

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115544	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Pine View Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 411 Pine Street Sylvania, GA 30467	
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 - 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 observations, staff and resident interviews, record review, and review of the facility's policy titled Abuse, Neglect, Exploitation, and Misappropriation, the facility failed to protect one of seven residents' (R11) right to be free from physical abuse from a resident (R10). Actual harm was identified to have occurred on 05/12/2026 when R10 struck R11, causing maxillary sinus and orbit fractures and lacerations to R11's face and scalp. Findings include: Review of the facility policy titled Abuse, Neglect, Exploitation, and Misappropriation, revised 11/28/2017, revealed the section titled, Policy included, It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The section titled Prevention revealed, The center is committed to the prevention of abuse, neglect, misappropriation of resident property, and exploitation. The following systems have been implemented: Department Heads and supervisors that monitor staff to identify inappropriate behavior. Monitoring of residents who may be at risk is the responsibility of all facility staff. This includes monitoring residents who are at risk or vulnerable for abuse, for indications of changes in behavior, changes in condition, or other non-verbal indications of abuse. Review of a Facility Incident Report dated 05/12/2026 revealed the facility reported an incident of resident-to-resident abuse. Details of the incident were as follows: R10 struck his roommate R11 with a metal object during an argument over the television (TV) being too loud. R11 received a laceration to the side of the face and head. R11 sent out to ER [emergency room]. Administrator, DON [Director of Nursing], MD [Medical Director], and responsible parties all notified of the incident. Police also notified of the incident. R10 is currently being closely monitored. Review of the Police Department Persons Crime Report dated 05/12/2026 at 11:50 PM revealed that an officer was dispatched to the facility in reference to an altercation that had taken place between two residents. The report documented that a nurse informed the officer that R10 had struck R10 with a metal pipe, and R11 was transported to the hospital for treatment. 1. Record review revealed R10 was admitted to the facility with diagnoses that included, but were not limited to, unspecified intellectual disabilities, schizophrenia, and major depressive disorder. Review of R10's Annual Minimum Data Set (MDS), dated [DATE], revealed Section C (Cognitive Patterns) documented R10 had a Brief Interview of Mental Status (BIMS) of 14 (indicating little to no cognitive impairment). Section E (Behaviors) documented that the resident exhibited physical and verbal behavioral symptoms towards others during the assessment period. Review of the care plan for R10 revealed the resident had impaired psychosocial well-being, mood, and behavior with episodes of anger, physical aggression, and pyromania. He threatened to burn the building down and was verbally aggressive with staff on 12/12/2025 and struck his roommate with an object on 05/12/2026. Interventions included approaching R10 in (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 - Actual harm Residents Affected - Few	non-judgmental manner, encourage R10 to use appropriate behavior, encourage R10 to participate in activities with peers, R10 placed on one to one supervision due to incident on 05/12/2026 with roommate, provide close observation when behavior is escalated, notify MD (Medical Director) of changes in behavior and refer for admission to behavioral health for in-patient services as ordered by MD if threats or aggressive behavior occurs. Review of the progress notes for R10 revealed an entry dated 5/13/2026 stating that, at approximately 11:20 PM (on 05/12/2026), a Registered Nurse (RN) found R10 and R11 in a physical altercation with each other. R10 had a metal bar in his hand. The residents were separated, and R10 was assisted from the room. A call was attempted to the Resident Representative (RP), the Director of Nursing (DON) and Administrator were notified. 2. Record review revealed R11 was admitted to the facility with diagnoses that included, but were not limited to, cerebrovascular disease, unspecified, other symptoms and signs involving cognitive functions and awareness, major depressive disorder, mild cognitive impairment, bipolar II disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, irritability and anger, vascular dementia, unspecified severity, with agitation. Review of R11's Quarterly MDS, dated [DATE], revealed that Section C (Cognitive Patterns) documented R11 had a BIMS of five (indicating severe cognitive impairment). Section E (Behaviors) documented that the resident exhibited hallucinations and delusions during the assessment period. Review of the progress notes for R10 revealed an entry dated 5/13/2026 that at approximately 11:20 PM (on 05/12/2026), a Registered Nurse (RN) found R10 and R11 in a physical altercation with each other. R10 had a metal bar in his hand. R11 had blood coming from a wound on his head. The residents were separated, R10 was assisted from the room, towels were applied to R11's head, Emergency Medical Services (EMS) was called, the on-call provider was paged, the RP, DON, and Administrator were notified. Review of the Emergency Department Discharge Instructions for R11, dated 05/13/2026, revealed the discharge diagnosis was maxillary sinus fracture, orbit fracture, and scalp laceration. The disposition was discharge to the nursing home. The follow-up information was to return to the emergency department within one to two weeks and have the staples removed in 10 days. In an interview on 07/21/2022 at 3:30 PM, the Administrator confirmed a physical altercation occurred between R10 and R11. The Administrator stated the residents were separated, R10 was placed on 15-minute checks, and R11 was transported to the ER for injuries to his head. The Administrator stated that behavioral health services, the physician, responsible parties, and law enforcement were notified of the incident for both residents. The facility implemented the following: 1. On 05/12/2026, the facility submitted an incident report to the State Survey Agency (SSA). 2. On 05/12/2026, a police report was completed at 11:50 PM. Case number: 202605121. 3. On 05/12/2026, R11 was transported to the ER for treatment. 4. On 05/12/2026, R10 was placed on 15-minute monitoring checks, one-to-one supervision on 05/20/2026, every thirty minute monitoring on 06/18/2026, and every sixty-minute monitoring on 06/21/2026. 5. Beginning 05/12/2026, R10 was placed in a private room. 6. On 05/13/2026, a room audit was conducted of R10 and R11's room. Three screwdrivers were removed from R11's nightstand. 7. On 05/13/2025, R11 had a room change to a separate hall from R10. 8. On 05/13/2026, care plan interventions were updated for R10 and R11. 9. On 05/13/2026 and 05/14/2026 Social Services provided services to R11. 10. On 05/13/2026 and 05/14/2026 Social Services provided services to R10. 11. On 5/13/2026, a psychological referral was submitted to the behavioral health services for R10 and R11. 12. On 05/13/2026, 05/14/2026, 05/15/2026, 05/22/2026, and 05/25/2026, the Social Service Director submitted referrals for R10 to behavior units. 13. On 05/13/2026 and 05/14/2026, education titled Abuse and De-Escalation was conducted with staff. Review of the sign-in sheets revealed 43 unique names/signatures. 14. The (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	facility is currently waiting for bed placement at a behavioral health unit for R10. R10 remains in a private room.		

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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. Based on observations, staff and resident interviews, and record review, the facility failed to ensure care plan interventions were implemented for one of 16 sampled residents (R) (R16). This deficient practice had the potential to place R16 at risk of falls and unmet care needs. Findings include: A review of the electronic medical record (EMR) revealed that R16 had diagnoses of, but not limited to, extrapyramidal and movement disorder, type 2 diabetes mellitus without complications, history of falling, unspecified dementia, osteoarthritis of hip, unspecified and displaced fracture of lateral end of left clavicle. Review of the most recent Significant Change Minimum Data Set (MDS) assessment for R16, dated 07/01/2026, revealed that Section GG (Physical Abilities and Goals) documented that R16 required substantial/maximal assistance with bed mobility and was dependent with transfers. Section J (Health Conditions) documented the resident had a fall in the last six months. Review of the care plan for R16 revealed a 'Focus,' last revised 05/21/2026, that the resident was at risk for injury from falls, had a history of falls, and had poor safety awareness. Interventions included an intervention dated 01/09/2026 for having a fall mat at bedside while in bed. During an observation on 07/20/2026 at 12:04 PM, R16 was observed lying in bed asleep. A fall mat was folded and positioned at the bottom of her bed. During observation on 07/20/2026 at 3:42 PM, R16 was observed lying in bed asleep. A fall mat was present and folded on the floor at the bottom of the bed. During observation and interview on 07/21/2026 at 9:05 AM, Hospice Registered Nurse (RN) AA confirmed that the fall mat was observed on the floor at the foot of the bed rather than beside the bed to provide protection in the event of a fall. During an interview and tour of R16's room on 07/21/2026 at 12:47 PM, the Assistant Director of Nursing (ADON) confirmed that the fall mat was not positioned at the resident's bedside as ordered. Instead, it was propped against the foot of the roommate's bed. The ADON confirmed that the resident's care plan included an intervention to place the fall mat beside the resident's bed whenever the resident was in bed.		