STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115488	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greene Point Health and Rehabilitation	1321 Washington Highway Union Point, GA 30669

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and family interviews, and review of the facility policy titled, Abuse Prohibition, the facility failed to protect the resident's right to be free from physical abuse by another resident (R) (R2) for one of three residents (R) (R1) reviewed for abuse. Findings include: A review of the facility policy titled, Abuse Prohibitions dated 4/7/2025 documented under Intent: It is the intent of this center to actively preserve each patient's right to be free from mistreatment, neglect, abuse, misappropriation of patient property. We believe each patient has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. 1. Review of the electronic medical record (EMR) revealed R1 was admitted to the facility with pertinent diagnoses including but was not limited to fracture of unspecified part of the neck of right femur, subsequent encounter for closed fracture with routine healing, unspecified dementia, unspecified severity with other behavioral disturbances, Alzheimer's disease with early onset, and anxiety disorder. Review of R1 quarterly and annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0, which indicates R1 has severe cognitive impairment. Section GG, functional status, revealed R1 requires moderate assistance for activities of daily living (ADLs) with one person assistance. R1 benefits from the use wheelchair toileting, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene requires moderate assistance. Review of R1's care plan dated 9/18/2024 indicated a problem of cognitive impairment. Goals included but not limited to patient needs will be maintained during review period and patient safety will be maintained during review period. Interventions included but not limited to administer medication as ordered, allow patient ample time to absorb and respond to information, provide consistent routine, and SATFF (sic) NOT TO ALLOW RESIDENT TO PUSH HER W/C (wheelchair). Continued review of R1's care plan dated 9/18/2024 indicated a problem of anxiety. Goals included but not limited to patients will demonstrate reduction in symptoms of anxiety episodes through the review period. Interventions included but not limited to Administer medication as ordered, analyze key times, places, circumstances, triggers, and what de-escalates anxiety, psychiatric/psychological evaluation as indicated. 2. Review of the EMR revealed R2 was admitted to the facility with pertinent diagnoses including but was not limited to Alzheimer's disease, altered mental status, unspecified, dementia in other diseases classified elsewhere, severe, with agitation. (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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(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	Review of R2 quarterly and annual MDS assessment dated [DATE] revealed a BIMS score of 99, which indicates R2 has severe cognitive impairment. Section GG, functional status, revealed R2 required/was assistance for activities of daily living (ADLs) with one person assistance. Walks without assistance, toileting, setup or clean-up assistance, shower/bathe self- partial/moderate assistance, upper body dressing, lower body dressing, putting on/taking off footwear- independent, and personal hygiene- supervision or touching assistance. Review of R2 care plan dated 10/1/2024 indicated a problem of behaviors. Goals included but not limited to patient's needs will be met and safety maintained during review period and patient will demonstrate improvements during the review period. Interventions included but not limited to administer medications for a clearly defined goal aimed at a specific target behavior for which the drug is effective, analyze key times, places, circumstances, triggers, and what de-escalates behavior, assess for the need of pain medication adjustment, and assess patterns of behavior with behavior monitoring. Review of the progress note in the HER that documented, CNA (certified nursing assistant) BB reported that R1 was grabbed around the neck by another resident by the name of R2. R2 was trying to snatch another resident's belongings, and the resident snatched her belongings back and R2 got upset and grabbed another resident, R1 around the neck. The CAN BB stated that she had to pull R2's hand from around R1's neck. No apparent injury of R1, made aware by Registered Nurse (RN) AA 8/31/2025. Review of the past 12 months of the facility's state reportable incidents (FRI's) revealed no incidents for August 2025 which included R1 and R2's incident of physical abuse. Review of the past 12 months of the facility's FRI's revealed a reportable from November 2024 in which R2 threw coffee on R1. Phone Interview with Registered Nurse (RN) AA on 10/29/2025 at 3:09 pm confirmed CNA BB was working and reported to her the choking incident between R1 and R2. She further revealed CNA BB stated she took R2's hands from around R1's neck. RN AA revealed when she reported the incident to the Director of Nursing (DON), she was instructed to put R2 on 1:1 (one to one) observations. RN AA revealed in order to keep the residents safe in the facility, they will do a 1:1 with R2 if enough staff was present. She revealed R2 was mostly in the hallways but would venture into another resident's room. They always try to keep eyes on R2 as best as they could, but she seemed to target R1. Interview on 10/29/2025 at 2:05 pm with the Scheduling Coordinator revealed R2 would go into other resident rooms and would walk up and down the hallway until she got tired. R2 would have restless nights and would sometimes push other residents. The Scheduling Coordinator revealed R2 would lash out at other residents and staff. The Scheduling Coordinator revealed RN AA was the RN on shift that day. She reported if she saw a resident have behaviors, then she would report it to the nurse. An interview with CNA BB on 10/30/2025 at 1:07 pm confirmed she did report to RN AA the choking incident between R1 and R2. She further stated she was in the front of the building near the nurse station when she saw R2 with her hands around R1's neck. CNA AA revealed she was not able to verbally prompt R2 to let go of R1 but had to use hand over hand physical assistance to remove R2's hand from around R1's neck. She then stated at that time she reported the incident to the weekend manager (RN AA). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/29/2025 at 4:49 pm with the Director of Nursing (DON) revealed she was aware of the reported choking incident. The DON revealed she did question CNA BB about the incident on the same day that it occurred, since she reported it. She spoke with the Nurse Practitioner (NP) because she wanted R2 to be 1013'd (involuntary treatment) to the psychiatric hospital. The NP said she would monitor her and review medications in house. From there the DON stated staff observed 1:1 ration with R2 on that Sunday when the incident happened and told the nurse on duty to get the 1:1 sheet off copier and start for two days. When the DON returned to work on the following Tuesday and R2 was reassessed by the NP (who comes three times per week). The 1:1 for R2 was discontinued on 9/2/2025 when the DON returned to work. Interview with the Administrator on 10/29/2025 at 5:09 pm revealed the Administrator had received complaints regarding R2 because she wandered into resident rooms and was touchy, but staff would redirect her. The Administrator further revealed she was not aware of the reported choking incident. Cross refer to F609 and F610

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F 0609 Level of Harm - Minimal harm or potential for 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 staff interviews, record review, and review of the facility policies titled, Abuse Prohibition - Reporting and Investigating and Abuse Prohibition, the facility failed to report an incident of physical abuse within two hours of identifying to the State Agency (SA) for two of three residents (R) (R1 and R2).Findings include: A review of the facility policy titled, Abuse Prohibition – Reporting and Investigating dated 12/27/2024 documented under Intent: It is the intent of this center to establish standards of practice for investigation and reporting of abuse, neglect, mistreatment, exploitation, and misappropriation of property. Guidelines: Reporting- All allegations of abuse or allegations involving serious bodily injury must be reported immediately but no later than 2 hours. A review of the facility policy titled, Abuse Prohibition dated 4/7/2025 documented under Identification of possible abuse, neglect, or exploitation: Identification and coverage: Any person observing abuse, neglect, or exploitation as previously defined, should immediately report it to the Administrator or the direct supervisor (i.e. Charge Nurse, Director of Nursing, Departmental Leaders) present at the time of the incident. Any person hearing or receiving an allegation or complaint of abuse, neglect, or exploitation should immediately report to the Administrator or the direct supervisor (i.e. Charge Nurse, Director of Nursing, Departmental Leaders) present at the time of the incident. 1. Review of the electronic medical record (EMR) revealed R1 was admitted to the facility with diagnoses including but was not limited to fracture of unspecified part of the neck of right femur, subsequent encounter for closed fracture with routine healing, unspecified dementia, unspecified severity with other behavioral disturbances, Alzheimer's disease with early onset, and anxiety disorder. Review of R1 quarterly and annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0, which indicates R1 has severe cognitive impairment. Section GG, functional status, revealed R1 requires moderate assistance for activities of daily living (ADLs) with one person assistance. R1 benefits from the use wheelchair toileting, shower/bathe self, upper body dressing, lower body dressing, putting on/ taking off footwear, personal hygiene requires moderate assistance. Review of R1 care plan dated 9/18/2024 indicated a problem of cognitive impairment. Goals included but not limited to patient needs will be maintained during review period and patient safety will be maintained during review period. Interventions included but not limited to administer medication as ordered, allow patient ample time to absorb and respond to information, provide consistent routine, and SATFF (sic) NOT TO ALLOW RESIDENT TO PUSH HER W/C. Review of R1 care plan dated 9/18/2024 indicated a problem of anxiety. Goals included but not limited to patients will demonstrate reduction in symptoms of anxiety episodes through the review period. Interventions included but not limited to Administer medication as ordered, analyze key times, places, circumstances, triggers, and what de-escalates anxiety, psychiatric/psychological evaluation as indicated. 2. Review of the EMR revealed resident R2 was admitted to the facility with diagnoses including but (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not limited to Alzheimer's disease, Altered mental status, unspecified, dementia in other diseases classified elsewhere, severe, with agitation. Review of R2 quarterly and annual MDS assessment dated [DATE] revealed a BIMS of 99, which indicates R2 has severe cognitive impairment. Section GG, functional status, revealed R2 required/was assistance for activities of daily living (ADLs) with one person assistance. Walks without assistance, toileting, setup or clean-up assistance, shower/bathe self- partial/moderate assistance, upper body dressing, lower body dressing, putting on/taking off footwear- independent, and personal hygiene- supervision or touching assistance. Review of R2 care plan dated 10/1/2024 indicated a problem of behaviors. Goals included but not limited to patient's needs will be met and safety maintained during review period and patient will demonstrate improvements during the review period. Interventions included but not limited to administer medications for a clearly defined goal aimed at a specific target behavior for which the drug is effective, analyze key times, places, circumstances, triggers, and what de-escalates behavior, assess for the need of pain medication adjustment, and assess patterns of behavior with behavior monitoring. Record review of the requested facility state reportable incidents from the last 12 months revealed no reported incident of R1 and R2 which involved choking. Interview on 10/29/2025 with Registered Nurse (RN) AA at 3:09 pm revealed she did complete an incident report regarding the choking incident between R1 and R2 and was told by the administrative team to start 1:1 (one to one) with R2. She further revealed the protocol was to report to the Director of Nursing (DON), Administrator, and family members along with ensuring resident safety first. Joint Interview on 10/29/2025 with the DON and the Administrator at 5:09 pm revealed the Administrator was not aware of choking incident between R1 and R2. The DON revealed she was aware, but she didn't report to state agency. The DON stated she cannot remember if she reported the incident to the Administrator. The DON further revealed she spoke to the facility Nurse Practitioner about the choking incident. Cross refer to F600 and F610

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and review of the facility policies titled, Abuse Prohibition, Abuse Prohibition - Reporting and Investigating, and Falls, the facility failed to complete a thorough investigation of witnessed physical abuse for two of two residents (R) (R1 and R2). Findings include: A review of the facility policy titled, Abuse Prohibition – Reporting and Investigating dated 12/27/2024 documented, All investigative information will be kept on file in a secured location. All information gathered is confidential information. A review of the facility policy titled, Abuse Prohibition dated 4/7/2025 documented, Identification of patients whose behavior is abusive to other patients. If a patient is identified in one of the following categories, a thorough assessment will be completed to include any identified situations or factors that trigger abusive behavior. Appropriate interventions should be implemented in an effort to protect patients and associates. A review of the facility policy titled, Fall Management dated 12/27/2024 documented, Defining a Fall: Current CMS guidelines regarding falls states that a fall is defined as an unintentional change in position that results in someone landing on the floor, ground, or lower surface including whether the event was witnessed/un-witnessed. Fall Event: When a fall occurs: The patient should receive a head-to-toe assessment to identify injuries or changes in condition. The patient should be observed and interviewed, along with any witnesses, to determine possible cause of the fall. The patient should have interventions implemented to prevent recurrence and maintain safety. The licensed nurse should complete the Initial Event in the EHR to capture the investigation of the fall and assessment of the patient. 1. Review of the electronic medical record (EMR) revealed R1 was admitted to the facility with pertinent diagnoses including but was not limited to fracture of unspecified part of the neck of right femur, subsequent encounter for closed fracture with routine healing, unspecified dementia, unspecified severity with other behavioral disturbances, Alzheimer's disease with early onset, and anxiety disorder. Review of R1 quarterly and annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 0, which indicates R1 has severe cognitive impairment. Section GG, functional status, revealed R1 requires moderate assistance for activities of daily living (ADLs) with one person assistance. R1 benefits from the use wheelchair toileting, shower/bathe self, upper body dressing, lower body dressing, putting on/ taking off footwear, personal hygiene requires moderate assistance. Review of R1 care plan dated 9/18/2024 indicated a problem of cognitive impairment. Goals included but not limited to patient needs will be maintained during review period and patient safety will be maintained during review period. Interventions included but not limited to administer medication as ordered, allow patient ample time to absorb and respond to information, provide consistent routine, and SATFF (sic) NOT TO ALLOW RESIDENT TO PUSH HER W/C. Review of R1 care plan dated 9/18/2024 indicated a problem of anxiety. Goals included but not limited to patients will demonstrate reduction in symptoms of anxiety episodes through the review period. Interventions included but not limited to Administer medication as ordered, analyze key times, places, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	circumstances, triggers, and what de-escalates anxiety, psychiatric/psychological evaluation as indicated. 2. Review of the EMR revealed resident R2 was admitted to the facility with pertinent diagnoses including but was not limited to Alzheimer's disease, Altered mental status, unspecified, dementia in other diseases classified elsewhere, severe, with agitation. Review of R2 quarterly and annual MDS assessment dated [DATE] revealed a BIMS of 99, which indicates R2 has severe cognitive impairment. Section GG, functional status, revealed R2 required/was assistance for activities of daily living (ADLs) with one person assistance. Walks without assistance, toileting, setup or clean-up assistance, shower/bathe self- partial/moderate assistance, upper body dressing, lower body dressing, putting on/taking off footwear- independent, and personal hygiene- supervision or touching assistance. Review of R2 care plan dated 10/1/2024 indicated a problem of behaviors. Goals included but not limited to patient's needs will be met and safety maintained during review period and patient will demonstrate improvements during the review period. Interventions included but not limited to administer medications for a clearly defined goal aimed at a specific target behavior for which the drug is effective, analyze key times, places, circumstances, triggers, and what de-escalates behavior, assess for the need of pain medication adjustment, and assess patterns of behavior with behavior monitoring. Review of the facility state reportable incidents (FRIs) of the last 12 months failed to document a complete investigation of the incident between R1 and R2 on 8/31/2025. Cross refer F600 and F609