STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115524	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Brandon Wilde	4275 Owens Road Evans, GA 30809

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interviews, record review, and policy review, the facility failed to ensure grievances were promptly resolved for five residents (Resident (R) 9) R23, R35, R50, and R61 of 22 sample residents. Specifically, the facility failed to date, summarize findings, and document corrective action taken as a result of the grievance. This failure had the potential to cause further grievances to be unresolved for residents throughout the facility. 1.Review of R23's) revealed a quarterly Minimum Data Set (MDS)" assessment, located under the "MDS" tab electronic medical record (EMR), with an Assessment Reference Date (ARD) of 03/13/26 revealed R23's admission date was 08/26/25. R23 had a diagnosis that included kidney insufficiency. R23 had a Brief Interview for Mental Status (BIMS)score of 14 out of 15 which indicated no cognitive impairment. 2.Review of R61's EMR revealed a quarterly "MDS" assessment, located under the "MDS" tab, with an ARD of 03/23/26 revealed R61's admission date was 12/17/25. R61 had a BIMS score of 9 which indicated moderate cognitive impairment. Active diagnoses included cancer, heart failure, stroke, and depression. 3.Review of R50's EMR revealed a quarterly "MDS" assessment, located under the "MDS" tab, with an ARD of 03/04/26 revealed R50's admission date was 12/29/21. R50 had a BIMS score of 13 which indicated no cognitive impairment. Active diagnoses included coronary artery disease, high blood pressure, diabetes, anxiety disorder, depression, and asthma. 4.Review of R35's EMR revealed a quarterly "MDS" assessment, located under the "MDS" tab, with an ARD of 01/13/26 revealed R35's admission date was 04/18/24. R35 had a BIMS score of 10 which indicated moderate cognitive impairment. Active diagnoses included chronic kidney disease, heart disease, and stroke. Review of the Resident Council Concerns dated June 25, 2025, revealed a Summary of Resident Concern. There was no documentation of Departmental Signature, or the Date Concern Returned to Administrator. No response from the complainant was documented.Review of the facility Resident Grievance Log for April 2025 through April 14th, 2026, revealed no documentation of any grievances filed on behalf of R61 or R50. Review of the Grievance Concern Form, provided by the facility, revealed six grievances had been filed on behalf of R35 on 09/7/2025, 02/21/2026, 03/19/2026, 03/22/2026, 03/30/2026, and 04/5/2026. The Name of Person Notified of Resolution listed at the end of the form was listed as R35's family member. The form was marked satisfied with no documentation of what was discussed with the family member or what the family member's response was. During an interview on 04/16/26 at 3:45 PM, R61's family member stated she had expressed her concerns to the facility staff numerous times, but there had been no change in staffing. R61's POA stated R61 was dependent upon staff and there were times when R61 was not receiving the care he needed. The POA stated her grievances had not been addressed or resolved. Review of the Grievance Concern Form, provided by the facility, revealed six grievances had been filed on behalf of R35 on 09/7/2025, 02/21/2026, 03/19/2026, 03/22/2026, 03/30/2026, and 04/5/2026. The Name of Person Notified of Resolution listed at the end of the form was listed as R35's family member. The form was marked satisfied with no documentation of what was discussed with the family member or what the family member's response was. During an interview on 04/17/26 at 12:03 PM, R35's family member stated he had reported he had filed several grievances regarding R35's care. R35's POA stated he had frequently been told by the Administrator (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he would get back to him, but he never did. During an interview on 04/17/26 at 5:02 PM, the Social Services Director (SSD) stated the documentation should be more in-depth and should include specific concerns, and how they determined the reporting party was satisfied for R35. The SSD revealed verbal complaints should be filed and addressed. During an interview on 04/17/26 at 11:42 AM, the Administrator confirmed follow-up for resident council concerns had been inconsistent.Review of the facility's policy titled, Grievance Complaints & Missing Property with a revision date of 01/11/19, revealed, It is the policy of our facility to support and assist the residents, representatives, interested family members or resident advocate in their right to file a grievance without discrimination or reprisal and without fear of reprisal.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review, interviews, and facility policy, the facility failed to ensure a Georgia Criminal History Check System (GCHEXS) fingerprint background check was completed prior to date of hire for one of seven new hire employees and reference checks were completed for seven of seven new hire employees. The deficient practice could result in a staff with an unknown criminal background having access to residents. 1.Review of employee records for the Administrator revealed he was hired on 12/01/25. The required GCHEXS fingerprint background check was completed on 12/02/25.During an interview on 04/17/26 at 3:42 PM, the Human Resources Director (HRD) stated GCHEXS background checks are completed for all employees except nurses and are required to be completed prior to the start date. The HRD stated the Administrator is not a facility employee but is a corporate employee based out of Iowa. 2.Review of employee records for the Administrator, Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN) 1, LPN 3, Registered Nurse (RN) 1, Certified Nurse Aide (CNA) 1, and CNA3, revealed reference checks were not completed.During an interview on 04/17/26 at 3:42 PM, the HRD stated the facility did not complete reference checks and only performed employment verification checks through the company that performed the background checks. The HRD further stated that the corporate office had directed the facility to resume completing reference checks.Review of the facility's policy titled, Resident Abuse Prevention Program provided by the facility, dated 12/15/04, indicated The community will not knowingly employ any direct care staff convicted of any of the crimes listed in the State Criminal History of Nurse Aides and Other Unlicensed Employees, or with a finding of abuse listed on the Nurse Aide Registry or criminal history background check. Prior to a new employee starting a work schedule, this community will: Initiate a reference check from previous employer(s), in accordance with community policy; obtain a copy of the state license of any individual being hired for a positionrequiring a professional license; if applicant is a nursing assistant, obtain a copy of the person's state nurse aide registry report from the state department; obtain a limited criminal history for nurse aides and other unlicensed employees.Review of the facility's policy titled, Hiring Process, provided by the facility, revised 11/14, indicated Once a hiring official has selected an applicant and notified Human Resource staffto begin hiring process, the job offer will only be extended after clearance from Human Resources based on several factors to include, but not limited to: acceptable references, review of criminal history; licensure/certification verification, and fingerprint records check as required for position. Final clearance to begin employment and start date will be determined after receiving negative drug screen results, completion of step one of TB test, and general medical evaluation from Occupational Health is received. Human Resources will notify the hiring official when all required documentation is complete.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy, the facility failed to ensure residents were informed of the benefits, risks, and alternatives of treatment prior to initiating psychotropic medication for one (Resident (R) 42) of five residents reviewed for unnecessary medications out of a total sample of 22 residents. This failure increased the risk of residents not knowing the potential side effects of the medications. 1. Review of R42's admission Record located under the Profile tab of the electronic medical record (EMR), revealed R42 was admitted to the facility on [DATE] with diagnoses that included depression, dementia, and anxiety disorder. Review of R42's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/20/26, located under the MDS tab of the EMR, revealed R42 was unable to complete a Brief Interview for Mental Status (BIMS) and was assessed by staff as severely cognitively impaired. The MDS revealed R42 took antianxiety medications.Review of R42's Medication Administration Record (MAR) dated January 2026 and Physician Orders located under the Orders tab of the EMR, revealed R42 received lorazepam (Ativan, an anxiolytic medication) 0.5 milligrams (mg) every eight hours as needed for anxiety, which originated on 01/16/26.Review of R42's medical records revealed no documentation that she or the resident's representative had been provided information in advance of receiving the medication for the risks and benefits of the prescribed medications, the treatment alternatives, or other options, and consented to the medications.During an interview on 04/17/26 at 5:34 PM, the Director of Nursing (DON) stated Psychotropic medications need to have informed consent prior to administration including upon admission. Nursing staff are responsible for obtaining consent. The DON was unable to provide documentation of consent prior to administration of lorazepam on 01/16/26.Review of the facility's policy titled, Psychotropic Medication use, dated February 2025, indicated Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/resident representative prior to obtaining documented consent or refusal: non-pharmacological alternatives; the indications and rationale for the recommendation; the potential risks and benefits (including possible side effects, adverse consequences, and black boxwarnings); and the resident's/representative's right to accept or decline the treatment.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility's policy, the facility failed to convey information to hospital at the time of transfer, failed to notify resident and resident representative in writing of the reason for the transfer/discharge to the hospital, and failed to notify the resident/resident representative of the facility policy for bed hold including reserve bed payment. one of three residents (Resident (R) 7) reviewed for hospitalization out of 22 sampled residents. This failure creates the potential for residents and responsible parties to be misinformed of the transfer out of the facility and to not have the information needed to safeguard their return to the facility. Review of R7's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R7 was admitted to the facility on [DATE] with diagnoses that included diastolic (congestive) heart failure (CHF), atrial fibrillation, presence of cardiac pacemaker, and anxiety disorder. Review of R7's annual Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 02/17/26 indicated R7 was coded as having a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated R7 was severely cognitively impaired.Review of R7's Progress Note, dated 02/09/26 and located under the Prog Notes tab of the EMR, revealed R7 was sent to the hospital for respiratory distress. Review of R7's entire medical record revealed no documented evidence that the facility conveyed information to hospital at the time of transfer, notified R7 or the resident representative in writing of the reason for the transfer/discharge to the hospital, and failed to notify the resident/resident representative of the facility policy for bed hold including reserve bed payment.During an interview on 04/17/26 at 7:16 PM, the Director of Nursing (DON) indicated that written notification of transfer to the hospital, written notification for the reason of transfer to R7 and/or their responsible party, and bed hold policy notification were not issued when R7 was emergently transferred to the hospital. Review of the facility's policy titled, Transfer or Discharge, dated March 2025, indicated When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider: the basis for the transfer or discharge; that an appropriate notice was provided to the resident and/or legal representative; the date and time of the transfer or discharge; the new location of the resident; . a summary of the resident's overall medical, physical, and mental condition; . The policy did not specify information regarding bed hold policy notification.

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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. Based on record review, interview, and facility policy review, the facility failed to ensure the Discharge Return Anticipated Minimum Data Set (MDS) was completed for one of three residents (Resident (R) 7) reviewed for hospitalization out of a total sample of 22 residents. This had the potential to lead to inaccurate goals of care, including functional and health status and strengths and needs of the resident. Findings include:Review of medical record 02/9/26 no evidence of documented transfer notification; einteract transfer or bed hold. 02/9/26 Discharge MDS marked out in error - not completed; 02/10/26 Entry MDS marked out in error - not completeAn interview on 04/17/2026 at 7:16 PM with the Director of Nursing (DON) revealed she was unable to locate transfer notice to hospital, transfer notification to resident/resident representative or bed hold notice. The DON stated a notice of transfer is required to be sent with the resident to the hospital, written notice to the resident representative, and bed hold notice is required to be sent. DON confirmed 2/9/26 Discharge Return Anticipated MDS should have been completed.

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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 record review, interview, and facility policy review, the facility failed to ensure the comprehensive assessment accurately reflected a discontinued antipsychotic medication for one (Resident (R) 22) of five residents reviewed for unnecessary medications in the sample of 22 residents. This failure had the potential to lead to a lack of alternative interventions. Review of R22's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R22 was admitted on [DATE] with diagnoses of Alzheimer's disease and dementia with behavioral disturbance.Review of R22's monthly Pharmacy Review provided by the facility revealed a pharmacy recommendation to discontinue quetiapine 25 milligrams (mg) one tablet by mouth daily starting on 03/05/26.Review of R22's Medication Administration Record located under the Orders tab of the EMR revealed Seroquel oral tablet 25 milligrams (mg) (quetiapine fumarate) give one tablet by mouth in the evening related to dementia with behavioral disturbance discontinued on 03/05/26 with the last dose being administered on 03/04/26.Review of R22's Care Plan located under the Care Plan tab of the EMR revealed R22 had her Seroquel antipsychotic medication discontinued starting 03/05/26.Review of R22's annual Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 03/12/26 indicated the resident received antipsychotics.During an interview on 04/17/26 at 3:22 PM, the MDS Coordinator confirmed the MDS has a seven day look back period and the antipsychotic medication should not have been coded on the MDS for R22 as the medication was discontinued 8 days prior.Review of the facility's policy titled, Comprehensive Assessments with a revision date of March 2022 indicated, Comprehensive assessments are conducted to assist in developing person-centered care plans. Policy Interpretation and Implementation 1. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual.

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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 observation, interview, record review, and facility policy review, the facility failed to ensure a physician's order for oxygen was obtained prior to administering oxygen; ensure appropriate oxygen signage was posted on the resident's door; and ensure respiratory supplies were dated and stored in a sanitary manner in accordance with professional standards for one of one residents (Resident (R) 68) reviewed for respiratory care out of a sample of 22 residents. This failure had the potential to compromise infection control and increase the risk of infection transmission within the facility. Cross Reference F658Findings include:Review of R68's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R68 was admitted on [DATE] with a diagnosis of pneumonitis due to inhalation of food and vomit.Review of R68's Care Plan located under the Care Plan tab of the EMR dated 04/07/26 revealed the resident was not care planned for oxygen.Review of Progress Notes located under the Progress Notes tab of the EMR revealed on 04/07/26 at 3:19 PM; 04/07/26 at 3:34 PM; 4/15/26 at 4:00 PM that R68 was administered oxygen.Review of R68's Order Summary Report located under the Orders tab of the EMR dated 04/14/26 revealed there is no physician's order for oxygen.During an observation on 04/14/26 at 10:51 AM, R68 was in her room with oxygen concentrator present and running at five liters per minute (LPM) through nasal cannula. Humidification present with no date. No storage bag present and oxygen tubing is not dated.During an interview on 04/14/26 at 2:13 PM, R68 said she is on oxygen because without it her oxygen level bottoms out.During an observation on 04/14/26 at 2:21 PM, R68 was in her room with oxygen concentrator present and running at five LPM through nasal cannula. Humidification present with no date. No storage bag present and oxygen tubing is not dated.During an observation on 04/15/26 at 12:58 PM, R68 was in her room with oxygen concentrator present in room running at seven LPM through nasal cannula. Humidification present with no date. No storage bag present and oxygen tubing is not dated. No oxygen sign was present outside door.During an observation on 04/16/26 at 9:07 AM, R68 was in her room with oxygen concentrator present in room running at seven LPM through nasal cannula. Humidification present with no date. No storage bag present and oxygen tubing is not dated. No oxygen sign was present outside door.During an interview on 04/16/26 at 9:10 AM, Registered Nurse (RN)2 at R68's bedside revealed the resident was currently receiving eight liters of oxygen through nasal cannula per the physician order, humidification and tubing were not dated and should be for infection control purposes, there should be a storage bag present for infection control purposes when the resident has her oxygen removed. RN2 confirmed there is no oxygen sign outside R68's door and that it is to be present to let people know there is no smoking. RN2 confirmed, after looking in the EMR at the physician's orders for R68, that there was no physician's order for oxygen.During an interview on 04/16/26 at 9:18 AM, the Director of Nursing (DON) while at R68's bedside confirmed the resident was currently receiving seven liters of oxygen through nasal cannula, humidification and tubing were not dated and should be for infection control purposes, there should be a storage bag present for infection control purposes when the resident has her oxygen removed. The DON confirmed there is no oxygen sign outside R68's door and that it is to be present to let people know the resident is on oxygen. DON confirmed, after looking in the EMR at the physician orders for R68, that there was no physician's order for oxygen.Review of R68's Medication Administration Record (MAR) revealed the resident did not have an order for oxygen until 04/16/26.During an interview on 04/17/26 at 2:03 PM, RN3 revealed the admission process is dependent on where a resident is admitted from. RN3 also revealed when a resident admits with hospice they does an assessment, gives orders, and the facility puts the orders in electronic health record. RN3 revealed she would look at the physician's order when starting oxygen on a resident. RN3 also revealed the hospice nurse told her how many liters to put the resident on as hospice provided the oxygen concentrator with higher liters. RN3 revealed she did not look at the physician orders that she was told verbally by hospice how many liters to place R68 on. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN3 revealed she would look at the MAR to know how many liters R68 was to remain on or if there were any changes in oxygen administration. During an interview on 04/17/26 at 2:22 PM, ADON r confirmed there was no order for oxygen in the hospital discharge paperwork. ADON revealed the hospice nurse was in the facility when R68 arrived. ADON confirmed that either the nurse, DON or herself put in hospice orders once they are faxed to the facility. ADON revealed the way they know if a resident is to be placed on oxygen is through the physician orders and that ultimately, they follow they orders placed in the EMR. ADON confirmed there was no order in the EMR until 04/16/26 due to it not being signed.Review of the facility's policy titled, Oxygen Administration with a revision date of October 2010 revealed, The purpose of this procedure is to provide guidelines for safe oxygen administration. 'Preparation:' 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. 'Equipment and Supplies:' The following equipment and supplies will be necessary when performing this procedure. 4. No smoking/ oxygen is use signs. 'Steps in the Procedure'. 2. Place an Oxygen in Use sign on the outside of the room entrance door.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to ensure personal resident refrigerators were maintained to prevent potential food borne illness for two residents of two sampled residents (Resident (R)33) and R50) who owned a refrigerator. This failure had the potential to cause the residents to eat spoiled food which could cause a decline in the residents' overall health. Findings include:1.Review of R33's quarterly "Minimum Data Set (MDS)" assessment, located under the "MDS" tab of the electronic medical record (EMR), with an Assessment Reference Date (ARD) of 03/03/26 revealed R33 admission date was 12/29/21. R33 had a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated severe cognitive impairment. R33 had a diagnosis that included high blood pressure.During an observation and interview on 04/14/26 at 2:56 PM, R33 had a personal refrigerator near the door in her room. On the outside of the refrigerator door, a Refrigerator Temperature Log was attached to the door. There were no temperatures recorded on 04/11/26 or 04/12/26. The temperature on the thermometer in the refrigerator read 46 degrees Fahrenheit (F). Inside the refrigerator a melamine cup was observed with peaches. On top of the peaches was thick yellow, white, and black fuzzy material that appeared to be mold. The cup had a lid on it that did not have a date marked. The Maintenance Director (MD) stated that resident's personal refrigerator temperatures should be checked and recorded every day. The MD confirmed the peaches in R33's refrigerator had mold on them.2.Review of R50's quarterly "MDS" assessment, located under the "MDS" tab of the EMR, with an ARD of 03/04/26 revealed R50's admission date was 12/29/21. R50 had a BIMS score of 13 out of 15 which indicated no cognitive impairment. Active diagnoses included coronary artery disease, high blood pressure, diabetes, anxiety disorder, depression, and asthma. During an observation on 04/14/26 at 3:13 PM, of R50's personal refrigerator located near the door revealed temperatures were not recorded on the Refrigerator Temperature Log on the days of 04/03/26, 04/05/26, 04/11/26, and 04/12/26. During an interview on 04/14/2026 at 3:16 PM, Licensed Practical Nurse (LPN) 2 stated the peaches that were in R33's refrigerator had a thick yellow, white, and black fuzzy material that appeared to be mold. During an interview on 4/14/2026 at 3:17 PM, Registered Nurse (RN) 2 confirmed the peaches in R33's refrigerator had peaches with thick yellow, white, and black fuzzy material that appeared to be mold and needed to be discarded.During an interview on 04/14/26 at 3:41 PM, the Administrator stated the residents' personal refrigerators were to be checked daily during rounds, by assigned staff. He stated their checks should include the temperature of the refrigerator and checking for outdated or spoiled food. The Administrator revealed the expectation was that resident refrigerators should be checked daily by the unit supervisor and temperatures were to be recorded and outdated/spoiled food should be discarded. Review of the facility's policy titled, Use of Personal Refrigerators, with an effective date of 03/19/26, revealed Personal refrigerators must maintain temperatures at or below 41 degrees F .Temperature monitoring must be performed daily. Logs must include date, time, recorded temperature, staff initials, and corrective actions if applicable. Expired, spoiled, or improperly stored items would be removed by staff .