STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115540	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin City Trails of Journey LLC	211 Mathis Avenue Twin City, GA 30471

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 staff and resident interviews, record review, and review of the facility policy titled ABUSE, NEGELECT, [sic] AND EXPLOITATION, the facility failed to protect the resident's right to be free from physical abuse for one of 16 sampled residents (R) (R3). Specifically, R13 pushed R3, causing a fall. This deficient practice had the potential to place R3 at increased risk of injury related to being pushed. Findings include:Review of the facility's policy titled ABUSE, NEGELCT, [sic] AND EXPLOITATION, reviewed 03/05/2024, documented Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident.that prohibit and prevent abuse. In addition, documented Definitions: ?Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. and .'Physical Abuse' includes, but is not limited to hitting, slapping, punching, biting, and kicking.1. Review of the admission Record for R3 documented diagnoses including, but not limited to, schizoaffective disorder bipolar type, mixed obsessional thoughts and acts, other somatoform disorders, dementia unspecified, unspecified psychosis, and major depression.Review of the Minimum Data Set (MDS) assessment for R3, dated 03/25/2026, revealed that section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated little to no cognitive impairment. Section GG (Functional Abilities and Goals) documented that R3 was independent in activities of daily living, except for setup assistance with meals.Review of the care plan for R3, revised 04/07/2026, revealed a Focus that R3 had a behavior problem of attempting to restrict other residents from using the shared restroom.Review of the Progress Notes for R3 revealed an entry dated 06/02/2026 at 5:28 PM of, Writer was in room [ROOM NUMBER] assisting another resident. This resident (referring to R3) was in the bathroom when resident 10-3 (referring to R13) came in the bathroom. This resident told her she was washing her hands, but other resident refused to leave so this resident came out. A few minutes later this resident noticed the bathroom light was off so she opened the door to go in. Writer heard this resident holler out and looked to see this resident falling backwards to the floor. Writer went immediately to the bathroom and observed resident 10-3 standing in the other door way watching this resident. I asked resident what happened and she stated that resident 10-3 pushed her.2. Review of the admission Record for R13 revealed diagnoses including, but not limited to, paranoid schizophrenia and Alzheimer's disease.Review of the MDS assessment for R13, dated 03/25/2026, revealed that section C (Cognitive Patterns) documented a BIMS score of 13, indicating little to no cognitive impairment. Section E (Behaviors) documented no indicators of psychosis. Section GG (Functional Abilities and Goals) documented that R13 was independent with transfers and walking but needed setup or clean-up assistance with toileting. Review of the care plan for R13, revised 05/09/2026, revealed Focus areas for R13, including, but not limited to: R13 is alert. She verbalizes wants and needs. Ambulates to and from areas. Very poor decision-making skills. Loud and disruptive. Uncooperative. Takes belongings from others, rummaging through others' belongings. Easily agitated when things don't go her way. Does not respond to redirection most of the time. Very (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	difficult to redirect.Review of the active Physician's Orders dated 06/10/2026, for R13 documented orders that included, but were not limited to:05/25/2026: Notify mental health provider that patients continue to refuse Haldol injection.05/04/2026: Refer to mental health provider for follow-up; recently released from behavioral unit.05/04/2026: Refer to mental health provider, patient appears t [sic] be non-compliant with medication regimen.Review of the Progress Notes for R13 revealed an entry dated 06/02/2026 of Writer was assisting resident 8-2 when resident 8-1 (R3) went to the bathroom to wash her hands. Resident 10-3 (R13) then went in the bathroom and resident 8-3 came out. After a few minutes, resident 8-1 opened the bathroom door. This resident (referring to R13) became aggressive and pushed her (referring to R3) out causing her to fall backwards to the floor. Resident {R13} using verbally abusive and aggressive language towards writer and resident {R3}. Other staff arrived and assisted with situation. Admin (Administrator), DON (Director of Nursing), MD (Medical Director), and police notified. 1013 Order (a legal document used to allow a licensed doctor, psychologist, or police officer to involuntarily hold someone for a mental health evaluation) received to send resident to ER (emergency room).Review of a facility-provided document title, FORM 1013-CERTIFICATE AUTHORIZING TRANSPORT TO EMERGENCY RECEIVING FACILITY & REPORT of TRANSPORTATION (Mental Health), and documented on the form, but not limited to, .This is to certify that I have personally examined (R13 name) on June 2, 2026 at 600pm, which was within the preceding 48 hours of the signing of this certificate. In my opinion this individual appears to be a mentally ill person requiring involuntary treatment in that he/she appears to be mentally ill AND: .presents a substantial risk of imminent harm to self or others as manifested by recent overt acts or recent expressed threats of violence which present a probability of physical injury to self or to other persons; . This individual: Has committed/expressed recent overt acts/threats towards others. In addition, a handwritten note was entered on the line that read For example: Assaulted Peer. The document was dated and signed by the Medical Director (MD) on June 2, 2026, at 6:00 PM. Further review of this document revealed that the DON completed the form and signed on June 2, 2026, at 6:00 PM by filling in the blanks, including R13's name. Review of the facility-provided document titled #3706 Resident to Resident Altercation-Recipient dated 06/02/2026 at 5:15 PM revealed the Incident Description section included Nursing Description: Resident entered bathroom and was pushed down by resident room [ROOM NUMBER]-3. Resident Description: I entered the bathroom to wash my hands. The light was off, and she pushed me. Documented under Immediate Action Taken and Description: Staff intervened, and this resident was assessed for injury. Resident lying on her back on the floor in doorway of the bathroom. Resident alert and responsive, asking staff to help her up.Review of the facility-provided document titled #3707 Resident to Resident Altercation-Aggressor dated 06/02/2026 at 5:15 PM revealed the Incident Description section included, Nursing Description: (R13) was attempting to get into the shared bathroom, at this time another resident who shares the bathroom was attempting to get into the bathroom and was told to wait, which she did. When R13 went back into the bathroom, R3 was seen falling through the doorway to the floor. Resident Description: Resident unable to give description.In an interview on 06/09/2026 at 11:16 AM, R3 stated that at the time of the incident, she was in the bathroom washing off. R13 kept coming in, and I told her I was there. The fourth time she came in, I came out and let her in the bathroom. As soon as she went out and turned off the light, I went in there, and she came in and pushed me down. She stated she feels a lot safer at night since the woman in the other room is gone.In an interview on 06/11/2026 at 2:17 PM, Licensed Practical Nurse (LPN) EE stated at the time of the incident, she was assisting the lady in the middle bed of room [ROOM NUMBER], and R3 was in the bathroom. She heard R3 say I'm in here. R3 came out of the bathroom and waited a few minutes. LPN EE stated the light was off, so R3 went back to the bathroom, opened the door, and then she saw R3 fall backward. LPN EE stated she went to look and saw R13 in the other doorway, hollering something. She told R13 she needed to check R3, as she noticed a skin tear, and then the other staff came. LPN EE stated the light was off, so that is why R3 went back into the bathroom.In an interview on 06/11/2026 at 3:07 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, Registered Nurse (RN) FF stated that at the time of the incident, she was in her office and heard screaming. She stated that when she entered R3's room, staff were assisting R3 to stand up and attempted to redirect R13 to her room, and R13 refused. RN FF stated that 911 and the police were called, as R13 refused to do anything. She stated that R13 was transported to the ER by Emergency Management Services (EMS).In a concurrent interview on 06/12/2026 at 12:07 PM, the Administrator and Director of Nursing (DON), the Administrator stated R13 had a diagnosis of schizophrenia, refused medications and care, and was not easily redirected. The DON stated that R13 had exhibited verbal aggression prior to the incident involving R3.

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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 policy titled ABUSE, NEGELECT, [sic] AND EXPLOITATION, the facility failed to report a resident-to-resident physical altercation to the State Survey Agency (SSA) within the required timeframe for two of 16 sampled residents (R) (R3 and R13). Specifically, R3 fell as a result of being pushed by R13. This deficient practice had the potential to increase the risk of other potential abuse not being reported. Findings include:Review of the facility's policy titled ABUSE, NEGELCT, [sic] AND EXPLOITATION, reviewed 03/05/2024, documented Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident.that prohibit and prevent abuse. In addition, documented Definitions: ?Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. and .'Physical Abuse' includes, but is not limited to hitting, slapping, punching, biting, and kicking. In addition, documented in section VII. Reporting/Response, .A.1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes.B. The Administrator will follow up with government agencies.and to report the results of the investigation when final within 5 workings days of the incident, as required by state agencies.1. Review of the admission Record for R3 documented diagnoses including, but not limited to, schizoaffective disorder bipolar type, mixed obsessional thoughts and acts, other somatoform disorders, dementia unspecified, unspecified psychosis, and major depression.Review of the Minimum Data Set (MDS) assessment for R3, dated 03/25/2026, revealed that section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated little to no cognitive impairment. Section GG (Functional Abilities and Goals) documented that R3 was independent in activities of daily living, except for setup assistance with meals.Review of the Progress Notes for R3 revealed an entry dated 06/02/2026 at 5:28 PM of, Writer was in room [ROOM NUMBER] assisting another resident. This resident (referring to R3) was in the bathroom when resident 10-3 (referring to R13) came in the bathroom. This resident told her she was washing her hands, but other resident refused to leave so this resident came out. A few minutes later this resident noticed the bathroom light was off so she opened the door to go in. Writer heard this resident holler out and looked to see this resident falling backwards to the floor. Writer went immediately to the bathroom and observed resident 10-3 standing in the other door way watching this resident. I asked resident what happened and she stated that resident 10-3 pushed her.2. Review of the admission Record for R13 revealed diagnoses including, but not limited to, paranoid schizophrenia and Alzheimer's disease.Review of the MDS assessment for R13, dated 03/25/2026, revealed that section C (Cognitive Patterns) documented a BIMS score of 13, indicating little to no cognitive impairment. Section E (Behaviors) documented no indicators of psychosis. Section GG (Functional Abilities and Goals) documented that R13 was independent with transfers and walking but needed setup or clean-up assistance with toileting. Review of the Progress Notes for R13 revealed an entry dated 06/02/2026 of Writer was assisting resident 8-2 when resident 8-1 (R3) went to the bathroom to wash her hands. Resident 10-3 (R13) then went in the bathroom and resident 8-3 came out. After a few minutes, resident 8-1 opened the bathroom door. This resident (referring to R13) became aggressive and pushed her (referring to R3) out causing her to fall backwards to the floor. Resident {R13} using verbally abusive and aggressive language towards writer and resident (R3). Other staff arrived and assisted with situation. Admin (Administrator), DON (Director of Nursing), MD (Medical Director), and police notified. 1013 Order (a legal document used to allow a licensed doctor, psychologist, or police officer to involuntarily hold someone for a mental health evaluation) received to send resident to ER (emergency room).Review of the facility-provided (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document titled #3706 Resident to Resident Altercation-Recipient dated 06/02/2026 at 5:15 PM revealed the Incident Description section included Nursing Description: Resident entered bathroom and was pushed down by resident room [ROOM NUMBER]-3. Resident Description: I entered the bathroom to wash my hands. The light was off, and she pushed me. Documented under Immediate Action Taken and Description: Staff intervened, and this resident was assessed for injury. Resident lying on her back on the floor in doorway of the bathroom. Resident alert and responsive, asking staff to help her up.Review of the facility-provided document titled #3707 Resident to Resident Altercation-Aggressor dated 06/02/2026 at 5:15 PM revealed the Incident Description section included, Nursing Description: (R13) was attempting to get into the shared bathroom, at this time another resident who shares the bathroom was attempting to get into the bathroom and was told to wait, which she did. When R13 went back into the bathroom, R3 was seen falling through the doorway to the floor. Resident Description: Resident unable to give description.In an interview on 06/11/2026 at 9:49 AM, the Administrator stated that no incidents had been reported to the SSA since April 2026.In a concurrent interview with the Administrator and Director of Nursing (DON) on 06/12/2026 at 12:07 PM, the Administrator stated the incident was not reported to the SSA because he understood that it was witnessed that R13 was behaving erratically, and he was under the impression there was no assault. He further stated that staff asked if R13 could be transferred to the ER with a 10-13 status, and he felt that R13 should have been moved for the safety of the other residents. He further stated at the time that he did not see the incident as intentional, and it was unwitnessed, so it was not reported. The DON stated she was unable to determine if R13 intended to hurt R3. The DON stated she notified the Regional Nurse, and the Administrator stated he notified the Corporate [NAME] President. Cross-Reference F600

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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 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 interviews, record review, and review of the facility policy titled ABUSE, NEGELECT, [sic] AND EXPLOITATION, the facility failed to thoroughly investigate a physical altercation between two of 16 sampled residents (R) (R3 and R13). Specifically, R13 pushed R3, causing a fall. This deficient practice had the potential to increase the risk for abuse to continue. Findings include:Review of the facility's policy titled ABUSE, NEGELCT, [sic] AND EXPLOITATION, reviewed 03/05/2024, documented Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident.that prohibit and prevent abuse. In addition, documented Definitions: ?Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. and .'Physical Abuse' includes, but is not limited to hitting, slapping, punching, biting, and kicking. In addition, documented in section V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B.4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.1. Review of the admission Record for R3 documented diagnoses including, but not limited to, schizoaffective disorder bipolar type, mixed obsessional thoughts and acts, other somatoform disorders, dementia unspecified, unspecified psychosis, and major depression.Review of the Minimum Data Set (MDS) assessment for R3, dated 03/25/2026, revealed that section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated little to no cognitive impairment. Section GG (Functional Abilities and Goals) documented that R3 was independent in activities of daily living, except for setup assistance with meals.Review of the Progress Notes for R3 revealed an entry dated 06/02/2026 at 5:28 PM of, Writer was in room [ROOM NUMBER] assisting another resident. This resident (referring to R3) was in the bathroom when resident 10-3 (referring to R13) came in the bathroom. This resident told her she was washing her hands, but other resident refused to leave so this resident came out. A few minutes later this resident noticed the bathroom light was off so she opened the door to go in. Writer heard this resident holler out and looked to see this resident falling backwards to the floor. Writer went immediately to the bathroom and observed resident 10-3 standing in the other door way watching this resident. I asked resident what happened and she stated that resident 10-3 pushed her.2. Review of the admission Record for R13 revealed diagnoses including, but not limited to, paranoid schizophrenia and Alzheimer's disease.Review of the MDS assessment for R13, dated 03/25/2026, revealed that section C (Cognitive Patterns) documented a BIMS score of 13, indicating little to no cognitive impairment. Section E (Behaviors) documented no indicators of psychosis. Section GG (Functional Abilities and Goals) documented that R13 was independent with transfers and walking but needed setup or clean-up assistance with toileting. Review of the Progress Notes for R13 revealed an entry dated 06/02/2026 of Writer was assisting resident 8-2 when resident 8-1 (R3) went to the bathroom to wash her hands. Resident 10-3 (R13) then went in the bathroom and resident 8-3 came out. After a few minutes, resident 8-1 opened the bathroom door. This resident (referring to R13) became aggressive and pushed her (referring to R3) out causing her to fall backwards to the floor. Resident {R13} using verbally abusive and aggressive language towards writer and resident (R3). Other staff arrived and assisted with situation. Admin (Administrator), DON (Director of Nursing), MD (Medical Director), and police notified. 1013 Order (a legal document used to allow a licensed doctor, psychologist, or police officer to involuntarily hold someone for a mental health evaluation) received to send resident to ER (emergency room).Review of the facility-provided document titled #3706 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident to Resident Altercation-Recipient dated 06/02/2026 at 5:15 PM revealed the Incident Description section included Nursing Description: Resident entered bathroom and was pushed down by resident room [ROOM NUMBER]-3. Resident Description: I entered the bathroom to wash my hands. The light was off, and she pushed me. Documented under Immediate Action Taken and Description: Staff intervened, and this resident was assessed for injury. Resident lying on her back on the floor in doorway of the bathroom. Resident alert and responsive, asking staff to help her up.Review of the facility-provided document titled #3707 Resident to Resident Altercation-Aggressor dated 06/02/2026 at 5:15 PM revealed the Incident Description section included, Nursing Description: (R13) was attempting to get into the shared bathroom, at this time another resident who shares the bathroom was attempting to get into the bathroom and was told to wait, which she did. When R13 went back into the bathroom, R3 was seen falling through the doorway to the floor. Resident Description: Resident unable to give description.In a concurrent interview with the Administrator and Director of Nursing (DON) on 06/12/2026 at 12:07 PM, the DON stated she interviewed R3 after the incident, and the resident stated she was not hurt. She stated she asked for psychological services to touch base with R3. The DON further stated she interviewed Licensed Practical Nurse (LPN) EE, who was in the room at the time of R3's fall. The DON confirmed that no other interviews were conducted with staff or other residents. The Administrator stated that he did not interview anyone regarding R3's fall or its circumstances. Cross-Reference F600