STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spalding Post Acute LLC	415 Airport Road Griffin, GA 30224

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review and review of the facility's policies titled Handwashing/Hand Hygiene, and Infection Prevention and Control Program, the facility failed to implement infection control protocol for two residents (R) (R34 and R82) of 14 residents observed for infection control. Specifically, nurse did not sanitize hands between glove change and nurse placed a tablet in her bare hand. The deficient practice increased the risk of cross contamination and the spread of infection to residents and staff. Findings include:Review of the facility's policy titled Handwashing/Hand Hygiene undated, documented Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; m. After removing gloves. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.Review of the facility's policy titled Infection Prevention and Control Program reviewed 03/02/2025, documented Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.1.Review of the facility's electronic medical records (EMR) documented R82 was admitted to the facility 01/29/2024 with diagnosis included but not limited to diabetes mellitus.Review of the Quarterly Minimum Data Set (MDS) dated [DATE], documented Section C (Cognition) Brief Interview for Mental Status (BIMS) score of 03 which indicated R82 had severe cognitive impairment, and Section I (Active Diagnosis) documented R82 had diabetes mellitus.Review of the care plan dated 03/02/2026, documented R82 has Diabetes Mellitus type 2. Goal: will have no complications related to diabetes through the review date. Intervention: Diabetes medication as ordered by doctor.Review of the Physician's orders dated 10/23/2024, documented metformin oral Tablet 500 milligrams (MG), give 2 tablets by mouth two times a day for Diabetes.Observation on 03/18/2026 at 9:06 AM during medication administration revealed Licensed Practical Nurse (LPN) FF used her bare hands to place a metformin tablet in the pill cutter to cut it in half to administer both halves to R82.2. Review of the facility's electronic medical records (EMR) documented R34 was admitted to the facility 06/02/2025 with diagnosis included but not limited to dysphasia.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview for Mental Status (BIMS) documented R34 was rarely or never understood, Section K (Swallowing/Nutritional Status) documented R34 had feeding tube.Review of the care plan dated 03/09/2026 documented R34 requires BOLUS PEG tube feeding with interventions to monitor/document/report as needed (PRN) any signs and symptoms (s/sx) of: Aspiration- fever, shortness of breath (SOB), tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormality.Review of the Physician's orders dated 10/23/2024 (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: 115537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	documented Cleanse G tube site with sterile saline, pat dry with dry, sterile dressing (DSD). Apply skin protectant to skin, then cover with split gauze and secure with tape.Observation on 03/19/2026 at 10:07 AM, revealed LPN EE did not sanitize her hands between glove change during R34's GT care.Interview on 03/18/2026 at 9:07 AM with LPN FF revealed she confirmed she used her bare hands to place a metformin 1000 mg tablet in the pill cutter to cut it in half to administer to R82. She stated R82 was ordered two 500 mg tablets but since the pharmacist sent 1000 mg tablets R82 preferred the tablet cut in half because it was a large tablet and she would take the two halves rather than one large tablet. LPN FF stated she should not have used her bare hands to hold the tablet because it caused cross contamination. and the R82 would get an infection.Interview on 03/18/2026 at 9:07 AM with the Director of Nursing (DON) revealed it is her expectations for the nurses not to handle medications with their bare hands. She stated that bare hands could contaminate the pills and if the residents get these medications, the residents could get whatever contamination was on the pills, possibly infection.Interview on 03/19/2026 at 10:15 AM with LPN EE confirmed and validated that she did not sanitize nor wash her hands between glove the change during GT care. She stated the hand sanitizer station in the room was empty and she did not have any hand sanitizer to use. She stated she should have washed her hands if there was no hand sanitizer. LPN EE further stated when she did not sanitize her hands nor wash her hands between glove change R34 could get an infection.Interview on 03/19/2026 at 2:01 PM with Nurse Manager (NM) CC confirmed that anytime gloves were removed, hands were to be washed or sanitized. She stated hands were to be washed or sanitized between glove changes and whenever this was not done, it was an infection control issue. The NM further stated that the residents could get infections such as Healthcare-Associated Infections (HAIs - infections patients contract while receiving treatment in healthcare settings, such as hospitals or nursing homes.)Interview on 03/19/2026 at 2:48 PM with the Director of Nursing (DON) revealed it is her expectation that staff sanitize their hands between glove changes. The DON stated that when the staff removed gloves they were to wash or sanitize their hands before putting on another pair of gloves because if they did not, it would cause spread of infection to the residents.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review and review of the facility's policy titled Medication: Self Administration and Bedside Medication Storage, the facility failed to remove one inhaler from the bedside of one resident (R) (R94) of 54 sampled residents. This deficient practice increased the risk of clinical complications. Findings include:Review of the facility's policy titled Medication: Self Administration reviewed December 2021 documented POLICY: Patients who request to self-administer medications will be assessed for capability. If it is determined that the patient is able to self-administer: A physician/mid-level provider order is required. Self-administration must be care planned. Patients must be provided with a secure, locked area to maintain medications. Patient must be instructed in self-administration. Periodic evaluation of capability must be performed. PURPOSE: To provide a safe, effective process for patient self-administration of medication.Review of the facility's policy titled Bedside Medication Storage undated, documented POLICY: Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgment of the nursing care center's interdisciplinary resident assessment team. PROCEDURES: The interdisciplinary team (IDT) will review and approve resident competencies and understanding prior to permission of bedside storage of medications as established in the nursing care centers policies and procedures. A written order for the bedside storage of medication is present in the resident's medical record. All nurses and nursing aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party.Review of the facility's electronic medical records (EMR) revealed R94 was admitted to the facility on [DATE] with diagnosis included but not limited to chronic obstructive pulmonary disease (COPD).Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview for Mental Status (BIMS) score of 15 which indicated R94 had little to no cognitive impairment, and Section I (Active Diagnosis) documented R94 had COPD.Review of the care plan dated 02/10/2026, revealed there was no documented care plan for self-administration of medication for R94.Review of the Physician's orders revealed there was no documented order for self-administration of medication for R94.Review of the Physician's orders dated 09/10/2025, documented included but not limited to Stiolto Respimat Inhalation Aerosol Solution 2.5-2.5 MCG/ACT (micrograms per actuation - the exact dose of medication delivered with each spray or puff of an inhaler), (Tiotropium Bromide-Olodaterol HCl [hydrochloride]), Give 2 puffs by mouth every morning and at bedtime for COPD. Evaluate resident during inhalation therapy to ensure proper use of holding device, inhalation of medication and toleration of therapy. Use in conjunction with specific inhaler or nebulizer medication orders.Observation on 03/17/2026 at 11:54 AM revealed one Stiolto Respimat inhaler on R94's overbed table.Observation on 03/17/2026 at 3:25 PM revealed one Stiolto Respimat inhaler on R94's overbed table.Observation on 03/18/2026 at 9:05 AM revealed one Stiolto Respimat inhaler, one VapoCool sore throat spray and one CareAll chest rub on R94's bedside table.Observation on 03/18/2026 at 9:55 AM revealed one Stiolto Respimat inhaler, one VapoCool sore throat spray and one CareAll chest rub on R94's bedside table.Record review of R94's Assessments revealed no documented interdisciplinary team (IDT) Assessment for medication self-administration.Interview on 03/17/2026 at 11:55 AM with R94, stated the Stiolto Respimat inhaler which was on his overbed table was his and he had it at his bedside since the time he was admitted to the facility. R94 stated that he used the inhaler whenever he wanted to use it up to a few times each day. R94 further stated that the nurses knew the inhaler was at his bedside and they come in the mornings and evenings to give him an inhaler from the facility.Interview on 03/18/2026 at 9:56 AM with R94 in the presence of Licensed Practical Nurse (LPN) DD confirmed the medications were at his bedside since his admission and he took them whenever he desired. He stated he used the (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inhaler between the times when the nurses come and give him the facility's inhaler medication.Interview on 03/18/2026 at 10:00AM with LPN DD, confirmed and verified that one Stiolto Respimat inhaler, one VapoCool sore throat spray and one CareAll chest rub were on R94's bedside table. She stated that R94 should absolutely not have medications at the bedside and he should not be taking the medications on his own without the nurse knowing that he was taking them. LPN DD further stated that when R94 took the inhaler, the nurses had no control over the administration of that inhaler, and it would interfere with the other medications including another inhaler which he was receiving from the facility. She further stated R94 could take more than the amount he was supposed to take and it could exacerbate his medical condition. LPN DD stated R94 should not have medications at his bedside or take his own inhaler without staff knowledge.Interview on 03/18/2026 at 4:34 PM with LPN BB, stated medications must not be in residents' rooms and the residents should not take medications without the nurses knowing that they were taking their own medications. She stated that the residents who take their own medications could take too much of the medication.Interview on 03/18/2026 at 4:45 PM with the Director of Nursing (DON) confirmed it is her expectation that the residents should not have medications at the bedside. She stated residents needed to have doctor's orders, assessment from the IDT and care plan to self-administer medications. The DON confirmed R94 did not have a doctor's order, did not have an IDT Assessment and R94 was not care planned to self-administer medications. She stated R94 was admitted [DATE] and she was not aware if he had the inhaler at the bedside since admission. She further stated R94 could overmedicate and damage his lungs.

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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 resident and staff interviews, review of facility documentation, and review of the facility policy titled, Abuse, Neglect, and Exploitation, the facility failed to ensure three residents (R) (R158, R140, and R59) of four residents reviewed were free from abuse. Specifically, R158 experienced physical abuse from a Certified Nursing Assistant (CNA) and R140 and R59 experienced emotional abuse by another resident. The deficient practice had the potential to affect resident psychosocial health and safety. Findings include:1. Review of the Facility Incident Report Form dated 11/21/2025 at 1:00 AM (Incident #202513043) revealed an allegation of staff-to-resident abuse in which R159 stated that he witnessed CNA AA kick R158 in the foot and leg while he was lying on the floor of the bathroom. Continued review of the initial report revealed that CNA AA was placed on suspension pending the outcome of the investigation and the staff were educated on the abuse policy and reporting requirements. Review of the Facility Incident Report (FRI) dated 11/21/2025 at approximately 2:00 AM, revealed that R159 alleged that a Certified Nursing Assistant (CNA) kicked R159 while he lay on the floor of his bathroom. Review of the undated Facility Incident Report (FRI) Follow Up revealed that R159 fell in the doorway of his shared bathroom where he laid for around 45 minutes before CNA AA arrived. He stated that CNA AA kicked R158 multiple times and spoke to him in a foreign language. R159 told CNA AA not to kick R158 but to get help. He stated she spoke to him in a foreign language and in a voice and tone which frightened him. He stated she left and returned with help, and they assisted R158 back to bed. Review of the electronic medical record (EMR) revealed that R158 was admitted to the facility with a diagnosis of dementia. He was assessed as being alert with confusion with a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognitive function. Continued review of the (FRI) Follow Up revealed that R159 (witness) was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (COPD), chronic kidney disease, and hearing loss. The investigation included interviews with R159, interviews with residents on that unit, skin assessments and staff education presented on 11/21/2025, 11/24/2025, 12/03/2025, and 12/04/2025 related to staff-to-resident, resident-to resident abuse, and preventing abuse. In addition, nursing staff conducted interviews and performed skin assessments on the residents of the unit. The abuse allegation was substantiated, and CNA AA was terminated effective 11/21/2025. She could not be reached by phone during the course of the investigation or the standard/complaint survey. R158 and R159 were also discharged from the facility at the time of the standard/complaint survey.2. Review of the FRI dated 03/02/2026 at 2:20 PM revealed two incidents of resident-to-resident abuse in which R115 went into R59's room and stole her Vienna Sausage and Spam. In addition, R140 stated she walked into her bathroom and R115 was urinating and she saw his penis. He stated to her, next time I'll give you a better peak at it.R115 was immediately placed on one-to-one supervision, and a referral was placed for transfer to a behavioral unit. R115 was transferred to the local hospital for evaluation and treatment for his behavior and did not return to the facility. All staff received education on abuse, neglect, and exploitation. Review of the electronic medical record for R115 revealed he was admitted to the facility with diagnoses to include traumatic subdural hemorrhage, Wernicke's encephalopathy, dementia, compression of the brain, alcoholism, and malnutrition. Review of the admission Minimum Data Set (MDS) assessment for R115 dated 02/27/2026 revealed a Basic Interview for Mental Status (BIMS) score of 00 which indicated severe cognitive impairment (Section C), mood score of 02 which indicated little to no depression (Section D), and wandering behavior (Section E).Review of the care plan for R115 revealed focus concerns to include altered neurological status, knowledge deficit, risk for disturbed sensory, subdural hemorrhage with compression to brain, elopement risk/wanderer related to impaired safety/wandering and exit-seeking (02/22/2026), behavior problem of urinating in hallway/wandering (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into female bathrooms and urinating on the floor/taking food from another female room. Appropriate goals and interventions in place. Review of the Physician's Orders revealed an order to place R115 on 1:1 supervision, and transfer to a behavioral unit on 03/02/2026.Review of the EMR for R59 revealed she was admitted to the facility with diagnoses to include chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and depression. Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating little to no cognitive impairment. In an interview with R59 on 03/18/2026 at 4:45 PM in the dining room, she stated she was sitting there in her bed when R115 came to the door and stood there for a moment then he kind of stormed into the room and grabbed her Spam and Vienna Sausage off her table and left the room. She stated it was kind of scary and she doesn't scare easily. She stated there have been no other incidents of that sort before or since then. She stated staff continued to check on her after the incident to make sure she was okay. In an interview with R140 on 03/18/2026 at 5:00 PM in her room, she stated she got up to go to the bathroom and when she opened the door, R115 was peeing into her toilet. She stated he entered from the other side of the adjoining bathroom. She stated she saw his penis, and he told her that he'd let her get a better peek next time. She stated she was shocked and scared and called for help. She stated staff came right away and he left with no problem. She stated no other incidents like that had occurred before or since and staff have been very attentive. Review of the facility policy titled, Abuse, Neglect, and Exploitation, reviewed/revised 04/15/2025, documented Policy statement: It is the policy of this facility to provide protections 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. Review of the Grievance Log dated 12/2025 through 1/2026 revealed no unresolved issues. Review of the Resident Council Minutes dated 12/2025 through 12/2025 revealed no unresolved issues. In an interview with CNA RR on 03/18/2026 at 2:30 PM, stated that she received education in abuse, neglect and exploitation and abuse reporting, at least monthly. She stated that they will also add more if something happens with a particular resident. She stated that she would report citing or allegation of abuse to the nurse and the Abuse Coordinator (AC) who is the Administrator. In an interview with CNA SS on 03/18/2026 at 2:40 PM, stated staff receive education in abuse and neglect all the time but at least monthly. She stated they also receive specific information for residents when they identify concerns. She stated she would report allegations to her charge nurse and the AC.In an interview with Licensed Practical Nurse (LPN) TT on 03/18/2026 at 2:50 PM, she stated that if she saw or heard of an abuse allegation, she would make sure her resident was safe, assess the resident, notify the physician or responsible party (RP), follow any new physician orders, and report to the Unit Manager (UM) and AC. She stated that staff receive abuse inservices sometimes several times a month.In an interview with LPN UU on 03/18/2026 at 3:00 PM, she stated that she would address abuse concerns by assessing the resident, notifying the physician, RP, UM, and AC. She stated that staff receive additional abuse inservice each time there is an abuse allegation. In an interview with LPN VV on 03/18/2026 at 3:10 PM, she stated that she would assess the resident who alleged abuse, notify the physician, RP, UM, and AC. She stated staff receive abuse education at least quarterly but usually more often. In an interview with LPN DD on 03/18/2026 at 3:20 PM, she stated that staff receive abuse education all the time, especially if there is an abuse allegation. She stated she would report an abuse allegation to her UM, Director of Nursing (DON), the physician or Nurse Practitioner (NP), RP, and the AC. In an interview with the Administrator on 03/18/2026 at 3:30 PM, she stated the staff receive frequent inservices on abuse, neglect, and exploitation, and she expected them to follow the protocols already in place to protect the residents

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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 staff interviews, record review, and review of the facility's policy titled Abuse, Neglect and Misappropriation, the facility failed to ensure three of three residents (R) (R94, R89 and R37) were free from misappropriation of medication when narcotic medications were signed out and not administered. This deficient practice increased the risk of adverse clinical outcomes.Findings include:A review of the facility's policy titled Abuse, Neglect, and Exploitation reviewed 01/01/2025 documented Policy Statement: It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law. The organization will include screening, training, prevention, identification, investigation, protection, and reporting to provide protection for the health, welfare, and rights of each resident residing in the facility.1. Review of the electronic medical record (EMR) revealed that R94 was admitted to the facility on [DATE] with diagnoses which included but not limited to left femur fracture and neoplasm of the tongue.Review of R94's Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognition) R94 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated little to no cognitive impairment, Section P (Restraints and Alarms) R94 was on pain medication therapy related to chronic pain and end of life care.Review of R94's comprehensive Care Plan dated 02/10/2026 documented a Focus area for pain medication therapy related to (r/t) chronic pain and end of life care and intervention to administer pain medications as ordered by physician.A review of the Physician's Orders dated 02/12/2026 documented orders for Oxycodone 10 milligram (mg) 1 tablet as needed (PRN) every 4 hours for pain.A review of the facility's Investigation of Misappropriation of Narcotics report dated 10/07/2025 documented On 10/03/2025, Licensed Practical Nurse (LPN)/ Unit Manager (UM) GG signed out 2 {two} 5 mg {milligram} tablets and on 10/04/2025 she signed out 2 more 5 mg tablets. The resident stated he only received pain medications once from LPN/UM GG.2. Review of the EMR revealed R89 was admitted to the facility on [DATE] with diagnoses included but are not limited to malignant neoplasm of lower lobe left lung.Review of the Annual MDS assessment for R89 dated 01/28/2026 revealed Section C (Cognition) R89 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated little to no cognitive impairment, Section I (Active Diagnosis) R89 had metastatic cancer.Review of R89's comprehensive Care Plan dated 01/09/2026 revealed Focus area for risk of acute/chronic pain r/t Cancer (Lung) and history (hx) of right foot pain with intervention to administer analgesia as ordered and PRN.A review of the Physician's Orders for R89 revealed orders dated 09/05/2025 documented HYDROcodone-Acetaminophen Oral Tablet 5-325 MG, give 1 tablet by mouth every 6 hours as needed for pain do not exceed 3000mg/day. The order was discontinued on 09/25/2025.A review of the facility's Investigation of Misappropriation of Narcotics report dated 10/07/2025 documented On 10/03/2025, LPN/UM GG removed a 5mg/ 325mg oxycodone from the cart per her signature in the narcotic book. Per the electronic MAR {medication administration record,} it was not documented as given. R89 stated he did not ask for or receive pain medication and stated he doesn't even take it.3. A review of the EMR revealed R37 was admitted to the facility on [DATE] with diagnoses which included but are not limited to low back pain.A review of the Quarterly MDS assessment for R37 dated 02/16/2026 revealed Section C (Cognition) R37 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated little to no cognitive impairment, Section N (Medications) R37 received opiod medication.A review of R37's Care Plan dated 03/02/2026 revealed Focus area for pain medication therapy r/t low back pain and intervention to administer analgesic medications as ordered by physician.A review of the Physician's Orders for R37 revealed orders dated (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/15/2025 documented tramadol 50 mg tablet, give 1 tablet by mouth every 8 hour (s) as needed for pain.A review of the facility's Investigation of Misappropriation of Narcotics report dated 10/07/2025 documented On 10/4/2025, LPN/UM GG removed a tramadol from the narcotic box and signed the electronic MAR that it was given. R37 stated he didn't ask for pain medication, nor did he receive any from LPN/UM GG.Observation on 03/18/2026 of Med Pass revealed narcotic medications were administered to the residents and were administered as prescribed. The nurses stayed with the residents to ensure the narcotics were taken.Review of the facility's documents revealed the facility conducted audits continued monitoring and reviewed in Quality Assurance and Performance Improvement (QAPI.)Attempts were made to interview LPN/UM GG but were unsuccessful.Interview on 03/19/2026 at 4:45 PM with the Director of Nursing (DON) revealed she confirmed a full investigation for misappropriation of the resident's property was conducted on 10/4/2025 when she received a call from LPN/UM HH who stated that multiple PRN narcotics had been signed out during the prior night shift by LPN/UM GG for residents who did not usually request pain medication.Interview on 03/19/2026 at 5:10 PM with LPN/UM HH revealed she stated on 10/4/2025 she was a floor nurse, and she checked the narcotics when she came on duty for her 7:00 AM - 7:00PM shift. She stated LPN/UM GG usually worked the day shift, but she covered the night shift 7:00PM - 7:00 AM the prior shift. She stated LPN/UM GG already left when she came on duty and she checked the narcotics on her own. She stated that she was very familiar with the residents on the hall she usually worked, and she knew the residents who did not ask for or received pain medications, so she knew something was off when she saw narcotics signed out for residents who would not usually receive pain medications. She stated she went to the alert residents whose narcotics were signed out as given and asked R94, R89 and R37 if they received narcotic medications from LPN/UM GG and they said no. She stated she immediately reported it to the DON.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spalding Post Acute LLC	415 Airport Road Griffin, GA 30224

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 0656 Level of Harm - Minimal harm or potential for 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 observations, record reviews, staff interviews, and review of the facility policy titled, Falls Management and Minimum Data Set (MDS)/Care Plans the facility failed to implement the care plan interventions to keep one resident (R) (R125) from a sample of 12 residents, free from avoidable falls. The deficient practice increased the risk of falls with injury.Findings include:Review of the facility policy undated and titled Falls Management, documented under Policy Standards .2. Develop individualized plan of care 3. Review and revise care plan regularly. Fall Prevention Ideas: Patients unable to transfer self: Mats at bedside. Fall out of W/C {wheelchair}: Keep wheelchair unlocked if resident has a need to move.Review of the facility policy titled, Minimum Data Set (MDS)/Care Plans dated 02/01/2024 documented under Procedure: . 2. The interdisciplinary team will develop and implement the Comprehensive Care Plan within 21 days of admission. The comprehensive care plan will address resident goals, actual and potential problems, needs, strengths and individual preferences of the resident.Review of the electronic medical record (EMR) revealed resident R125 was admitted to the facility on [DATE], with pertinent diagnoses including but was not limited to Medically Complex Conditions, Non-Alzheimer's Dementia, or Macular DegenerationReview of R125 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00, which indicated severe cognitive impairment. Section GG, functional status, revealed R125 required extensive assistance for activities of daily living (ADLs) with one/two or more-person assistance. R125 does benefit from the use of a wheelchair. Self-care: Partial/moderate assistance (eating, upper body dressing), Supervision or touching assistance (oral hygiene and personal hygiene), Substantial/maximal assistance (toileting, shower/bathe self, lower body dressing and putting on/taking off footwear). Mobility: Substantial/maximal assistance in most areas with the exception of Partial/moderate assistance sit to stand.Review of R125 care plan dated 01/01/2026 documented a problem area at risk for a fall related to impaired mobility, impaired cognitive functions and use of psychotropic medications. 03/10/2026 Fall no injury, 03/11/2026 Fall no injury, 03/16/2026 Fall no injury. Goals included but not limited to that R125 will not have falls with significant injury through review date. Interventions included but not limited to staff to assist resident to and from dining room and ensure wheelchair brakes are locked when wheelchair not in use.An interview on 03/19/2026 at 4:55 PM with LPN MDS Director stated MDS team does update care plans and add interventions based on information reported in the morning meetings. All changes are then conveyed to the team by the unit managers as MDS has no responsibility to ensure interventions are implemented.Observation on 03/19/2026 beginning at 11:31 AM, of staff that assisted R125 to the nurse's station area and locked his wheelchair. 11:44 AM revealed R125 trying to move his wheelchair in order to ambulate and he is unable to move the wheelchair with his feet. He is observed shuffling the locked wheelchair to the left. He stopped then looked down to see if he could unlock it and was not able as evidenced by him holding his hand out in confusion. At that point he stopped trying to move the wheelchair.Interview on 03/19/2026 at 12:52 PM with LPN GG revealed she does not lock resident's (R125) wheelchair because he should have free will. LPN GG stated she has seen him scoot in his wheelchair when the wheel is locked. She revealed if the resident/resident family asks for the wheelchair to be locked, they will lock it, if it is care planned, they will lock it.Interview on 03/19/2026 at 12:47 PM with CNA QQ revealed they constantly must check in on R125 because he is fast, very fast. She stated we unlock his wheelchair and try to leave it unlocked because he will attempt to ambulate in it with it locked. He will scoot, side by side in his wheelchair. Interview on 03/19/2026 at 1:06 PM with the Administrator revealed R125 knows how to unlock it [wheelchair] and other days he does not. She further revealed we do the best we can to manage his care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Spalding Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Airport Road Griffin, GA 30224	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and review of the facility's policies titled Minimum Data Set (MDS)/ Care Plans and Advance Directives, the facility failed to update the care plan for Advance Directives of Do Not Resuscitate (DNR) for one resident (R) (R94) of 54 residents reviewed for advance directives. This deficient practice had the potential to cause staff to initiate cardiopulmonary resuscitation (CPR) and all other necessary, life-sustaining treatments for cardiac and/or respiratory arrestFindings include:Review of the facility's policy titled Minimum Data Set (MDS)/ Care Plans reviewed [DATE] documented Policy Statement: Each resident will have an individualized interdisciplinary plan of care in place. The Comprehensive Care Plan will be reviewed and revised on a quarterly basis. Procedure: 2. This comprehensive care plan will address resident goals, actual and potential problems, needs, strengths and individual preferences of the resident. 3. Each discipline will be responsible for the initiation and ongoing follow up for care plans as related to their area of expertise.Review of the facility's policy titled Advance Directives undated, documented Policy Statement: .Advance directives are honored in accordance with state law and facility policy. Policy Interpretation and Implementation: Definitions: Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. Page 9. If the Resident has an Advanced Directive: 4. The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive. Facility staff are not required to provide care that conflicts with an advance directive.Review of the facility's electronic medical records (EMR) revealed that R94 was admitted to the facility on [DATE] with diagnosis included but not limited to malignant neoplasm of the tongue.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented Section C (Cognition) Brief Interview for Mental Status (BIMS) score of 15 which indicated R94 had little to no cognitive impairment,Review of the care plan for R94, which was reviewed [DATE] documented included but not limited to Advance Directives, the resident signed a POLST upon admission into the facility and has selected to be a Do not resuscitate (DNR). The facility will honor the resident's wishes and perform CPR in the event of a medical emergency.Review of the Physician's orders dated [DATE] documented included but not limited to DNR.Interview on [DATE] at 11:38 AM with the MDS Director, stated that the MDS updated care plans and at times the nurses also updated the care plans. The MDS Director stated that the Social Services Director (SSD) was responsible for updating her sections of the care plan which included the Advance Directives. The MDS Director further stated the staff could administer CPR when they were not supposed to administer CPR to R94 and the staff would be going against R94's wishes since his Advance Directives stated that he was DNR.Interview on [DATE] at 11:52 AM with the SSD, confirmed and validated that the care plan goal for R94's Advance Directives stated, The facility will honor the residents wishes and perform CPR in the event of a medical emergency. She stated she was responsible for updating the Advance Directives care plan. The SSD stated that the care plan was to honor the resident's wishes and it was a personalized care plan. She stated the staff should look at the focus, but the goal and the interventions were the supporting details of the focus. The SSD further stated that it was human error and it was an oversight. She stated that when the care plan goal was to perform CPR and R94's Advance Directive was DNR there would be a conflict in care.Interview on [DATE] at 9:33 AM with Nurse Manager (NM) CC, stated the Advance Directives care plan was updated by the SSD. She stated care plans were individualized, and nurses followed the care plan for providing care.Interview on [DATE] at 2:50 PM with the Director of Nursing (DON), stated the Interdisciplinary Team (IDT) updated the care plan and each section was updated by the specific team member. She stated the SSD was responsible for (continued on next page)

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	115537	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spalding Post Acute LLC	415 Airport Road Griffin, GA 30224

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updating the Advance Directives. The DON further stated that when the care plan goal stated to perform CPR and the focus stated DNR the nursing staff would try to find out if CPR was to be done for R94 or not and this could delay care.

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NAME OF PROVIDER OR SUPPLIER Spalding Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 415 Airport Road Griffin, GA 30224	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, staff interviews, and review of the facility policy titled Accidents/Incidents, and Falls Management, the facility failed to provide supervision for the prevention of falls for one resident (R) (R125) from a sample of five residents reviewed for falls and accidents. The deficient practice increased the risk of avoidable falls and injury.Findings include:A review of the facility policy undated and titled Accidents/Incidents, documented An accident is defined as any unexpected or unintentional incident which may result in injury or illness to a resident/patient. This does not include adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current standards of practice (e.g., drug side effects or reaction). An incident is defined as any occurrence not consistent with the routine operation of the Center or normal care of the patient. An incident can involve a visitor or staff member, malfunctioning equipment, or observation of a situation that poses a threat to safety or security.A review of the facility policy undated and titled Falls Management, documented Policy: Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce the risk and minimize injury.Review of the electronic medical record (EMR) revealed resident R125 was admitted to the facility on [DATE], with pertinent diagnoses including but was not limited to Medically Complex Conditions, Non-Alzheimer's Dementia, or Macular DegenerationReview of R125 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 00, which indicated severe cognitive impairment. Section GG, functional status, revealed R125 required extensive assistance for activities of daily living (ADLs) with one/two or more-person assistance. R125 does benefit from the use of a wheelchair. Self-care: Partial/moderate assistance (eating, upper body dressing), Supervision or touching assistance (oral hygiene and personal hygiene), Substantial/maximal assistance (toileting, shower/bathe self, lower body dressing and putting on/taking off footwear). Mobility: Substantial/maximal assistance in most areas with the exception of Partial/moderate assistance sit to stand.Review of R125 care plan dated 01/01/2026 documented a problem area at risk for a fall related to impaired mobility, impaired cognitive functions and use of psychotropic medications. 03/10/2026 Fall no injury, 03/11/2026 Fall no injury, 03/16/2026 Fall no injury. Goals included but not limited to that R125 will not have falls with significant injury through review date. Interventions included but not limited to staff to assist the resident to and from the dining room and ensure wheelchair brakes are locked when the wheelchair not in use.Review of R125 care plan dated 01/01/2026 and revised 03/16/2026 indicated a problem of R125 is an elopement risk/wanderer related to demented and wanders aimlessly. Goals included but not limited to R125 will not leave facility unattended through the review date. Interventions included but not limited to Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes, Wander alert bracelet on right wrist.Observation on 03/19/2026 beginning at 11:31 AM, of staff that assisted R125 to the nurse's station area and locked his wheelchair. 11:44 AM revealed R125 trying to move his wheelchair in order to ambulate and he is unable to move the wheelchair with his feet. He is observed shuffling the locked wheelchair to the left. He stopped then looked down to see if he could unlock it and was not able as evidenced by him holding his hand out in confusion. At that point he stopped trying to move the wheelchair.Interview on 03/19/2026 at 12:52 PM with LPN GG revealed she does not lock resident's (R125) wheelchair because he should have free will. LPN GG stated she has seen him scoot in his wheelchair when the wheel is locked. She revealed if the resident/resident family asks for the wheelchair to be locked, they will lock it, if it is care planned, they will lock it.Interview on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/19/2026 at 12:47 PM with CNA QQ revealed they constantly must check in on R125 because he is fast, very fast. She stated we unlock his wheelchair and try to leave it unlocked because he will attempt to ambulate in it with it locked. He will scoot, side by side in his wheelchair. Interview on 03/19/2026 at 1:06 PM with the Administrator revealed R125 knows how to unlock it [wheelchair] and other days he does not. She further revealed we do the best we can to manage his care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and review of the facility's policies titled Storage of Medications, and Medication Administration, the facility failed to record an open date on one bottle of blood sugar strips in one medication cart and failed to lock one medication cart from the six medication carts reviewed for medication storage. This deficient practice had the potential to cause inaccurate blood sugar readings for the residents and unauthorized access of the medication cart with increased risk of diversion. Findings include:Review of the facility's policy titled Storage of Medications, revised [DATE] documented Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.Review of the facility's policy titled Medication Administration undated, documented PURPOSE: To provide a safe, effective medication administration process. PRACTICE STANDARDS: 1. Maintain security of cart and keys at all times.Observation on [DATE] at 10:18 AM revealed one medication cart outside of room [ROOM NUMBER] was unlocked and unattended. Observation further revealed no nurse was visible anywhere along the hall at that time.Observation on [DATE] at 5:40 PM during review of the Cedar cart medication cart revealed one bottle of glucometer strips was in the top drawer of the cart with no open date.Interview on [DATE] at 5:42 PM with Unit Manager (UM) CC, who was present during the review confirmed there was one bottle of blood sugar strips in the top drawer of the cart with no open date. She stated there should be an open date on the bottle because the strips lose their effectiveness after a certain time and no one would know when to discard the strips which if used might result in inaccurate blood sugar readings.Interview on [DATE] at 11:46 AM with Licensed Practical Nurse (LPN) EE, stated blood sugar strips should have open dates because there is a certain time frame they are good for use. She stated that if there was no open date no one would know when to throw out the strips and if used the strips might result incorrect blood sugar readings.Interview on [DATE] at 12:09 PM with the Director of Nursing (DON), stated it is her expectation for the medication carts to be locked when not in use. She stated medication carts must never be left open and unattended in the hallways of the facility. The DON stated blood sugar strips bottles must have open dates. She stated if the bottles do not have open dates, no one would know when the strips expired and may result in inaccurate blood sugar readings.