STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115542	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sadie G. Mays Health & Rehabilitation Center	1821 Anderson Avenue NW Atlanta, GA 30314

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 - 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 observation, interview, record review, and a review of the policy titled Food Preparation Guidelines, the facility failed to prevent avoidable accidents for two of three sampled residents (R) (R41 and R56) related to (1) hot chocolate burn and (2) fall risk. Harm was identified to have occurred on 3/18/2025 when R41 spilled hot chocolate on her left arm, causing a burn, blisters, and requiring transport to an acute care setting and wound treatment. Findings included:1. A review of a facility policy titled Food Preparation Guidelines dated 11/11/2025 indicated that proper (safe and appetizing) temperature means both appetizing to the resident and minimizing the risk for scalding and burns.A review of R41's electronic medical record (EMR) titled admission Record indicated the facility admitted the resident on 4/18/2025.A review of R41's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 1/2/2025 indicated the staff could not determine a Brief Interview for Mental Status (BIMS) score. The assessment indicated the resident had an impairment on one side of her upper extremity. A review of R41's Progress Notes dated 3/18/2025 indicated the resident sustained a burn when an Activity Assistant (AA)1, a former staff member, gave the resident a cup of hot chocolate. R41 had a private sitter next to her during this incident. Licensed Practical Nurse (LPN) 2 applied a cool cloth to the resident's left arm and contacted the physician, who ordered the resident to be sent to the emergency room for evaluation and treatment. The resident returned to the facility on the same day with an ace bandage wrapped around her arm.A review of R41's hospital records provided by the facility titled After Visit Summary, dated 3/18/2025, failed to identify the type of burn the resident sustained.A review of R41's Progress Notes dated 3/20/2025 indicated the resident was evaluated by the wound team, and the burn had some drainage. A review of R41's Weekly-Wound Observation Tool dated 3/20/2025 revealed the resident sustained a burn on her left arm. The assessment indicated the resident had a small amount of serous fluid, and the wound measured nine centimeters (cm) by 20 cm by 0.1 cm. A review of R41's Orders dated 3/21/2025 indicated the physician ordered Silvadene External Cream 1 percent to be applied to the resident's left arm on Monday, Wednesday, and Friday. During an interview conducted on 12/18/2025 at 9:01 am, the Activities Director (AD) stated the facility provides an activity called Coffee Club and this activity was held Monday through Friday. The AD stated that coffee, hot chocolate, and cappuccino were served to the residents who attended this activity. The AD stated the kitchen staff brought coffee and hot water for the instant hot chocolate and cappuccino to the main dining room for this activity program. The AD stated she was not present when R41 spilled hot chocolate on her left arm. The AD stated she provided training to the activity staff on allowing the hot chocolate to cool off completely before serving it to R41. During an interview conducted on 12/18/2025 at 9:15 am, LPN 1, who was also the facility's wound nurse, stated R41 did have some weakness in her left hand. Also present during this interview was Restorative Aide (RA) 1, who confirmed R41 had weakness in her left hand and could not hold anything in that hand. RA1 confirmed that R41 wore a splint on her left hand. During an observation on 12/18/25 at 9:19 am, R41 was observed sleeping in her wheelchair and had a splint on her left hand.During an interview on 12/18/2025 at 9:30 am, [NAME] 1 stated that she typically (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
	115542	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sadie G. Mays Health & Rehabilitation Center	1821 Anderson Avenue NW Atlanta, GA 30314

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 - Actual harm Residents Affected - Few	would take the temperature of the coffee and hot water served to the residents during activities. During this interview, a dual coffee maker was observed in the kitchen. Bunn was the title of the coffee maker. Both coffee pots sat on dual burners. [NAME] 1 verified that when the coffee was brewed, and the hot water ran through the coffee maker, the temperature reached 200 degrees Fahrenheit (F). The digital temperature could be observed on the outside of the coffee maker. Cook1 poured coffee from the coffee maker into a large plastic pitcher. Cook1 took the temperature from the freshly poured coffee, and the temperature read 176.80 degrees F. Cook1 then took the pitcher of coffee and poured it into the coffee urn. The lid remained off. The coffee urn was on top of a three-shelf wheeled cart, and steam was observed coming from the coffee urn. At 9:42 am, [NAME] 1 brought a coffee urn for the hot water. [NAME] 1 turned on the coffee maker to create hot water. Cook1 took the temperature from the freshly poured hot water, and the temperature read 176.8 degrees F. [NAME] 1 poured the hot water into a second coffee urn. At 9:50 am, [NAME] 1 left the kitchen with hot coffee and hot water and walked to the main dining room. The activity staff were preparing the Coffee Club activity. The cook stated that hot coffee and water should have a temperature of 165 degrees F. At 10:04 am, [NAME] 1 poured out three separate cups of hot liquid, which included coffee, hot chocolate, and hot water. [NAME] 1 took the temperature of the hot chocolate, and it was 148.8 degrees F. [NAME] 1 took the temperature of the hot water, and it was 155 degrees F. [NAME] 1 took the temperature of the coffee, and it was 155.6. All three cups of hot liquid sat until the Activities Assistant (AA) 2 began to serve the residents at 10:15 am, hot coffee and hot chocolate. [NAME] 1 then took the temperature of the hot chocolate, and it was 133.4 degrees F; the hot water was 133.20 degrees F; and the hot coffee was 133.7 degrees F. During an interview on 12/18/2025 at 10:32 am, the Director of Nursing (DON) stated she was unsure whether there were hot liquid assessments for residents. During an interview on 12/18/2025 at 11:38 am, the former private sitter (Sitter) for R41 stated she was present during the hot chocolate spill and confirmed that the resident could not open her entire left hand. The former Sitter stated she was with the resident when the resident was sent to the local emergency room. The former Sitter stated she observed the resident's left arm, and the resident sustained several blisters from the hot chocolate burn. A telephone call was placed on 12/18/2025 at 11:50 am to AA1, and no return call was received. During an interview on 12/18/2025 at 2:13 pm, the Maintenance Director stated he was unable to locate the coffee temperature logs for the month of March 2025. 2. A review of R56's Record of admission revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, peripheral vascular disease, and muscle weakness A review of R56's Care Plan Report dated 8/26/2024 revealed that R56 was at risk for falls due to limited mobility and was unaware of safety needs. An intervention was for R56 to have floor mats on both sides of the bed. An additional focus included that R56 had limited physical mobility due to Alzheimer's disease and weakness. A review of R56's annual MDS assessment, with an ARD of 10/13/2025, revealed a BIMS score of two out of 15, which indicated severe cognitive impairment. The MDS also indicated R56 was dependent on staff to complete toileting hygiene, bathing, dressing, personal hygiene, and transfers. A review of R56's Visual/Bedside Kardex Report revealed that staff were to ensure R56 had floor mats on both sides of the bed. During an observation on 12/16/2025 at 10:09 am, R56 had a fall mat on the floor on the right side of the bed. During an observation on 12/18/2025 at 11:13 am, R56 had one fall mat on the floor on the right side of the bed. During an interview on 12/18/2025 at 11:14 am with LPN 5, she confirmed there was only one mat on R56's floor. She added that there should be mats on both sides of the bed. During an interview on 12/19/2025 at 11:07 am, the DON stated that all interventions should be carried out. The mats are in place for safety. During an interview on 12/19/2025 at 12:37 pm, the Administrator stated that both mats should have been on the floor. If a staff member comes into the room and sees a mat leaning against the wall, the expectation is for them to determine whether it needs to be on the floor for the resident and if so, they need to place the mat or mats on the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115542	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sadie G. Mays Health & Rehabilitation Center	1821 Anderson Avenue NW Atlanta, GA 30314

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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and a review of the policy titled Management of Beneficiary Funds, the facility failed to ensure that the surety bond was sufficient to cover the resident trust fund deposits. This deficient practice had the potential to adversely affect 129 of 129 residents in the facility.Findings included:A review of the undated facility's policy titled Management of Beneficiary Funds describes the process of managing beneficiary funds, but does not address the Surety [NAME] review of the facility's Surety Bond Document dated 3/26/2025 through 5/26/2025, indicated the amount of the bond was $190,000.00.A review of six months of the facility's Bank Statements from May 2025 to November 2025 revealed that five out of six bank statements had daily balances that were greater than the surety bond: The May 2025 beginning balance was $224,998.91 and ending balance was $229,239.06 The July 2025 beginning balance $229,239.06 and the ending balance was $228,566.62 The August 2025 beginning balance was $228,566.62 and the ending balance was $233,366.33 The October 2025 beginning balance was $187,220.09 and the ending balance was $197,124.53 The November 2025 beginning balance was $197,124.53 and the ending balance was $199,028.62The total amount of the 123 Resident Accounts as of 12/19/2025 was $205,144.77.During an interview with the Business Office Manager on 12/19/2025 at 12:30 pm, she confirmed the amount shown on the Resident Trust Fund bank statements and acknowledged the balance amount listed on the Trust Account Reconciliation document.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115542	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sadie G. Mays Health & Rehabilitation Center	1821 Anderson Avenue NW Atlanta, GA 30314

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 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, and record review, the facility failed to have an adequate water management program for 129 of 129 residents in the facility. The facility's water management program was incomplete and was not consistent with current ASHRAE (American Society of Heating, Refrigerating, and Air-Conditioning Engineers) Guidelines, which specifically called for design and maintenance procedures for the potential exposure of Legionnaires' disease (a serious pneumonia infection) within a healthcare facility. Findings included:A review of the website for ASHRAE titled Successfully Managing the Risk of Legionellosis, dated 4/7/2021, indicated that Legionellae, the biological classification name for a [NAME] of bacteria, is the plural, referring to more than one Legionella bacterium. Legionellosis is any illness (disease) caused by exposure to Legionella. Legionnaires' disease (LD) and Pontiac fever (PF) are the two known types of legionellosis and are potentially fatal. These multisystem respiratory illnesses are accompanied by pneumonia. Symptoms include high fever, chills, muscle pain, headache, dry cough, diarrhea, vomiting, confusion, and delirium. Describe the building water systems using flow diagrams and a written description. Include details such as where the building connects to the (municipal) water supply, how water is distributed and used (processed), and where hot tubs, water heaters, cooling towers, etc., are located. A review was conducted of a facility document titled Water Management Program, dated 11/28/2025. The document failed to show a risk assessment and a diagram of the facility's water system or text that would describe the facility's water system, which would include areas indicated as high-risk areas in which water pathogens might develop.During an interview on 12/18/2025 at 10:32 am, the Maintenance Director stated that he only had blueprints of the building and no diagram of the facility's water system. A request was made to the Administrator for the total number of residents over the age of 65. No information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115542	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sadie G. Mays Health & Rehabilitation Center	1821 Anderson Avenue NW Atlanta, GA 30314

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled Call Lights: Accessibility and Timely Response, the facility failed to ensure the call button was accessible for one of 27 sampled residents (R) (R56). This failure had the potential to place R56 at risk for accidents, injuries, or unmet needs related to an inability to call for staff assistance.Findings included:A review of the policy titled Call Lights: Accessibility and Timely Response dated 12/2/2025 revealed, The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.A review of R56's Record of admission revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, peripheral vascular disease, and muscle weakness.A review of R56's Care Plan Report dated 8/26/2024 revealed that R56 was at risk for falls due to limited mobility and was unaware of safety needs. An additional focus included [R56] had limited physical mobility due to Alzheimer's disease and weakness. A review of R56's annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/13/2025, revealed a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated severe cognitive impairment. The MDS also indicated R56 was dependent on staff to complete toileting hygiene, bathing, dressing, personal hygiene, and transfers. During an observation on 12/16/2025 at 10:09 am, R56's call button was observed under the bed, out of reach of the resident. During an observation on 12/17/2025 at 1:06 pm, R56's call button was observed under the bed, out of reach of the resident. During an observation and interview on 12/17/2025 at 1:07 pm with Licensed Practical Nurse (LPN) 6, she confirmed R56's call button was not within reach; she added that it should be at all times. She confirmed that R56 uses her call button. During an interview on 12/18/2025 at 3:04 pm, Certified Nurse Aide (CNA) 1 confirmed that R56 used her call button, and it should always be within her reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115542	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sadie G. Mays Health & Rehabilitation Center	1821 Anderson Avenue NW Atlanta, GA 30314

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident family member and staff interviews, and a review of the policies titled Medication Administration and Notification of Changes, the facility failed to ensure the physician was notified of a change of condition for one of 27 residents (R) (R93) related to a refusal of bedtime medications for four days in a row. This failure had the potential to result in clinical complications and potentially hospitalization.Findings included:A review of the policy titled Medication Administration dated 11/11/2025 revealed, Report and document any adverse side effects or refusals. A review of the policy titled Notification of Changes dated 12/2/2025 revealed, The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 3. Significant change in the resident's physical, mental, or psychosocial condition, such as a deterioration in health, mental, or psychosocial status. This may include.b. Clinical complications.A review of R93's Record of admission revealed she was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, dementia, type two diabetes mellitus, chronic obstruct pulmonary disease (lung condition causing airflow blockage and breathing difficulties), chronic kidney disease, and encephalopathy. A review of R93's Care Plan Report dated 4/29/2025 revealed that R93 refused all medications and times and refused care. A care plan dated 4/29/2025 revealed R93 had the potential for behaviors related to a diagnosis of paranoid schizophrenia. An intervention for staff was to discuss with the physician and family regarding the ongoing need for use of the medication. A care plan dated 4/29/2025 revealed R93 had impaired cognitive function and decision-making due to dementia. An intervention is for staff to administer medication as ordered.A review of R93's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/14/2025, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated severe cognitive impairment. The MDS also indicated R93 rejected care one to three days in the seven-day look-back period.A review of R93's Order Summary Report revealed an order date 4/17/2025, for insulin glargine-yfgn subcutaneous solution pen injector, 100 units/ml (milliliter), inject 10 units at bedtime. A review of R93's Medication Administration Record dated 12/1/2025 to 12/31/2025 revealed R93 refused insulin glargine-yfgn during the 9:00 pm medication administration time on 12/3/2025, 12/6/2025, 12/7/2025, 12/8/2025, 12/9/2025, and 12/13/2025.A review of R93's Order Summary Report revealed an order dated 4/17/2025, for mirtazapine (antidepressant), 7.5 mg (milligrams), one tablet at bedtime. A review of R93's Order Summary Report revealed an order dated 4/17/2025, for Seroquel (antipsychotic), 100 mg, one tablet at bedtime. A review of R93's Order Summary Report revealed an order dated 4/17/2025, for simvastatin (helps lower bad cholesterol), 20 mg, one tablet at bedtime for cholesterol. A review of R93's Order Summary Report revealed an order dated 4/17/2025 for tamsulosin hcl (hydrochloride); treat symptoms of an enlarged prostate; 0.4 mg, one capsule at bedtime. A review of R93's Order Summary Report revealed an order dated 9/30/2025 for trazodone HCL (anti-depressant), 100 mg, one tablet at bedtime. A review of R93's Medication Administration Record dated 12/1/2025 to 12/31/2025 revealed R93 refused mirtazapine, Seroquel, simvastatin, tamsulosin HCl, and trazodone during the 9:00 pm medication administration time on 12/3/2025, 12/6/2025, 12/7/2025, 12/8/2025, and 12/9/2025. A review of R93's clinical records revealed no indication that the physician was notified of the medication refusals. During an interview on 12/16/2025 at 3:06 pm with R93's Family Member (FM), she stated she was not sure if the physician was notified if R93 refused his medication. Adding that he had refused medications multiple days in a row. She stated she thought the physician needed to know the information. During an interview on 12/18/2025 at 12:05 pm, the Administrator confirmed there was no documentation that the physician was notified of R93's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115542	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sadie G. Mays Health & Rehabilitation Center	1821 Anderson Avenue NW Atlanta, GA 30314

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication refusals. During an interview on 12/18/2025 at 9:17 am, Licensed Practical Nurse (LPN) 4 stated that if a resident refused to take their medication, the physician was notified. She added that this notification was documented in progress notes. During an interview on 12/18/2025 at 9:23 am, LPN 3 stated that if a resident refused their medication, s/he would notify the physician and document this in the progress notes. During an interview on 12/18/2025 at 11:07 am, the Director of Nursing (DON) stated that if a resident refused their medications three consecutive times, the family and the physician needed to be notified. During an interview on 12/18/2025 at 12:37 pm, the Administrator stated that if a resident refused their medications at any time, the family and the physician needed to be notified. She added that there could be adverse effects if their medications were not taken. Additionally, the facility needed to determine why R93 refused their medications. She stated this should be documented in progress notes.