STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115365	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thomson Health and Rehabilitation	511 Mt. Pleasant Road Thomson, GA 30824

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and facility policy reviews, the facility failed to ensure that food items in the kitchen and resident pantries were properly dated and stored. In addition, the facility failed to ensure sanitary conditions in the kitchen and properly clean and sanitize dishes. The deficient practices had the potential to place the 103 residents who received meals from the dietary department at increased risk of foodborne illness.Findings include:On 02/09/26 at 8:40 AM, observation revealed a 0.25-inch-thick cardboard-like cover surrounding the entire kitchen hood system near the oven that was peeling, severely cracked, and flaking for a two-foot-wide by three-foot area. Interview with the Dietary Manager (DM) at the time of the observation verified the problem. On 02/09/26 at 9:00 AM, observation revealed a 2.07-pound container of partially used chicken salad without a date of opening inside the residents' refrigerator in the 400-medication room. Interview with the DM at the time of the observation verified the finding and indicated she would remove the chicken salad and throw it away. On 02/09/26 at 9:05 AM, observation revealed a chicken dinner, which included a chicken breast, greens, pasta, and pudding in the residents' refrigerator in the 100-medication room without a name or date. Interview with the DM at the time of the observation verified the contents and the lack of name or date. On 02/11/26 at 7:50 AM, observation revealed that Dietary Aide 1 (DA1) was washing dishes at the main kitchen dishwasher. The DA1 scrubbed two pans and then placed them in a rack to run through the dishwasher. DA1 placed three drink trays on the dishwasher rack and ran both full racks through the dishwasher. Wearing the same gloves, DA1 removed the two clean racks from the dishwasher and stacked them in the final cleaning area. Interview with DA1 at the time of the observation stated she was just cleaning up. On 02/11/26 at 7:55 AM, observation revealed a two-foot-wide by two-foot-high cork bulletin board in the main kitchen above the foil wrapping paper area was peeling and missing cork, four inches in diameter in one place, and smaller sections in many additional places on the same board. Interview with the DM at the time of the observation verified the condition of the bulletin board. On 02/11/26 at 8:00 AM, observation revealed a large amount of brown and red dried liquid stains on the wall between the two and three-compartment sinks in the main kitchen. In addition, observation revealed 10 dime-sized holes in the wall directly above both sinks. Interview with the DM at the time of the observation verified the condition of the wall. On 02/11/26 at 8:15 AM, observation revealed a large amount of brown and red dried liquid stains in a pattern below the coffee machine/preparation area extending over six feet in the main kitchen. Interview with the DM at the time of the observation verified the condition of the wall. On 02/11/26 at 8:50 AM, observation revealed a brown substance on the ceiling above the main kitchen steam table/food service area. In the same ceiling, above the stove in the back of the room, was a large amount of dust hanging from the ceiling in a two-foot area near the air vent. Interview with the DM at the time of the observations verified the condition of the ceiling and stated they had a new cleaning schedule. On 02/11/26 at 8:55 AM, observation revealed a large split in the ceiling near the stove in the main kitchen, measuring three feet long by two feet wide. The area was peeling and flaking at the split joint. Interview with the CDM at the time of the observation verified the condition of the ceiling joint. On 02/11/26 at 9:00 AM, observation revealed thick black (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	marks on the white door leading from the main kitchen to the dry food storage area. The marks were located two feet above and below the door handle. Interview with the DM at the time of the observation stated that the marks are from the staff's dirty hands touching the white door. On 02/11/26 at 9:05 AM, observation revealed a four-prong electrical wall outlet with plugs in each outlet near the toaster in the main kitchen, full of debris and grease. The color of each plug could not be determined. Interview with the DM at the time of the observation verified the condition of the wall electrical outlet. During an interview with the Administrator and Director of Nursing (DON) on 02/12/26 at 12:30 PM, the Administrator stated that they were unaware of the condition in the main kitchen. Interview with the Registered Dietitian (RD) on 02/12/26 at 3:15 PM, the RD said that she had been reporting the poor condition of the main kitchen monthly over the past 12 months. The RD stated that she had not reported to the new Administrator. Reviewing the facility's policy, taken from the current United States Department of Agriculture (USDA) guidelines, section 15 indicated that the facility must label and date each leftover item before refrigeration. Review of the facility's undated policy titled Food Brought in By Visitors revealed all perishable foods shall be in tight containers, labeled and dated. Review of the facility's policy titled Sanitation dated November 2022 indicated, all kitchen and dining areas are kept clean.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of the facility's policy titled Work Orders, Maintenance, the facility failed to ensure one of two sit-to-stand lifts was clean and in good repair. This deficient practice had the potential to place residents at risk of living in a non-home-like environment. Findings include: Review of the facility's policy titled Work Orders, Maintenance, revised April 2010, provided by the facility revealed, Policy Statement Maintenance work orders shall be completed in order to establish priority of maintenance service. Policy Interpretation and Implementation 1. In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director .Observation on 02/11/2026 at 12:16 PM with Licensed Practical Nurse (LPN) 5 in the hallway on the 500 unit revealed a sit-to-stand lift with several exposed foam areas due to missing leather on the knee rest cushion and debris on the footplate. LPN5 confirmed that the sit-to-stand lift was not in good condition and that someone should have submitted a work order so maintenance could replace the damaged parts. Observation on 02/11/26 at 12:19 PM of the sit-to-stand lift, Certified Nursing Assistant (CNA) 5 confirmed the sit-to-stand lift was used for residents on the 500 and 600 units. CNA5 stated that the knee rest had several areas with missing leather, exposing foam, and that the footplate was covered in debris. CNA5 stated the floor techs cleaned the lift, and maintenance was responsible for replacing the knee rest. CNA5 also stated she did not complete a work order for the replacement of the knee rest, but should have, as she was aware of it. In an interview on 02/11/26 at 12:34 PM, the Maintenance Director revealed that he was not aware that the knee rest cushion was not in good repair or that the footplate was not clean. The Maintenance Director stated he inspected the building's lifts quarterly but did not document the results of the inspections, and he should have noticed that the knee rest pad needed to be replaced. The Maintenance Director also stated that he had not received a work order to replace the knee pad to date. In an interview on 02/11/26 at 12:58 PM, the Housekeeping Supervisor (HS) stated she was not aware that the floor techs were responsible for cleaning the sit-to-stand lifts in the building. In an interview on 02/11/26 at 1:07 PM, Floor Tech (FT) 1 stated he did not clean the sit-to-stand lifts and was not trained to do it. In an interview on 02/11/26 at 2:24 PM, the Administrator stated that the floor techs were responsible for cleaning the lifts and the maintenance staff were responsible for the repairs on them. The Administrator also stated lifts should be cleaned twice a month, and when visibly dirty, maintenance should replace parts identified during quarterly inspections.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, review of the facility's policy titled Comprehensive Assessments, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessments to the Centers for Medicare and Medicaid Services (CMS) system in a timely manner for one resident (Resident (R) 99) out of six residents reviewed for accurate assessments in the sample of 37. This deficient practice prevented the transmission of resident-specific information used for payment, quality measures, and ongoing clinical data analysis.Findings include:Review of the facility's policy titled Comprehensive Assessments, revised October 2023, indicated, Policy interpretation and implementation: The facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity using the Resident Assessment Instrument specified by CMS.An admission Assessment - is a comprehensive assessment for a new resident that must be completed by the end of day 14.Review of the RAI Manual 3.0 version dated October 2025 indicated, Chapter 5: submission and correction of the MDS assessments. 5.2 Timeliness Criteria, Completion timing: For the admission assessment, the MDS completion date must be no later than 13 days after the entry date.Review of R99's listing of MDS assessment, located under the MDS tab in the electronic medical record (EMR), indicates that the resident was admitted to the facility on [DATE] and had an Entry assessment completed, transmitted, and accepted into the CMS system. Further review revealed there were no other assessments completed.During an interview on 2/12/26 at 9:18 AM, the MDS Coordinator (MDSC) acknowledged R99 did not have an admission MDS entered, completed, or transmitted. Further record review revealed that an admission MDS dated [DATE] was opened but later struck out, and the status reads SO (struck out) -incorrect documentation. The MDS tracking record showed that the full admission assessment was 154 days overdue. The MDSC stated, I removed it, but I do not know why. Maybe I was going to put it back in, but I forgot. I do not know what happened.During an interview on 02/12/26 at 9:49 AM, the Director of Nursing (DON) said that her expectations would be that the MDSC would let her know if she was getting behind or unable to complete the assessment on time. She stated that all MDS assessments should be done in a timely manner and according to the RAI manual.During an interview on 02/12/26 at 10:35 AM, the Administrator stated she was not aware that the MDSC was behind on the MDSs.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review, staff interview, and review of the facility's policy titled Resident Assessments, the facility failed to complete quarterly Minimum Data Set (MDS) Assessments not less that once every three months, for two resident (Resident (R) 30 and R77) out of six residents reviewed for accuracy of assessments in the sample of 37. This deficient practice prevented the transmission of resident-specific information used for payment, quality measures, and ongoing clinical data analysis.Findings include:Review of the facility's policy titled Resident Assessments, revised October 2023, indicated, Policy interpretation and implementation: Omnibus Budget Reconciliation Act (OBRA) required MDS assessments are federally mandated and therefore must be performed for all residents of Medicare and/or Medicaid certified nursing homes. OBRA assessments include Quarterly Assessments. A quarterly assessment must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessment to ensure critical indicators of gradual change in a resident's status are monitored. https://www.cms.gov/Medicare/Quality-InitiativesPatient-Assessment-Instruments/NursinghomeQualityInits/MI Review of R30's listing of MDS assessment located under the MDS tab in the electronic medical record (EMR) indicated that the resident had an annual MDS assessment completed on 08/29/25 and was due for a quarterly assessment on 11/29/25. Review of R30's listing of MDSs revealed there were no quarterly assessments in the system. While reviewing the incomplete assessment, it was noted that the MDS Coordinator (MDSC) had put in the quarterly assessment, then removed it and struck out (SO) the assessment as incorrect documentation. Tracking sheet indicates that the quarterly assessment for 11/29/25 was 61 days overdue.During an interview on 02/12/26 at 9:18 AM, MDSC stated, I removed it, but I do not know why. I was just not able to do them all. I may have just struck it out for some reason and did not put it back. I do not know. 2. Review of R77's listing of MDS assessment located under the MDS tab in the EMR indicated that the resident had an admission MDS assessment completed on 04/24/25 and was due for a quarterly assessment on 07/25/25 and 10/26/25. Review of R77's EMR revealed there were no quarterly assessments in the system. While reviewing the incomplete assessment, it was noted that the MDSC had put in the quarterly assessment multiple times but then removed them and struck out (SO) the assessments as incorrect documentation. Tracking sheet indicated that the quarterly assessment for 07/25/25 was 188 days overdue.During an interview on 02/12/25 at 9:24 AM, MDSC stated that R77 had so many discharges with his returns anticipated and then reentry that she was unable to do the quarterly assessments. MDSC acknowledged that the last MDS assessment done was the admission assessment with an ARD of 04/24/25. MDSC stated, I just did not know all the rules on the MDS and how to do it.During an interview on 02/12/26 at 9:49 AM, the Director of Nursing (DON) said that her expectations would be that the MDSC would let her know if she was getting behind or unable to complete the assessment on time. She stated that all MDS assessment should be done in a timely manner and according to the RAI manual.During an interview on 02/12/26 at 10:35 AM, the Administrator stated she was not aware that the MDSC was behind on the MDSs.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled, Resident Assessments, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment that reflected the resident's status at the time of the assessment for two (Residents (R)8 and R59) of six residents reviewed for accuracy of assessments in the sample of 31 residents. This failure had the potential to affect nutritional assessments and dietitian evaluations, as well as fall precautions and care planning.Findings include: Review of the facility's policy titled, Resident Assessments, revised October 2023, indicated: .10. Assessment are completed by staff members who have the skills and qualification to assess relevant care areas and who are knowledgeable about the resident's strengths and areas of decline. 11. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 1. Review of R59's admission Record located under the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. R59 was admitted with diagnoses of depression, congestive heart failure (CHF), and stroke. Review of R59's quarterly Minimum Data Set (MDS) assessment under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 12/05/25, revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15, indicating moderate cognitive impairment. She had a recorded weight of 130 pounds and a weight loss of five percent in the last month or a loss of 10 percent or more in the last six months at the time of assessment. Review of R59's weight records, found under the Vitals tab of the EMR, revealed her weight as follows prior to the 12/05/25 MDS assessment. 12/02/25: 130.0 pounds (lbs.) 11/04/25: 133.0 lbs.10/07/25: 134.0 lbs.09/02/25: 129.0 lbs.08/07/25: 132.0 lbs.07/02/25: 124.0 lbs. On 07/02/25, R59 weighed 124.0 lbs., and on 12/02/25, R59 weighed 130.0 lbs., which was a weight gain of 6.0 lbs. in six months. On 11/04/25 R59 weighed 133.0 lbs., on 12/02/25 R59 weighed 130.0 pounds. Resident 59 did not lose 6.65 pounds in 30 days to determine a 5 percent weight loss. During an interview on 02/09/26 at 11:22 AM, R59 stated, I have not lost weight, I have gained weight. During an interview on 02/10/26 at 4:10 PM, the MDS Coordinator (MDSC) stated that the Dietary Manager (DM) is responsible for entering information in the section of the MDS that reflects the resident's weight and nutritional status. During an interview on 02/11/26 at 12:42 PM, the DM stated that she does not know why she coded the MDS section of the last quarterly assessment with an ARD of 12/5/25 with a weight loss. While reviewing the record, the DM stated it was an overall weight gain. During an interview on 02/12/26 at 9:49 AM, the Director of Nursing (DON) stated that she expected the MDS assessment to be completed accurately. 2. Review of R8's undated admission Record located in the EMR under the Profile tab revealed she was admitted to the facility on [DATE] with contractures to the left and right knee, cerebral infarction, and hemiplegia and hemiparesis. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R8's quarterly MDS with an ARD of 01/15/26, located in the EMR under the MDS tab, revealed the resident had sustained a fall with major injury since admission/reentry. Review of the Facility Reported Incident (FRI) dated 01/10/26 provided by the facility revealed the five-day report was sent to the State Survey Agency (SSA) on 01/14/26 which documented Certified Nursing Assistant (CNA) 6 stated she was pushing R87 to her room at 2:30 PM to provide incontinence care and she tripped over two clear plastic trash bags that she laid on the floor next to the bed and fell into R8's geriatric chair which caused it to move forward into the dresser and fold the bottom of the chair on the left leg. During an interview on 02/12/26 at 10:13 AM, the MDSC confirmed she incorrectly coded the incident that caused R8's left tibia fibula fracture that occurred on 01/10/26 as a fall with major injury on the quarterly assessment dated [DATE]. The MDSC stated she attended the morning clinical meeting on 01/12/26, where the incident was discussed, so she does not know why she coded it as a fall. The MDSC indicated she used the latest RIA Manual to code the MDS. During an interview on 02/12/26 at 10:24 AM, the Administrator stated she expected the MDSC to complete MDS assessments accurately and in a timely manner.