STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115421	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodstock Center for Nursing and Healing LLC	105 Arnold Mill Road Woodstock, GA 30188

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 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. Based on record review, interviews, and review of facility policy, the facility failed to ensure one Resident (R) (R8) of seven residents reviewed for abuse was free from verbal abuse. The deficient practice had the potential to affect resident safety. Findings include:1.Review of R7's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed an admission date of 05/01/2025 with diagnoses including paranoid schizophrenia and dependent of wheelchair. Review of R7's quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/19/2026 revealed R7's Brief Interview for Mental Status (BIMS) score was 15 out of 15, which indicated little to no cognitive impairment.2. Review of R8's Face Sheet located under the Profile tab of the EMR revealed an admission date of 07/17/2024 with diagnoses which included type two diabetes mellitus without complications, pain in leg, and unilateral primary osteoarthritis.Review of R8's quarterly MDS located under the MDS tab of the EMR, with an ARD of 03/02/2026 revealed R8's BIMS score was eight out of 15, which indicated moderate cognitive impairment.During an interview on 03/17/2026 at 3:45 PM, R8 stated she did not recall the actual incident that occurred.Review of the facility's Incident Summary Report, provided by the facility, dated 10/16/2025, revealed that the Activities Director (AD) informed the facility Abuse Coordinator that she heard R7 say to R8, I will blow your brains out (profanity). The report indicated that the AD instructed R7 not to speak to anyone in that manner and redirected R7 to her room. During the same time, the Director of Nursing (DON) interviewed R8. R8 reported that she had been in the activities room and heard R7 rambling, which she did not understand. R8 further stated that R7 rolled her wheelchair towards her and said, (profanity) I will blow your brains out. R8 shared that she felt a little confused afterward and that the AD instructed her to return to her room. The Administrator attempted to speak with R7 but was unsuccessful, as R7 stated to her she did not want to talk. The local police department was contacted, along with the facility's Nurse Practitioner (NP) of the incident on 10/13/2025. The report further reflected that the NP recognized that R7 continued to demonstrate behavioral disturbances and recommended that nursing staff encourage medication compliance. It was also noted by the NP that R7 was verbally abusive at times but had not posed any physical threat to residents or facility staff. The conclusion of the facility investigation revealed that the allegation of verbal abuse was substantiated. Review of R7's Care Plan located under the Care Plan tab of the EMR, dated 09/22/2025, revealed R7 used psychotropic medications that had the potential to cause sedation, falls and changes in her mood of behavior along with the resident having the potential to demonstrate verbal abuse related to her mental and emotional illness, paranoid schizophrenia. During an interview on 03/16/2026 at 4:32 PM, the Administrator revealed the previous AD informed her of the incident that occurred between the two residents. She further shared that she was also the abuse coordinator and initiated the investigation. The Administrator stated that R8 did not appear to be shaken up by the incident however, R8 did share she was confused about what R7 was mumbling and why she used profanity towards her. The AD was unable to be interviewed during the survey. During an interview on 03/16/26 at 4:32 PM, the DON stated for allegations of abuse or neglect, resident-to-resident incidents, the facility would separate or if needed moved resident rooms. The (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated staff were immediately suspended if there was suspected staff to resident abuse. The DON further shared, the process was to immediately start an investigation, report to the state website, and the abuse coordinator was contacted. She continued to share the process of the investigation, which included all staff and residents that lived on the unit or were present during an incident were interviewed and provided a written statement. She stated all documentation was placed in the investigation folder. The DON was able to share that for any allegation of abuse, neglect, or misappropriation; the investigation process began within two hours. The DON shared that she was familiar with resident R7, that R7 had a diagnosis of paranoid schizophrenia, and was non-compliant with her medication regimen. The DON shared that R7 utilized a wheelchair in the facility as she was unable to walk. The DON continued to share that R7 had never been physical with any residents or staff however, when her medication needed to be adjusted due to an increase in hallucinations and increased paranoia, her behavior increased. She stated there was an increase in verbal abuse but never physical. Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 10/2025, revealed It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to ensure residents were free from misappropriation of medications, specifically controlled substances for three Residents (R) (R9, R10, and R11) of 19 sampled residents reviewed for medication misappropriation. The deficient practice resulted in delayed administration of prescribed medication and placed residents at risk for unrelieved or worsening pain, anxiety, agitation and psychological distress, compromising resident safety and well-being.Findings include: 1. Review of R9's Face Sheet located in the Profile tab of the electronic medical record (EMR), revealed R9 was admitted to the facility on [DATE] with diagnoses that included chronic pain, muscle spasm, spinal stenosis, osteoarthritis, hypertension, and Alzheimer's.Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/24/2026 and located in the resident's EMR under the MDS tab, revealed R9 had a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated moderate cognitive impairment. Review of the MDS indicated R9 experienced occasional pain that limited daily activities, received scheduled pain medication, and indicated a level of pain of six on a numeric rating scale, indicating pain was present. Review of R9's Physician Order, dated 08/24/2025 and located under the Orders tab of the EMR, revealed an order for Morphine Sulfate Extended Release 15 milligrams (mg) one tablet per mouth twice a day for pain.Review of R9's Care Plan, revision date 11/18/2025 and located under the Care Plan tab of the EMR, revealed an identified focus addressing pain related to chronic back pain related to spinal stenosis osteoporosis, and muscle spasm. Review of the facility incident report form provided by the facility, dated 11/22/2025, indicated the Director of Nursing (DON) was notified several residents including R9 had not received their scheduled 9:00 AM narcotic medication. The incident report indicated Licensed Practical Nurse (LPN) 1, had signed out the Morphine Sulfate 15mg tablet in the narcotic book indicating that the Morphine had been administered. The report further indicated that LPN1 was contacted and initially confirmed administration of the medication; however, LPN1 later stated that after being asked to leave the facility due to not being formally assigned to the shift she discarded the medication(s) without a witness. The investigation report indicated LPN1 refused to return to the facility for drug testing. Further review of the investigation report revealed that the physician and Nurse Practitioner (NP) had been notified and received an order to proceed with administering the missed dose of medication. Review of R9's Medication Administration Record (MAR) for November 2025 revealed that on 11/22/2025 at 9:00 AM, the residents' pain level was documented as three indicating mild pain. The MAR further indicated that the scheduled Morphine dose was initialed as administered at 9:00 AM, however, no documentation was found to support the actual time of administration or to account for the delayed or missed administration of the medication. Review of R9's Progress Note, dated 11/22/2025, located under the Progress Notes tab of the EMR, indicated Resident verbalized that he did not receive his scheduled morning dose of Morphine 15mg PO [orally].NP [Nurse Practitioner] to order one time dose to supplement missed dose. 2. Review of R10's Face Sheet located in the Profile tab of the EMR, revealed R10 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction due to embolism, fracture of T [thoracic]11-T12 vertebra, fall, arthritis (multiple sites) and hypertension. Review of R10's quarterly MDS with an ARD of 01/18/2026 and located in the resident's EMR under the MDS tab, revealed R10 had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. Review of the MDS indicated R10 received scheduled pain medication and experienced frequent pain almost constantly with pain interfering with their day-to-day activities. The MDS further revealed the pain occasionally limited their day-to-day activities and indicated a level of pain of seven on a numeric rating scale, indicating pain is intense and difficult to ignore and may cause emotional distress, agitation, or anxiety. Review of R10's Physician Order, dated 08/28/2025 and located under the Orders tab of the EMR, revealed an order for Tramadol HCL (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(hydrochloric acid) 50mg one tablet per mouth twice a day for pain.Review of R10's Care Plan, revision date 12/01/2025 and located under the Care Plan tab of the EMR, revealed an identified focus addressing pain related to arthritis and limited mobility, and musculoskeletal related to fracture of T11-T12 vertebra. Review of the facility incident report form, provided by the facility, dated 11/22/2025, indicated that on 11/22/2025 the DON was notified that several residents including R10 had not received their scheduled 9:00 AM narcotic medication. The incident report indicated LPN1 had signed out the Tramadol HCL 50mg tablet in the narcotic book indicating that the Tramadol had been administered. The report further indicated that LPN1 was contacted and initially confirmed administration of the medication; however, LPN1 later stated that after being asked to leave the facility due to not being formally assigned to the shift she discarded the medication(s) without a witness. The investigation report indicated LPN1 refused to return to the facility for drug testing. Further review of the investigation report revealed that the physician and Nurse Practitioner had been notified and received an order to proceed with administering the missed dose of medication. Review of R10's MAR for November 2025 revealed that on 11/22/2025 at 9:00 AM, the resident's pain level was documented as zero and nine indicating inconsistent and conflicting documentation regarding the resident pain level. A pain level of zero indicated no pain, whereas a pain level of nine indicated severe to extreme pain that was difficult to tolerate and significantly interfered with function. The MAR for November 2025 further revealed that on 11/22/2025 at 9:00 AM, Tramadol was initialed as administered; however, no documentation was found to indicate the actual time of administration for the scheduled 9:00 AM dose or to account for the delayed or missed administration. Review of R10's Progress Note, dated 11/22/2025, located under the Progress Notes tab of the EMR, indicated that the Tramadol medication was signed out in the narcotic book but not signed off on the MAR. A progress note written by the NP indicated Notified of Tramadol 50mg being administered late on 11/22/2025 due to a nursing incident.3. Review of R11's Face Sheet, located in the Profile tab of the EMR, revealed R11 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, anxiety, gout, and psoriasis vulgaris. Review of R11's quarterly MDS with an ARD of 01/10/2026 and located in the resident's EMR under the MDS tab, revealed R11 had a BIMS score of 13 out of 15, which indicated little to no cognitive impairment. Review of the MDS indicated R11 received scheduled pain medication and experienced frequent pain occasionally, with pain occasionally interfering with their day-to-day activities. The MDS further revealed the pain occasionally limited their day-to-day activities and indicated a level of pain of six on a numeric rating scale, indicating moderate pain. Review of R11's Physician Order, dated 08/28/2025 and located under the Orders tab of the EMR, revealed an order for Alprazolam (anti-anxiety medication) 0.5mg one tablet per mouth once a day for anxiety.Review of R11's Care Plan, revision date 11/18/2025 and located under the Care Plan tab of the EMR, revealed an identified focus addressing anxiety related to adjustment disorder, anxiety, and depressed mood. Review of the facility incident report form provided by the facility, dated 11/22/2025, indicated that on 11/22/2025 the DON was notified that several residents including R11 had not received their scheduled 9:00 AM anxiety medication. The incident report indicated LPN1 had signed out the Alprazolam 0.5mg tablet in the narcotic book indicating that the medication had been administered. The report further indicated that LPN1 was contacted and initially confirmed administration of the medication; however, LPN1 later stated that after being asked to leave the facility due to not being formally assigned to the shift she discarded the medication(s) without a witness. The investigation report indicated LPN1 refused to return to the facility for drug testing. Further review of the investigation report revealed that the physician and Nurse Practitioner had been notified and received an order to proceed with administering the missed dose of medication. Review of R11's MAR for November 2025 revealed that on 11/22/2025 at 9:00 AM, Alprazolam was initialed as administered; however, no documentation was found to indicate the actual time of administration for the scheduled 9:00 AM dose or to account for the delayed or missed administration. Review of R11's Progress Note, dated 11/22/2025, located under the Progress Notes (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tab of the EMR, indicated med .was not signed off on EMAR [electronic MAR] but signed off in narc book as given at 9am. A progress note dated 11/24/2025 by the NP indicated Notified of Xanax 0.5mg being administered late on 11/22/2025 due to a nursing incident.During an interview on 03/17/2026 at 3:45 PM, the DON stated it was her expectation that nurses were to administer controlled medications as ordered by the physician, were accounted for and documented in the narcotic book, MAR, and progress notes. The DON stated that the residents involved were all assessed for pain, and the family, physician, and NP were notified. The DON further stated the affected residents were administered their missed medication after notification of the physician and Nurse Practitioner. During an interview on 03/18/2026 at 4:17 PM the Consultant Pharmacist revealed he was aware of the narcotic related incident that occurred on 11/22/2025. The pharmacist stated he conducted monthly visits to the facility to complete medication regimen reviews, gradual dose reductions for psychotropic medications, inspections of medication carts for expired medications and audits of controlled substances, including reconciliation of the narcotic log with the electronic medication administration record (EMAR) to ensure accurate counts. The Consultant Pharmacist further stated that during a random controlled substance audit in January 2026, discrepancies were identified in which nursing staff documented controlled substances in the narcotic log but failed to document administration on the MAR. The pharmacist stated the findings were discussed with the DON and in-service education recommendations were provided to nursing staff. The pharmacist further stated that no concerns were identified during controlled substance random audits conducted in February 2026 and March 2026. Interview with the Administrator on 03/18/2026 at 5:45 PM revealed following the incident on 11/22/2025 which involved failure to document controlled substances on the MAR; the facility immediately initiated education for the licensed nursing staff on proper MAR documentation. The Administrator stated the consultant pharmacist reviewed on 01/20/26, continued non-compliance was identified; at which point the facility responded with re-education and implementation of ongoing pharmacy audits. Review of the facility's policy titled, Controlled Substance Administration & Accountability, dated June 2025, revealed .to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances .Under section 1. H, the policy indicated, The Controlled Drug Record . serves the dual purpose of recording both narcotic disposition and patient administration. Section 1I, the policy indicated The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient -specific narcotic dispensed from the pharmacy. Under section 4 d, the policy revealed, Two licensed staff must witness any disposal or destruction of a controlled substance and document same on the Drug Disposition Record .