STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115484	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Healthcare	1011 South Green Street Thomaston, GA 30286

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 - 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 observation, record review, staff interviews, and review of the facility policy titled Freedom of Abuse - Abuse Prevention Fast Alert and the Certified Nursing Assistant (CNA) job description, the facility failed to assess and provide wound care in a timely manner to one resident (R) (R9) reviewed for wound care. On 2/21/2026, actual harm occurred when CNA BB neglected to provide (R9) adequate incontinent care, resulting in R9 developing a blister on the left upper thigh. R9 required a debridement to remove necrotic tissue on 3/5/2026. The sample size was 9.Findings include: Review of the policy titled Freedom of Abuse Abuse Prevention Fast Alert dated 1/2025 revealed. Policy: The purpose of this written Freedom of Abuse, Neglect, and Exploitation; Abuse Prevention Standard is to outline the preventive and action steps taken to reduce the potential for abuse, mistreatment, and neglect of residents. Neglect: Failure of a facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the job description titled CNA/STNA dated 11/2023. Position Summary: Under the direction of a licensed nurse, the CNA/STNA delivers efficient and effective nursing care while achieving positive clinical outcomes and patient/family satisfaction. CNA/STNA performs various patient care activities and related non-professional services essential to caring for personal needs and comfort for patients. Responsibilities: Reports changes in the patient's condition, patient/family concerns, or complaints to the charge nurse and/or supervisor. An observation on 3/19/2026 at 10:10 am with the Wound Care Nurse (WCN) R9 was sitting up in bed finishing morning care. The resident permitted the surveyor to observe the area on her left upper thigh. An observation of R9 left upper thigh open to air (no dressing) the area was shiny pink granular in appearance, the size of a half dollar. Review of the admission Record for R9 revealed she was admitted to the facility on [DATE], and a diagnosis of, but not limited to, disorder of the skin and subcutaneous tissue and lymphedema. Review of the resident's most recent Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that a Brief Interview for Mental Status (BIMS) was assessed as 15, which indicated cognitively intact. Section M was assessed as at risk for developing pressure ulcers with no unhealed pressure ulcers at the time of the assessment. Review of the care plan dated 6/6/2024 revealed R9 has the potential for pressure ulcer development and/or skin integrity issues related to immobility and diagnosis of lymphedema. Intervention to be implemented included Observe/document/report as needed any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), stage. Review of the Skin Wound Note dated 3/2/2026 revealed: New open area noted to the left Posterior thigh, Resident stated she is now having pain while sitting on the bedpan. Area noted 0.7 centimeters (cm) x 0.3 cm x 0.2 cm. The physician and nurse practitioner were notified, and treatment was in place. Review of the __ Nurse Practitioner (NP) progress note dated 3/5/2026 revealed: Chief Complaint: Open Wound. History Of Present Illness: The patient was seen today for a new wound care consult for evaluation and management of a right thigh wound that has been present for approximately two weeks per nursing report. Wound measurement 3.5 cm x 4.0 cm x 0.2 cm. Medically indicated sharp excisional debridement was performed to remove (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 - Actual harm Residents Affected - Few	necrotic tissue and decrease bacterial burden. Sharp debridement was used to remove nonviable devitalized soft tissue. Debridement was carried to viable tissue as evidenced by bleeding. An interview on 3/18/2026 at 2:45 pm with R9 stated on 2/21/2026 on the night shift she was on the bed pan for approximately an hour and half. She stated CNA BB came and assisted her with getting cleaned up. The resident stated she informed CNA BB that she did not feel as though she was cleaned good. She stated the CNA BB did not check to see if she was cleaned but left the room. She stated the next morning, 2/22/2026, when CNA EE arrived at work and came to her room, she informed her of what happened and that her left upper thigh was burning. She stated that when CNA EE checked her, she informed her that the linen was soiled with feces and there was a blister on her (R9) left upper thigh. The resident stated she sent a text to the Administrator and informed her that CNA BB did not provide adequate incontinent care, and she had developed a blister that was burning. In an interview on 3/20/2026 at 10:19 am with CNA EE stated that when she arrived at work last month (February 2026), she did not recall the exact date, on the 7 am-3 pm shift. She stated that during her initial round, R9 informed her that the CNA BB from the previous shift (7 pm-7 am) did not clean her well, and she was itchy. The CNA stated she provided incontinent care and found that the pad underneath R9 had feces on it and was wet with urine. She stated the resident also had a blister on the left upper thigh. She stated she informed R9 that the area on her thigh had a blister. The CNA stated she did not report that R9 had developed a blister on the left upper thigh to the charge nurse or Director of Nursing.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on record review, staff interview, review of the facility policy titled Freedom Of Abuse Abuse Prevention Fast Alert the facility failed to ensure Georgia Criminal History Check System (GCHEXS) Fingerprint check was conducted for one (1) Certified Nursing Assistant (CNA) of ten employee files selected for review. The facility census was eighty residents.Review of the policy titled Freedom of Abuse Abuse Prevention Fast Alert dated 1/2025. revealed Pre-Employment Screening: When a potential new employee is considered for hire, take the following steps to ensure the applicant is suitable for hire. 3. Criminal Background Checks are required; all employment candidates are required to authorize the facility to conduct a background check for conviction of crimes. The Human Resource Manager's job description was requested but not provided. During a record review of the employee files with the Human Resources Manager (HRM), there was no documentation that a fingerprint records check was conducted on CNA BB. An interview on 3/24/2026 at 2:15 p.m. with the HRM stated that she is responsible for background checks, fingerprint checks, reference checks, and maintaining the employees' files. She confirmed that CNA BB did not have a GCHEXS fingerprint check conducted. The HRM stated she has started an audit of employees' files to ensure that GCHEXS fingerprint checks were conducted for the required employees. Refer to F-Tag 600.

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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 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of the facility policy titled Freedom Of Abuse Abuse Prevention Fast Alert the facility failed to ensure an allegations of neglect was reported to the State Survey Agency (SSA) within the required time frame for one Resident (R) (R9) of nine sampled residents. Resident (R9) verbally and via text reported to the facility that one Certified Nursing Assistant (CNA) BB neglected to provide her (R9) adequate incontinent care. As a result, R9 developed a blister on the left upper thigh. Due to the delay in care the blister progressed to an open wound.Findings include: Review of the policy titled Freedom Of Abuse Abuse Prevention Fast Alert dated 1/2025. Policy: The purpose of this written Freedom of Abuse, Neglect, and Exploitation; Abuse Prevention Standard is to outline the preventive and action steps taken to reduce the potential for abuse, mistreatment, and neglect of residents. Reporting/Investigation/Response Policy: Any complaint, allegation, observation, or suspicion of resident neglect, whether physical or verbal. mental or sexual. involuntary, or voluntary, is to be communicated to the Abuse Coordinator, thoroughly reported, investigated, and documented uniformly as detailed below. Reporting-All employees are required to immediately notify the administrator or nursing supervisory staff who is on duty of any complaint, allegation, observation, or suspicion of resident neglect so that the investigation can be undertaken promptly. Investigation: All alleged violations involving mistreatment, sexually inappropriate behaviors, and abuse or neglect will be thoroughly investigated by the facility under the direction of the Administrator and in accordance with state and federal law. Review of the admission Record for R9 revealed she was admitted to the facility on [DATE], and a diagnosis of, but not limited to, disorder of the skin and subcutaneous tissue and lymphedema. Review of the resident's most recent Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that a Brief Interview for Mental Status (BIMS) was assessed as 15, which indicated cognitively intact. Section M was assessed as at risk for developing pressure ulcers with no unhealed pressure ulcers. Review of the Skin Wound Note dated 3/2/2026 revealed: New open area noted to the left Posterior thigh, Resident stated she is now having pain while sitting on the bedpan. Area noted 0.7 centimeters (cm) x 0.3 cm x 0.2cm. The physician and nurse practitioner were notified, and treatment was in place. An interview on 3/18/2026 at 2:45 pm with R9 stated on 2/21/2026 on the night shift, she pressed the call light for a CNA to assist her with incontinent care after using the bedpan. She stated that after about thirty minutes, a Licensed Practical Nurse AA entered the room and asked what she needed. The resident stated she needed the CNA to assist her with getting cleaned up. She stated that thirty minutes later, CNA DD entered the room and asked what she needed. The resident informed the CNA DD that she had been on the bedpan for a while and was starting to hurt. She stated the CNA DD left the room, and about twenty minutes later, CNA BB came and assisted her with getting cleaned up. The resident stated she informed CNA BB that she did not feel as though she was clean. She stated the CNA BB did not check to see if she was cleaned, but left the room. She stated the next morning, 2/22/2026, when CNA EE arrived at work and came to her room, she informed her of what happened and that her left upper thigh was burning. She stated that when CNA EE checked her, she informed her that the linen was soiled with feces and there was a blister on her (R9) left upper thigh. The resident stated she sent a text to the Administrator and informed her of what had happened. The resident stated she reported the incident to the SSA because nothing was ever done. A telephone interview on 3/20/2026 at 10:52 am with Administrator CC stated that on 2/23/2026, she received a text from R9. She stated the text read: Good morning, CNA BB left feces on me, and I have developed a blister on the back of my left thigh at the crease. The area is burning. I hope we can get this under control. The Administrator stated she texted R9 back and told R9 she would get the nurse to come in and assess the area. The Administrator stated that the allegation of neglect was not reported to the SSA. The (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Administrator stated she is aware that the allegation of neglect should have been reported. An interview on 3/20/2026 at 11:32 am with Administrator FF stated that the allegation of neglect would be reported immediately to the SSA. She also stated CNA BB will be suspended pending the investigation. Refer to F-Tag 600.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and review of the facility policy titled RAI Care Planning Management the facility failed to implement the care plan interventions for a newly develop pressure ulcer for one (1) Resident (R) (R9) out of nine (9) care plans reviewed. Findings include: Review of the policy titled RAI Care Planning Management, revised date of 8/2017. Standard: It is the practice of this facility to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. If modifications, deletions, or additions are necessary, changes should be made at the time of occurrence. Review of the admission Record for R9 revealed she was admitted to the facility on [DATE], and a diagnosis of, but not limited to, disorder of the skin and subcutaneous tissue and lymphedema. Review of the resident's most recent Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that a Brief Interview for Mental Status (BIMS) was assessed as 15, which indicated cognitively intact. Section M was assessed as at risk for developing pressure ulcers with no unhealed pressure ulcers at the time of the assessment. Review of the care plan dated 6/6/2024 revealed R9 has the potential for pressure ulcer development and/or skin integrity issues related to immobility and diagnosis of lymphedema. Intervention to be implemented included Observe/document/report as needed any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X width X depth), stage. Review of the __ Nurse Practitioner (NP) wound report dated 3/5/2026 revealed: Chief Complaint: Open Wound. History of Present Illness: The patient was seen today for a new wound care consult for evaluation and management of a right thigh wound that has been present for approximately two weeks, per nursing report. Wound measurement 3.5 centimeters (cm x 4.0 cm x 0.2 cm. An interview and observation on 3/19/2026 at 10:00 am of R9's left upper thigh with the Wound Care Nurse HH. The resident and WCN confirmed that the area that the wound care NP is treating is the left upper thigh. An interview on 3/24/2026 at 1:04 pm with the MDS-Coordinator GG, stated that in the past, she would receive a weekly wound sheet from the WCN. She stated she has not received one from the WCN in a month or so. She stated the facility's procedure is that the Director Of Nursing is now responsible for emailing the weekly wound report. The MDS-Coordinator reviewed her emails, stating that the last report that she received was on 3/2/2026, and R9 was not part of that wound report. She also stated any new wound occurrence would be discussed in the am management meeting, and the care plan is updated in real time. The MDS Coordinator stated she recently became aware that R9 had a wound on the upper left thigh. She confirmed that the care plan was not updated for the wound on the upper left thigh. Refer to F-Tag 600.