STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Powder Springs Center for Nursing & Healing	3460 Powder Springs Road Powder Springs, GA 30127

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 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. Based on observations, staff interviews, and review of the facility policy titled, Smoking Debris Protocol/Procedures, the facility failed to dispose of cigarette butts in the appropriate receptacle in the outdoor designated smoking area. This deficiency had the potential to cause a fire. The sample size was five residents reviewed for smoking.Findings include:Review of the undated facility policy titled, Smoking Debris Protocol/Procedures, revealed the following: Activities' staff is responsible for the general clean up and cleanliness of the assigned smoking areaActivities' staff to empty the individual smoking ash containers when smoking the session is overAsh containers are emptied into the step on red containerShould the red container be found full, activities is to contact maintenance immediately.After the last smoking session of the day, the maintenance department executes the following protocols:Maintenance will remove the red container from the smoking areaMaintenance floods the container with water or sand to ensure there are no red or smoking embers.Maintenance will then empty the container into a trash bag. Maintenance will then place the trash bag into the applicable refuse container.Observation of the smoking session on 1/7/26 at 11:03 AM revealed a red step-on container which was empty, but a trash receptacle which contained trash and more than 50 cigarette butts. In an observation and interview with Activities Assistant (AA) HH on 1/7/2026 at 11:10 am, she confirmed the presence of cigarette butts in the trash only receptacle. She stated she was a recent hire to the Activities Department and received instruction on the smoking supervision task during orientation where she was instructed to empty ash containers (trays) into the red step-on container and to call the Maintenance Department when it was full. She also stated this current smoking session was the first one she monitored today and she did not know who discarded cigarette butts into the trash receptacle. In a joint observation and interview with the Administrator and the Assistant Administrator on 1/7/26 at 11:15 am, they each confirmed the presence of cigarette butts in the trash only receptacle and acknowledged they should not be emptied into the trash only receptacle. The Administrator stated the Maintenance Director was responsible for disposal of cigarette butts from the red step-on container after the last smoking break of the day. In an observation and interview with the Activities Director on 1/7/2026 at 11:20 am, she stated she trained her staff to empty cigarette butts into the red step-on container and to only place trash in the trash only receptacle. She confirmed that AA GG did not supervise the previous smoking break. In an observation and interview with the Maintenance Director (MD) on 1/7/2026 at 11:25 am, he stated at the end of his day he took the red step-on container away from the smoking area, flooded it with water, then dumped the cigarette butts into a trash bag for disposal. In an interview with the Administrator on 1/7/2026 at 4:15 pm, he stated he removed the trash only receptacle from the smoking area and will only leave the smoking ash container and the red step-on container. He stated he re-educated the activities and maintenance staff regarding the proper disposal of cigarette butts.

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
	115538	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Powder Springs Center for Nursing & Healing	3460 Powder Springs Road Powder Springs, GA 30127

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, record review, and review of the facility's policies titled, Food Receiving and Storage and Appendix 14: Emergency Water Supply, the facility failed to ensure emergency drinking water was stored in safe and sanitary manner for residents in the facility. This deficient practice had the potential to cause contamination and compromise all facility resident's safety. The facility census was 195 residents. Findings include:Review of the facility's policy titled Food Receiving and Storage revised 4/1/2024 section; 1.150 revealed foods shall be received and stored in manner that complies with safe food handling practices.Review of the facility's policy titled Appendix 14: Emergency Water Supply dated/ revised 8/17/2022, further review of Emergency Preparedness Binder page 117 number 4 revealed, Primary water storage emergency water is stored away from kitchen in alternative location in AU (Alzheimer's unit) unit.Observation and Interview on 1/7/2026 at 10:09 am revealed multiple brown boxes stacked on top of each other up against the building outside behind the kitchen where the dumpster and grease trap were located. There was a broom on top of the boxes. Some were moistened and others were opened where gallons were missing and debris such as sticks and dirt was present. The boxes were next to a non-operating freezer. The Dietary Supervisor (DS) revealed that it was their emergency water. She stated they did not have room to fit all in the closet on the AU, so it was put outside. Observation with the Dietary Supervisor and the Registered Dietitian (RD) for the facility of the AU revealed the remaining emergency water and the closet where emergency water was stored was cluttered with boxes in the closet with no order. They counted 66 boxes of emergency water on hand which they stated was enough for each resident for three days.Observation on 1/7/2026 at 11:32 am revealed a portion of emergency water remained outside. The Administrator, the Dietary Supervisor, and the Regional Registered Dietitian went outside where the emergency water was located, and all confirmed that this was some of their emergency water. The Administrator stated that the water was placed outside because of renovations and they were moving from one area to AU and just did not have room for it. The Regional Registered Dietitian stated that they would not use the emergency water outside and that it would be poured out and more would be purchased.

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F 0848 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on staff interviews, record review and review of the facility's policy titled, Binding Arbitration Agreements, the facility failed to ensure the arbitration agreement specifically provided for the selection of a convenient venue: a location in which to carry out arbitration proceedings which should be agreed upon and was convenient and suitable to both parties for three of three residents (R) R246, R140 and R251 reviewed for arbitration.Findings include: Review of the facility's policy titled Binding Arbitration Agreements reviewed 9/12/2025 documented under Policy Explanation and Compliance Guidelines: . 2. The agreement must: . b. Provide for selection of a venue that is convenient for both parties.Review of the facility's arbitration agreement document revealed there was no mention of a venue nor specifically provided for the selection of a venue should be agreed upon and suitable to both parties.Interview on 1/8/2026 at 4:46 pm with the facility's Concierge II revealed she confirmed the venue was not documented on the arbitration agreement. She further stated that she was responsible for informing residents and their family of arbitration, and she did not inform any residents or family members including R246, R140 and R251 of a venue. She stated she did not know the information of where the arbitration venue would be, and there was nothing in the arbitration agreement that stated there should be a mutual venue.Interview on 1/8/2026 at 5:35 pm with the Administrator revealed he confirmed the facility's arbitration agreement did not specifically state a venue for the arbitration. He stated he could not say for sure that the agreement was required to state the venue.Interview on 1/9/2026 at 1:30 pm with the Assistant Administrator revealed she confirmed there was no mention of a mutual venue in the facility's arbitration agreement.