently [AGE] years old. Review of R63's Immunizations, located under the Immunization tab in the EMR, indicated no documentation to reflect that R63 was offered or refused the Pneumovax vaccination. During an interview on 11/21/25 at 2:15 PM, the IP/WCN stated she did not keep up with vaccinations and that they were being completed by Licensed Practical Nurse (LPN4). During an interview on 11/21/25 at 4:15 PM, LPN4 was notified of the missing documentation for R25 regarding being offered or refusing the Pneumovax vaccination. R63 had missing documentation to reflect being offered or refusing the Pneumovax vaccinations. LPN4 stated she would gather this information and bring it to the surveyor. During an interview on 11/21/25 at 4:45 PM, the Director of Nursing (DON) stated, Upon admission, we review with the resident their immunizations. Our expectation is to check and see if the resident is in the GRITS system [Georgia Registry of Immunization Transactions Services]. We started consents for flu vaccines in September, and we also revisited the residents' Pneumovax vaccines. No further information was provided to the survey team prior to the exit conference.