STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115360	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayetteville Center for Nursing & Healing LLC	110 Brandywine Boulevard Fayetteville, GA 30214

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, family and staff interviews, and review of the facility policy titled Notification of Changes, the facility failed to notify the physician and Responsible Party (RP)/family of a fall of one of seven Residents (R) (R7) reviewed for notification of change.Findings include:Review of the facility policy titled Notification of Changes, reviewed/revised date of January 2024, revealed: Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative (consistent with their authority) when there is a change requiring such notification. Circumstances requiring notification include: 1. Accidents. Review of the admission Record for R7 revealed he was admitted to the facility on [DATE] with diagnoses of, but not limited to, bilateral rotator cuff injuries, cerebral infarction, and nontraumatic intracerebral hemorrhage. Review of the admission Minimum Data Set (MDS) for R7, dated 6/24/2025, revealed a Brief Interview for Mental Status (BIMS) was not assessed. Review of the Employee Punch Report revealed LPN III worked the following hours on 7/14/2025 8:01 pm to 7/15/2025 7:24 am. Review of the SBAR (Situation, Background, Assessment, Recommendation) Communication Form, dated 7/15/2025, created on 7/16/2025 at 3:41 am, revealed that R7 had a fall. The SBAR documented that the family was notified on 7/15/2025 at 6:50 am, and the primary care physician was notified on 7/15/2025 at 11:00 am. A telephone interview on August 27, 2025, at 2:13 pm with R7's family member, who is the RP, revealed that the family stated they did not receive a call at 6:50 am on July 15, 2025, from the facility stating that R7 had a fall. A telephone interview on 9/3/2025 at 12:40 pm with Licensed Practical Nurse (LPN) III stated she did not call the family prior to leaving work regarding R7's fall on 7/15/2025. She stated she notified __ (the medical service that takes calls from the facility after 5 pm or weekends) of R7's fall prior to leaving work on the morning of 7/15/2025. An interview on 9/23/2025 at 1:44 pm with LPN JJJ stated she received report from LPN III on 7/15/2025. She stated LPN III never mentioned that R7 had a fall on the 7 pm to 7 am shift. LPN JJJ stated the family was visiting and asked if their dad had a fall last night. LPN JJJ immediately called LPN III and was initially told that R7 did not fall. LPN JJJ stated that after having a further conversation with LPN III, she admitted that R7 had a fall. Licensed Practical Nurse JJJ stated she assessed the resident and notified the Nurse Practitioner of the fall and received an order for x-rays. An interview on 9/24/2025 at 9:23 am with the Director of Nursing stated she was not able to verify that the physician/medical service was notified of R7's fall on the morning of 7/15/2025.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record reviews, and review of the facility policies titled Resident and Family Grievances, and Resident Personal Belongings, the facility failed to make a prompt effort to file a grievance for one of nineteen sampled residents (R) (R8) who's family/responsible party (RP) reported both a written and verbal grievance. This deficient practice had the potential to place residents at risk of not having their grievances resolved in a timely manner. Findings include: Review of the policy titled Resident and Family Grievances, with a reviewed/revised date of 12/2024, revealed: Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Policy Explanation and Compliance Guidelines: 8. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Official. b. Written complaint to a staff member or Grievance Official. 10. Procedure: b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form. Review of the policy titled Resident Personal Belongings, with a reviewed/revised date of 3/2024 revealed: Policy: It is the policy of this facility to protect the resident's right to possess personal belongings such as clothing and furnishings for their use while in the facility and assure the personal belongings and/or possessions are rightfully returned to the resident, or to the resident's representative in the event of the resident's death or discharge from the facility. Policy Explanation and Compliance Guidelines: 3. All resident personal items will be inventoried at the time of admission by the resident or their representative and then verified by social services designee, or another designated staff member and documentation shall be retained in the medical record. Review of the admission Record for R8 revealed he was admitted to the facility on [DATE] with diagnoses of, but not limited to, cerebrovascular disease, chronic obstructive pulmonary disease, and obstructive sleep apnea. Review of the resident's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was assessed at 13, indicating cognitively intact. Review of the Skin Wound Note dated 7/17/2025 revealed: New admit resident wears glasses. Review of the __ admission Packet revealed it was signed by the family on 7/19/2025 and the facility representative on 7/21/2025. On page 31, titled Inventory of Personal Items, it was documented that R8 was admitted with a pair of eyeglasses. Review of the Grievance Reports from 6/13/2025 to 8/26/2025 revealed one documented grievance filed by the family for R8 on 8/11/2025. The grievance did not include missing items. Review of an email from R8's Family titled Second Formal Complaint Regarding Care of R8 dated 8/3/2025, and addressed to the Administrator, Assistant Director of Nursing (ADON), Director of Nursing (DON), Business Office Manager, Human Resources, and the wound care nurses. Four family members were carbon-copied on the email. The email revealed R8's glasses are missing, with no accountability. In an interview on 9/3/2025 at 11:35 am, the Social Service Director (SSD) stated the facility uses __ to report, log, and track the facility's grievances. She stated that any staff person can input the information into __. The SSD stated that if a resident/family/RP had a concern, it was entered into the grievance tracking system. The grievances were sent out to all departmental heads, including the department(s) that were required to address and investigate the grievance. She stated that grievances were discussed in the morning management meeting. The SSD stated that the Administrator and herself oversaw and ensured that the grievances were resolved in a timely manner and closed out. The SSD stated that no one reported or logged in the grievance tracking system that R8 lost his eyeglasses. In a telephone interview on 9/4/2025 at 2:45 pm, R8's family member, who is the RP, stated that on 8/1/2025, it was reported to the ADON and a Certified Nursing Assistant (CNA) that R8's shorts and eyeglasses were missing. The family member stated the CNA returned with R8's shorts, but the glasses could not be located. She (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she reported the missing items again in a formal email on 8/3/2025. In an interview on 9/9/2025 at 11:10 am, the ADON stated she never had any communication with the family of R8 regarding lost eyeglasses or clothes. She stated that if a resident or family reported lost items, she would report it to the Social Worker. The ADON stated the Social Worker was responsible for logging the resident/family grievances into the __ system. The ADON stated she would also report the lost items to the laundry department so that they could look for the missing items. In an interview on 9/16/2025 at 10:57 am, the ADON confirmed that she did receive an email from R8's family. She stated she does not remember reading the email. She stated, Those things are handled by the DON.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family and staff interviews, record reviews, observations, and the facility policies titled Abuse, Neglect and Exploitation, and Safe Resident Handling/Transfer, the facility failed to protect two out of five Residents (R) (R7 and R16) by neglecting to use the designated mechanical lift to transfer the residents. Specifically, Licensed Practical Nurse (LPN) III and Certified Nursing Assistant (CNA) DDDD attempted to transfer R7 from the floor to the bed by his legs and his neck. During this improper transfer from the floor to the bed CNA DDDD lost control and dropped R7, causing his head to hit the floor. The facility allowed the LPN III and CNA DDDD to continue working with the vulnerable residents for an additional 15 days. CNA EEEE transferred R16 from the bed to the chair without using the required mechanical lift, causing a laceration to R16's right great toe. The neglect had the potential to affect fifty residents who require a mechanical lift for transfer. Findings include:A review of the policy titled Abuse, Neglect and Exploitation, reviewed/revised date of April 2024. Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect. A review of the policy titled Safe Resident Handling/Transfer, reviewed/revised date of March 2025. Policy Explanation: All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual Lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical Lifts are a safer alternative and should be used. Compliance Guidelines: 14. Resident lifting and transferring will be performed according to the resident's individual plan of care. 1. A telephone interview on 8/27/2025 at 2:13 pm with R7's family member who is the Responsible Party (RP). The family stated that upon reviewing the camera located in R7's room on 7/15/2025 around 1:00 pm Central Standard Time (CST). The family stated that around 6:40 am Eastern Standard Time (EST), R7's legs were hanging over the side of the bed that was in a high position. The family stated R7 fell out of the bed and yelled out for about ten minutes before the nurse entered the room. The family stated the staff left the room and returned 4-5 minutes later with another nurse or CNA. The family stated, dad was picked up by the neck and legs and dropped on the floor. The family stated dad was picked up a second time and thrown in the bed, causing the mattress to move off the bed. The family stated the entire time dad was crying out. No one from the facility notified the family of the fall until after the family reached out to the Regional Director of Operations on 7/15/2025 at 2:20 pm CST. An interview on 8/29/2025 at 2:00 pm with R7 at __ Nursing Home with the Director of Nursing (DON) DDD, and Unit Manager (UM) BBBBBB. The interview took place in UM's office. The resident appropriately answered the screening questions. The resident answered yes when he was asked about being in a different place. He answered yes when asked if he had fallen at the previous home. The resident verbalized that he fell and lay on the floor. He was able to verbalize he was dropped and had hurt his head. He verbalized that he bumped his head on the headboard. The resident became tearful during the interview when talking about the previous facility. He verbalized he wanted to go home to Jesus. He (R7) expressed that he was in pain at the time of the interview. Review of the admission Record for R7 revealed he was admitted to the facility on [DATE] and a diagnosis of, but not limited to bilateral rotator cuff injuries, cerebral infarction, and nontraumatic intracerebral hemorrhage. Review of the resident's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not assessed. Section GG revealed R7 is dependent on staff for transfers. Functional Abilities (Self-Care and Mobility) triggered as an area of concern on the Care Area Assessment Summary (CAAS). Review of the care plan initiated on 6/20/2025 revealed that R7 has a deficit in activities of daily living (ADL) self-care. Intervention to be implemented includes a mechanical lift with two staff assistants for transfers. A review of the video of R7 on the floor and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transferred by two staff to the bed, provided to the surveyor by the family, revealed that on 7/15/2025 at 6:53 am, a person in a blue shirt was in R7's room. The resident was on the floor, lying on his right side, facing the door, and moaning. The bed was in a high position and lowered by the person in the room. The person was standing over the resident and pulled out a phone. The person left the room at 6:55 am and returned at 6:59 am with a person in a white lab jacket. The person in blue was positioned at R7's feet, and the person in the white lab jacket was positioned at the right side of R7's body. R7 was picked up by the legs and neck from the floor. The resident was lifted to the level of the bed. During this transfer from the floor to the bed, R7 was dropped with his head hitting the floor first, then his legs. The resident was picked up off the floor a second time by the same two people by the legs and neck and transferred to the bed. The resident was moaning and crying throughout the video, 6:53 am -7:01 am. This video was also viewed by the DON CC, who confirmed the person in the blue was LPN III and the person in the white was CNA DDDD. Review of a Nurses Note created on 7/15/2025 at 11:37 pm and dated 7/15/2025 at 6:50 am revealed that the writer went into the room when resident was yelling, then found resident almost on the floor, resting his back on the bed rails, resident was assisted to the floor, and writer called for her, resident was assessed, no bruises or injuries noted at this time. with 1-assist, resident was transferred to bed, well-position, telemeds were notified, orders said to initiate neuro-checks. vital signs within normal limits. resident in bed resting at this time. will continue to monitor for further changes in condition. There was no documentation in this nurse's note that the family was notified. Review of the document titled Mechanical Lift Transfer Resident List dated 9/15/2025 revealed that fifty residents require a mechanical lift for transfer. Review of the Employee Punch Report revealed LPN III worked the following shifts after 7/15/2025: 7/15/2025 6:44 pm to 7/16/2025 7:20 am 7/16/2025 6:46 pm to 7/17/2025 7:23 am7/17/2025 6:48 pm to 7/18/2025 6:57 am7/20/2025 6:48 pm to 7/21/2025 7:43 am7/21/2025 6:46 pm to 7/22/2025 7:37 am 7/22/2025 6:46 pm to 7/23/2025 7:30 am7/25/2025 6:47 pm to 7/26/2025 7:33 am7/26/2025 6:50 pm to 7/27/2025 6:59 am7/27/2025 6:50 pm to 7/28/2025 7:19 am 7/28/2025 6:45pm to 7/29/2025 7:11 am7/30/2025 6:51pm to 7/31/2025 7:14 am7/31/2025 6:42 pm to 8/1/2025 7:18 am8/2/2025 6:53 pm to 8/3/2025 7:30 am8/4/2025 6:50 pm to 8/5/2025 7:26 am8/5/2025 6:45 pm to 8/06/2025 7:23 am Review of the Employee Punch Report revealed CNA DDDD worked the following shifts after 7/15/202:7/18/2025 7:24 pm to 7/19/2025 8:02 am7/19/2025 7:01 pm to 7/20/2025 7:31 am7/20/2025 7:03 pm to 7/21/2025 7:44 am7/21/2025 7:00 pm to 7/22/2025 7:41am7/22/2025 7:01pm to 7/23/2025 7:26 am7/23/2025 7:09 pm to 7/23/2025 7:37 pm7/25/2025 6:49 pm to 7/26/2025 7:32 am7/26/2025 6:58pm to 7/27/2025 7:05 am7/27/2025 7:19 pm to 7/28/2025 7:25 am7/28/2025 7:11 pm to 7/29/2025 7:13 am7/31/2025 6:31 pm to 8/1/2025 7:14 am8/01/2025 7:04 pm to 8/2/2025 8:05 am8/02/2025 6:57 pm to 8/3/2025 7:01 am8/03/2025 7:10 pm to 8/4/2025 7:30 am8/4/2025 7:03pm to 8/05/2025 7:16 am8/08/2025 7:16 pm to 8/8/2025 7:36 pm Review of the LPN III employee file in the presence of the Human Resource Director revealed: Separation Notice, hire date of 3/28/2025, and a termination date of 8/21/2025 for gross misconduct, failed to do a proper assessment and care plan update signed by Human Resource on 8/22/2025. Review of CNA DDDD employee file in the presence of the Human Resource Director revealed: Separation Notice, hire date of 6/17/2025, and termination date on 8/21/2025 for gross misconduct, participated in an improper transfer of patient during an incident signed by Human Resource on 8/22/2025. An interview on 8/27/2025 at 10:04 am with DON CC stated R7 was admitted to a private room The DON stated that when R7 was admitted , the family requested to place a camera in the room. She stated the camera was there for a few weeks with signage alerting anyone who entered the room that there was a camera. She stated the upper management had the family remove the camera. She stated on 7/15/2025 LPN III was making rounds and found R7 sliding off the bed, and the resident was lowered to the floor. The LPN went to get help to assist with transferring R7 back to bed. The CNA DDDD assisted with transferring R7 back to bed. The LPN assessed the resident, and no injuries were identified. The DON stated the family was notified of R7's fall. The DON stated that (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when she spoke with the LPN on 7/15/2025, she did tell her that no fall documentation was located in R7's Electronic Medical Record (EMR). The DON stated she instructed the nurse to complete the required documentation. The DON stated on 8/1/2025 family arrived to the facility for an impromptu meeting to inform the facility that R7 was dropped on the floor during a transfer. The DON stated she reviewed the resident's EMR, and the only documented fall was 7/15/2025. She decided to reinvestigate the fall from 7/15/2025. The DON stated the family's allegation was reported to the State Survey Agency immediately, and the investigation was started. She stated she called the nurse and CNA who was involved and was told absolutely a mechanical lift was used to transfer R7 off the floor into the bed. The DON stated LPN III and CNA DDDD were terminated on 8/1/2025. A telephone interview on 9/3/2025 at 12:40 pm with LPN III stated on 7/15/2025 she worked on 800 halls. She stated that around 6:57 am, she could hear R7 yelling. She stated when she entered the room the bed was in low position and R7 had one leg on the floor and one leg in the bed on the body pillow. She stated R7 was assisted to the floor. The LPN stated she assessed and checked R7's vital signs and disconnected the feeding. She stated she checked the care plan and Kardex and R7 were care plan for transfer with a mechanical lift. The LPN stated she could not locate a sling for the mechanical lift on 800/900 linen closet or the linen closet on the other side of the facility. The LPN stated she went to the other side of the building to get help. The LPN stated that because R7 needed to get off the floor a two-person transfer was done. She stated during the transfer herself, and the CNA had to lay R7 back on the floor. She stated the second time doing the two-person assist transfer they were able to get R7 back into the bed and R7 was fine. The LPN stated during the interview she did not notify the family of the fall. She stated the family was called later that day. A telephone interview on 9/3/2025 at 1:05 pm with CNA DDDD stated on 7/15/2025, she was working on 400/500 hall. She stated around 6 something LPN III ask for assistants to get a resident off the floor. The CNA stated when she arrived in R7's room the resident was on the floor. The CNA stated she placed her hands under the resident's shoulders, no I mean arm pits to transfer the resident from the floor to the bed. She stated the mattress on the bed started sliding and the resident was lowered back to the floor. She stated the mattress was adjusted and R7 was transferred from the floor to the bed. After helping the nurse get R7 back in bed she left the room. An interview on 9/3/2025 at 2:15 pm with the Human Resource Director (HRD) JJ confirmed there was no documentation for a suspension or disciplinary action on or after 7/15/2025 in LPN III's file. An interview on 9/3/2025 at 2:16 pm with the HRD JJ confirmed there was no documentation for a suspension or disciplinary action on or after 7/15/2025 in CNA DDDD's file. An interview on 9/5/2025 at 2:00 pm with the Director of Clinical Operations stated the management team spent a weekend reeducating the staff on safe transfers. She stated that the management team reeducated the staff on the use of mechanical lifts during transfers. The staff was also required to complete the skills check-off for proper use of a mechanical lift. 2. An observation and interview on 9/16/2025 at 10:43 am of R16's skin along with UM LLL. The resident complained of right knee pain. The resident stated she did tell the nurse and was given a pill. The UM asked the resident for permission to look at her skin. An observation of the right and left legs elevated on a pillow. An observation of swelling in the right knee, laceration on the right great toe open to air with red drainage, and an observation of an open area on the left second toe. Review of the admission Record for R16 revealed she was admitted to the facility on [DATE] and a diagnosis of, but not limited to, dementia, quadriplegia, and type 2 diabetes mellitus with diabetic neuropathy. Review of the resident's admission MDS dated [DATE] revealed a BIMS assessed at eight, indicating moderately impaired. Section GG revealed that R16 requires partial/moderate assistance with transfer. Functional Abilities (Self-Care and Mobility) triggered as an area of concern in the CAAS. Review of the care plan initiated 7/25/2025 revealed that R16 has an ADL self-care performance deficit related to limited mobility. Intervention to be implemented included a mechanical lift with two staff for assistance with transfers.Review of the Facility Reportable Incident dated 9/8/2025 revealed: Employee transferred R16 from bed to wheelchair causing a laceration on right leg. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation revealed that as a result of CNA EEEE failure to follow the facility policy of using a mechanical lift when transferring R16 causing a small laceration to R16's great right toe. Review of the CNA EEEE employee file in the presence of the Human Resource Director revealed: a Disciplinary Action Form description of violation and events leading to personnel action: employee fail to use lift to transfer resident from bed to the wheelchair. Work improvement plan: Employee must perform all job duties outlined in the description as requested by manager/supervisor. Signed by the employee, UM, and the DON dated 9/8/2025. Further review revealed a Separation Notice with a hire date of 9/1/2019 and a termination date of 9/9/2025 for violating company policies; poor performance; transferred resident without using lift as educated, signed by Human Resources on 9/10/2025. A telephone interview on 9/17/2025 at 10:24 am with CNA EEEE stated she was educated on reviewing the kiosk for the residents' plan of care for transfers. The CNA stated R16 was assigned to her on 9/8/2025. She also stated she was aware that R16 required a transfer with two people using the mechanical lift. The CNA stated R16 had been crying and complained of general hurting and refused to get out of bed for the day. She stated R16 did not want to get up using the mechanical lift to be transferred from the bed to the chair. The CNA stated she asked R16 was it okay for her (CNA) to be transferred from the bed into the chair. The CNA stated the resident agreed and was transferred from the bed to the wheelchair. The CNA stated she did not report to the charge nurse or the UM that the resident was in pain and did not want to get up. The CNA stated she was not aware that R16 sustained an injury to the right knee and toe during the transfer. An interview on 9/17/2025 at 10:32 with UM LLL stated she has daily huddles with the staff on 100-700 hall. She stated that because of the incident with R7, she educates the staff to review the resident's plan of care. All mechanical lifts must be done with two staff; in the event there is not a second person available she (UM) will assist with the transfer. The UM stated on 9/8/2025, R16's family approached her and asked, Why was my mom transferred out of bed today without using the mechanical lift? The family went on to inform the UM that R16 was in pain, and her knee had been injured during the transfer. She stated the resident was assessed and sent to the hospital. The UM stated she asked the CNA assigned to R16 did you transfer R16 without using the mechanical lift. The CNA confirmed she had transferred the resident from the bed to the wheelchair alone without the lift. She stated she reported the incident to the Administrator immediately, and the CNA was sent home by the Assistant Director of Nursing.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, family and staff interviews, text messages, and the facility policies titled Bed Hold Prior To Transfer, EXHIBIT B Bed Hold Policy, and the Immediate Discharge Notice the facility failed to permit one of three Residents (R) (R7) to return to the facility after being sent to the hospital emergency room. The facility also denied R7's family from entering the building to obtain the resident's personal belongings. This deficient practice had the potential to place the residents who are sent to the hospital in an unsafe and unsuitable situation and cause stress and harm to the residents.Findings include:Review of the policy titled Bed Hold Prior To Transfer, with a reviewed/revised date of March 2025, revealed: Policy: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices at the time of a transfer for hospitalization. Policy Explanation and Compliance Guidelines: 2. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. Review of the admission Packet and an undated document titled EXHIBIT B Bed Hold Policy revealed that the Resident and Resident's Authorized Representative and/or Responsible Party shall receive a copy of the facility's bed hold policy within twenty-four (24) hours of hospitalization. Should the following restrictions (as allowed by state and federal guidelines) not be met and the Resident is discharged , it is the policy of this facility to offer the next available bed to the Resident. Private Pay Residents: If the resident chooses not to reserve the bed through payment, he/she will be readmitted to the Facility upon the first availability of a bed in a semi-private room. At the end of the admission packet, signed by the family, was a copy of R7's identification, social security card, and insurance information. Review of the facility's Midnight Census Report dated 7/31/2025 revealed there were twenty-four empty beds. Out of the twenty-four empty beds, fourteen were open for male admission. Review of the facility's Midnight Census Report dated 8/1/2025 revealed there were twenty-five empty beds. Out of the twenty-five empty beds, twelve were open for male admission. Review of the admission Record for R7 revealed he was admitted to the facility on [DATE] with diagnoses of, but not limited to, bilateral rotator cuff injuries, cerebral infarction, and nontraumatic intracerebral hemorrhage. Review of the resident's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not assessed. Review of the Document titled Memorandum for Record Subject: Representatives of the Resident (R7) The following are appointed resident representatives by R7. All parties of [facility name] and all affiliates, to include (owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others working for [facility name]), agree to contact the primary representative prior to any medication orders or administering of medication to a resident not already known. This document had four individuals listed as contacts. There was no indication that only the primary contact could be contacted about any other matters regarding R7. Review of the Care Plan Participation Record dated 7/21/2025, provided to the surveyor revealed: signatures by six interdisciplinary team members; Social Service Director (SSD), Director of Rehab, Nurse Practitioner (NP), Business Office Manager (BOM), Unit Manager, Clinical Marketing Director, and one family member via telephone participated in R7's care plan development. The document is unclear whether R7 attended his care plan meeting. There was no documentation that the family was informed that if R7 went out to the hospital, he would not be allowed to return to the facility. Review of the Immediate Discharge Notice dated 7/28/2025, addressed to R7, and the representative revealed: Effective Date of discharge: The discharge will take place effective immediately on the date of this notice, on 8/28/2025. The resident will not be discharged before this date. Review of [hospital name] emergency room (ER) documentation revealed R7 arrived at the ER on [DATE] at 11:16 am, with a diagnosis of a urinary (continued on next page)

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	115360	A. Building B. Wing	11/19/2025

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tract infection without hematuria (blood in urine). The resident was treated with antibiotic intravenous. At 4:18 pm, the emergency department case manager attempted to contact the facility's liaison but was unable to reach or leave a voicemail. Contacted the facility, spoke with [facility staff name], who confirmed that R7 was a resident at the facility. At 6:00 pm, the nurse attempted four times to call in a report to the facility, and no one picked up the call. At 6:02 pm, the nurse called the facility and notified them that R7 will be transported by [transport name] at 10:00 pm. Case Management note on 8/1/2025 at 12:53 am: R7 was discharged back to the facility after being cleared by the provider. When emergency medical service (EMS) arrived at the facility, staff stated, the resident is banned from the facility and not allowed back. Per EMS, staff would not give a reason. The resident was brought back to the hospital ER, and case management will be consulted. The resident is tube-fed dependent with a [urinary catheter]. Resident (R7) blood pressure 149/84, heart rate 115. Per ER physician, unclear etiology (cause) of tachycardia (elevated heart rate), though improving as R7 rests in the emergency department. Case Manager note on 8/1/2025 at 3:47 pm: R7 was sent back to the emergency department by the facility, stating that R7 cannot return to the facility. Per the facility, they cannot manage R7's needs. After several lengthy discussions with the hospital leadership and the facility leadership, the facility still would not accept R7. Referral was sent to several other long-term care facilities. Review of a telephone text message from the Director of Nursing (DON) sent to Licensed Practical Nurse (LPN) NNN dated 7/31/2025 at 5:18 pm revealed: R7 is not to be taken back. Do not take report. Do not allow them to bring him. Refer them to __. An interview on 8/27/2025 at 10:40 am with the DON, who explained the facilities policy and procedure for residents returning from the hospital. The DON verbalized that the nurses are required to review __ (a digital dashboard) to confirm if a resident is cleared for admission. If a resident's name does not appear on the digital dashboard, they are not permitted to be admitted . The DON stated it is the responsibility of the marketing liaison (Clinical Marketing Director) to update the dashboard for all admissions. The DON stated this holds true for residents who have been sent out to the hospital by the Physician/Physician Assistant/Nurse Practitioner (NP). The DON stated that on 7/31/2025, R7 complained of suprapubic pain. The NP assessed the resident and gave an order to send the resident to the local hospital emergency room for further evaluation. She stated the supervisor on duty called around 11:30 pm on 7/31/2025, stating that R7 was not on the dashboard. The DON instructed the supervisor to reach out to the marketing liaison (Clinical Marketing Director) to get permission for the resident to return to the facility. She stated that, as the DON of the facility, she could not give permission for R7 to return because he was not listed on the dashboard. The DON stated she was not part of a meeting that discussed that the resident could not return to the facility after being sent out to the hospital on 7/31/2025. She stated she had no knowledge of the resident not being able to return. An interview on 8/27/2025 at 3:43 pm with the Clinical Marketing Director stated that the decision was made by her not to allow R7 to return after being sent out to the hospital. She stated the facility had a care plan meeting with the family discussing the resident's discharge. The Clinical Marketing Director stated she was clear in the meetings that if R7 was sent out to the hospital and we do not have a payment your dad will not be allowed to return to the facility. She assured the surveyor that the information was documented in the care plan meeting notes on 7/21/2025. She stated the bed hold policy was sent with the hospital paperwork when the resident was transferred to the hospital on 7/31/2025. The Clinical Marketing Director stated that not taking R7 back worked because the family is cooperating with the Medicaid process at the new facility. A phone interview on 9/2/2025 at 12:36 pm with the facility's Ombudsman stated she received the 30-day discharge letter for R7 on 7/29/2025. She stated she did not reach out to the resident or the family until returning to work (no date given). She stated that when she spoke with the family, she was informed that the resident was no longer at the facility. She stated she spoke with the staff at the facility regarding R7's discharge. She attempted to explain to the facility that when given the 30-day discharge letter, the resident goes back to square one and should have an opportunity to decide regarding the stay. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated the facility did not allow R7 or the family of R7 to comply with or appeal the discharge. She stated the leadership at the facility needs more education regarding resident discharges. An interview on 9/3/2025 at 10:37 am with LPN JJJ stated she assisted with sending R7 out to the hospital on 7/31/2025. She stated the only paperwork that was sent with R7 was a face sheet and an order summary. The LPN stated she has never sent a copy of the residents' bed hold. The LPN stated she does not know where to get a copy of a bed hold policy. An interview on 9/3/2025 at 11:35 am with the SSD stated that one of her responsibilities includes resident discharge plans. The SSD stated she was not aware that R7 was not allowed back into the facility after being sent to the emergency room. She stated that had she been aware, she would have assisted R7 and the family in finding placement and ensuring that the discharge/transfer was safe. An interview on 9/3/2025 at 6:48 pm with LPN NNN stated she worked 7:00 pm to 7:00 am on 7/31/2025. She stated the DON had texted her around 5:18 pm that day and told her not to take R7 back. She stated transportation arrived around 11:30 pm with R7. She stated that transportation called from the front entrance, to be let in, to return R7. The LPN stated that as she arrived at the door, LPN III was also walking towards the door. She stated LPN III informed her she had received a text from the DON not to allow R7 back inside the facility. She stated there was a CNA in the lobby who was concerned that she was not allowing R7 back inside the facility. She stated that herself, LPN III, and the CNA went to the door. She told the drivers, I have been instructed not to allow Mr. __ (R7) back inside the facility. She stated she did not realize the family was also at the door. The LPN stated the family was not aggressive, but had a look of shock on their face. She stated the family did ask, What should we do? The LPN stated she encouraged them to take R7 home. She stated the family asked if they could come inside to get his belongings. She stated she told the family she could not allow them inside. An interview on 9/4/2025 at 9:23 am with the BOM stated that she never communicated with the resident or the family about the bed hold policy on 8/1/2025. The BOM stated that upon her return to work, the resident had been discharged . She stated she only communicated with one family member regarding establishing a payor source or carrying out the Medicaid and Medicare process. The BOM stated she never communicated with the resident or any other family member regarding establishing a payor source or the Medicare Medicaid process. A phone interview on 9/19/25 at 2:58 pm with the facility's Medical Director stated he was aware that R7 was sent out to the hospital and was not allowed to return. The Medical Director stated his understanding was that R7 was at the end of the 30-day discharge notice. He stated he did not realize the notice was issued on 7/28/2025. The Surveyor confirmed on 9/26/2025 with the regional staff that the Clinical Marketing Director was not an LPN or a Registered Nurse. A post survey interview on 10/5/2025 at 3:21 pm with R7's family, and his emergency contact number two, stated that he visited with R7 every week. The family stated no one from the facility ever contacted them with any issues regarding R7's stay at the facility. The family stated that they would have assisted if they had known. The family stated they were shocked when R7 was not allowed to return on 7/31/2025. He stated the nurse informed the family R7 no longer had a bed and was not allowed to obtain R7's belongings. The family did meet with the Administrator, DON, and the Clinical Marketing Director on 8/1/2025. The family stated that the Clinical Marketing Director informed the family that it was her decision that R7 was not allowed to return.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record reviews, the facility policy titled Comprehensive Care Plans, and the Charge Nurse Job Description, the facility failed to implement the care plan interventions for mechanical lift with two staff assistants for transfers for two Residents (R) (R7 and R16). In addition, the facility failed to implement fall mats and update R7's care plan after an incident and an accident.Findings include: A review of the policy titled Comprehensive Care Plans, reviewed/revised date of March 2025. Policy: 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. Policy Explanation and Compliance Guidelines: 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions. Review of the undated document titled Charge Nurse Job Description, revealed: Required Qualifications: A Nursing Degree from an accredited college or university or a graduate of an approved Licensed Practical Nurse (LPN)/Licensed Vocational Nurse (LVN) program. Major Duties and Responsibilities: Initiates, reviews, and updates care plans as required. 1. Review of the resident's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not assessed. Section GG revealed R7 is dependent on staff for transfers. Functional Abilities (Self-Care and Mobility) triggered as an area of concern on the Care Area Assessment Summary (CAAS). Review of the care plan initiated on 6/20/2025 revealed that R7 has a deficit in activities of daily living (ADL) self-care. The intervention to be implemented includes a mechanical lift with two staff for assisted transfers. Review of the care plan initiated 6/20/2025 revealed that R7 is at risk for a fall. Intervention to be implemented fall mats. A telephone interview on 9/15/2025 at 1:12 pm with LPN III stated that on 7/15/2025 she worked on 800 hall. The LPN confirmed that R7 was care planned to transfer with two people using a mechanical lift and fall mats on the floor. She stated the resident did not have fall mats on the floor at the time of the transfer. The LPN stated R7 was transferred from the floor to the bed with the assistance of a Certified Nursing Assistant (CNA) without using a mechanical lift. The LPN confirmed that R7's care plan was not updated. The LPN stated updating a resident's care plan is not part of her job description. She stated the facility never educated her on updating care plans or the use of a mechanical lift. 2. Review of the resident's admission MDS dated [DATE] revealed a BIMS assessed at eight, indicating moderately impaired. Section GG revealed R16 is partial/moderate assistance with transfer. Functional Abilities (Self-Care and Mobility) triggered as an area of concern in the CAAS. Review of the care plan initiated 7/25/2025 revealed that R16 has an ADL self-care performance deficit related to limited mobility. Intervention to be implemented included a mechanical lift with two staff for assistance with transfers. Review of the Facility Reportable Incident dated 9/8/2025 revealed: Employee transferred R16 from bed to wheelchair, causing a laceration to the right leg. The investigation revealed that as a result of CNA EEEE failure to follow the facility policy of using a mechanical lift when transferring R16 causing a small laceration to R16's great right toe. A telephone interview on 9/17/2025 at 10:24 am with CNA EEEE stated she was educated on reviewing the kiosk for the residents' plan of care for transfers. The CNA stated she was aware that R16 required a transfer with two people using the mechanical lift. The CNA stated she asked R16 was it okay to be transferred from the bed into the chair. The resident agreed and was transferred from the bed to the wheelchair. The CNA stated she was not aware R16 sustained an injury to the right toe due to the transfer. An interview on 9/9/2025 at 9:30 am with the Administrator stated his expectations that all (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation is completed after a fall and or incident. He stated that documentation includes updating the residents' care plan. Cross reference F689

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F 0689 Level of Harm - Minimal harm or potential for 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 family and staff interviews, record reviews, observations, and the facility policy titled Safe Resident Handling/Transfer, the facility failed to provide appropriate interventions while transferring two of five residents (R) (R7 and R16), reviewed for mechanical lift transfers. Findings include:A review of the policy titled Safe Resident Handling/Transfer, reviewed/revised date of March 2025. Policy Explanation: All residents require safe handling when transferred to prevent or minimize the risk of injury to themselves and the employees that assist them. While manual Lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical Lifts are a safer alternative and should be used. Compliance Guidelines: 14. Resident lifting and transferring will be performed according to the resident's individual plan of care. 1. Review of the admission Record for R7 revealed a diagnosis of, but not limited to bilateral rotator cuff injuries, cerebral infarction, and nontraumatic intracerebral hemorrhage. Review of the resident's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not assessed. Section GG revealed R7 is dependent on staff for transfers. Functional Abilities (Self-Care and Mobility) triggered as an area of concern on the Care Area Assessment Summary (CAAS). Review of the care plan initiated 6/20/2025 revealed that R7 has an activity of daily living (ADL) self-care performance deficit. Intervention to be implemented includes a mechanical lift with two staff assistants for transfers. Review of the video of R7 on the floor and transferred by two staff without a mechanical lift. The video was also viewed by the Director of Nursing (DON) CC who confirmed the person in the blue was Licensed Practical Nurse (LPN) III and the person in the white was Certified Nursing Assistant (CNA) DDDD. On 7/15/2025 at 6:53 am LPN III was in R7's room the resident was on the floor lying on his right side facing the door and moaning. The bed was in a high position the LPN lowered the bed. The LPN left the room at 6:55 and R7 remained on the floor. The LPN returned at 6:59 am with CNA DDDD. The LPN was positioned at R7's feet. The resident's right leg was at a 90-degree angle. The LPN placed her left hand on R7's right calf and her (LPN) right hand was under the resident's left knee. The CNA's body was positioned on the right side of the resident. The CNA held the resident with her right hand under R7's right knee. The CNA's left hand grasped the left underside neck of the resident with four fingers while the thumb grasped the resident's throat. During this transfer from the floor to the bed the CNA let go of R7 and his head hit the floor first followed by his legs. An interview on 9/10/2025 at 11:55 am with Nurse Practitioner (NP) BBB stated that R7 was physically assessed on 7/16/2025, and that she issued an order based on information provided by the nursing staff. NP BBB stated that an order for x-rays of the right shoulder, left shoulder, and cervical spine was given. The NP BBB revealed that had she known the R7 had been dropped and hit his head, the orders would have been different. A telephone interview on 9/15/2025 at 1:12 pm with LPN III stated that on 7/15/2025, around 6:57 am, she could hear R7 yelling. She stated that when she entered the room, the bed was in a low position, and R7 had one leg on the floor and one leg on the body pillow. LPN III stated R7 was assisted to the floor. The LPN III stated that R7 did not have fall mats on the floor and that the mechanical lift sling was not located. LPN III stated that R7 was transferred from the floor to bed with assistance from a CNA. The LPN III stated that she reported to the oncoming nurse that R7 had a fall and to follow up with the family. An interview on 9/23/2025 at 1:20 pm with LPN RRR stated she was the oncoming nurse on 7/15/2025. She stated LPN III gave a verbal report to her (LPN RRR) and the other nurse working on the 800 hall. She stated there was no report about any residents falling on the 7 pm-7 am shift. LPN RRR stated there was no discussion about following up with R7's family regarding a fall. 2. Review of the admission Record for R16 revealed a diagnosis of, but not limited to, dementia, quadriplegia, and type 2 diabetes mellitus with diabetic neuropathy. Review of the resident's admission MDS dated [DATE] revealed a BIMS (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed at eight, indicating moderately impaired. Section GG revealed R16 is partial/moderate assistance with transfer. Functional Abilities (Self-Care and Mobility) triggered as an area of concern in the CAAS. Review of the care plan initiated 7/25/2025 revealed that R16 has an ADL self-care performance deficit related to limited mobility. Intervention to be implemented included a mechanical lift with two staff assistance for transfers. Review of the Facility Reportable Incident dated 9/8/2025 revealed: Employee transferred R16 from bed to wheelchair causing laceration on the right leg. The investigation revealed that as a result of CNA EEEE's failure to follow the facility policy of using a mechanical lift when transferring R16, a small laceration to R16's great right toe. A telephone interview on 9/21/2025 at 4:37 pm with R16's family stated that on 9/8/2025, while visiting mom, she (R16) verbalized that her knee was hurting. She stated she was informed by B that a CNA had transferred mom without using the mechanical lift. She stated she was told that her mom's right leg/foot was injured. She stated she immediately reported the incident to the Unit Manager. A phone interview on 9/19/2025 at 2:58 pm with the facility's Medical Director (MD) stated he was part of the Quality Assurance and Performance Improvement Meeting and discussed and reviewed the safe transfers policies. He stated that during the meeting, the team discussed educating the staff to report incidents as they happen and accurately. The MD stated he was not aware that another incident with failing to use the mechanical lift had occurred. The MD was informed on 9/8/2025 that R16 was transferred without the mechanical lift and sustained an injury to her right great toe. The MD stated he would follow up with the Administrator and the other Health Care Providers regarding R16's unsafe transfer on 9/8/2025. Cross-reference to F600

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility policy titled Oxygen Administration, the facility failed to obtain a physician's order for oxygen use, including the frequency of use and flow rate, and an order for a continuous positive airway pressure (CPAP) for one of four sampled resident (R) (R8) of four sampled residents. This deficient practice had the potential to place R8 at increased risk for respiratory complications.Findings include:Review of the policy titled Oxygen Administration reviewed/revised date 12/2025. Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under orders of a physician. Types of delivery systems include: a. Nasal Cannula. d. CPAP Mask - This mask is part of a system that allows a resident to receive continuous positive airway pressure (CPAP), with or without an artificial airway. The system is comprised of a mask, tubing, and a machine that generates a constant flow of air pressure. Review of the admission Record for R8 revealed an admission date of 7/16/2025 with diagnoses of, but not limited to, asthma, chronic obstructive pulmonary disease (COPD), and obstructive sleep apnea (OSA).Review of the resident's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) assessed as 13, which indicated cognitively intact. Section O revealed oxygen and a non-invasive mechanical ventilator while a resident. Review of the care plan initiated 7/17/2025 revealed that R8 has CPAP related to COPD. Interventions included implementing CPAP as ordered by the physician. Review of the admission summary dated [DATE] revealed: Addendum. Resident's daughter brought in CPAP machine from home. Oncoming nurse alerted. CPAP is set up and resident's bedside. He has oxygen place and functioning properly per ordered liter.Review of the Encounter Note dated 7/20/2025 revealed: Physician admission History and Physical. History of Present Illness: Right frontal hemorrhagic stroke, left side weakness. COPD with baseline 2 liters nasal cannula requirement, obstructive sleep apnea on CPAP. Maintain spot oxygen 88-92 percent. Supplement oxygen as needed. CPAP on at night.Review of the Encounter note dated 8/3/2025 by the Physician Assistant revealed: History of Present Illness: Right frontal hemorrhagic stroke left side weakness. COPD with baseline 2 liters nasal cannula requirement, obstructive sleep apnea on CPAP.Review of the electronic medical record (EMR) oxygen concentration log revealed R8 received oxygen on the following days: 7/16/2025, 7/17/2025, 7/29/2025, 8/5/2025, 8/9/2025, and 8/10/2025.Review of R8's physician order summary report revealed that there was no order written for the resident to receive oxygen or a CPAP at night.In an interview on 9/4/2025 at 2:54 pm, R8's family member, who was the responsible party (RP), stated that R8 lived at home prior to his admission to the facility. The family stated R8 was dependent on oxygen and slept with a CPAP every night. The family stated that before R8 was admitted to the facility, they received a call from the marketing liaison, and the family was told R8 could not be admitted if he did not have the CPAP machine. In an interview on 9/8/2025 at 9:09 pm, Licensed Practical Nurse (LPN) CCCC stated her regular assignment was the 500 Hall, where R8 resided. She stated R8 used oxygen and was consistent with sleeping with his CPAP machine at night. In an interview on 9/10/2025 at 8:59 am, Certified Nursing Assistant (CNA) MMMM stated R8 always had his oxygen on when in bed. In an interview on 9/10/2025 at 9:18 am, the Director of Nursing (DON) explained the admission process. The DON stated that when a resident was admitted from the hospital, the nurse was responsible for reviewing the hospital discharge orders and entering the orders into the resident's EMR. She stated on the following day, during the clinical meeting, the hospital physician's orders were reviewed, and the team ensured the orders were correctly entered into the resident's EMR. She stated there was always a Nurse Practitioner (NP) in the clinical meeting as the orders were reviewed and adjustments could be made by the NP at that time. She stated that after hours and on weekends, the nurse reviewed the hospital orders with the after-hours medical (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115360	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayetteville Center for Nursing & Healing LLC	110 Brandywine Boulevard Fayetteville, GA 30214

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	service. The DON stated she was not aware that R8's CPAP and oxygen were not part of the order summary. The DON stated she would review the resident's chart.In an interview on 9/10/2025 at 9:50 am, the DON stated R8 did use oxygen and had a CPAP machine, and there was no order. She stated that the nurses would be educated to ensure that the hospital orders were accurately transcribed.