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 02/19/2026
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, staff interviews, record review, and review of the facility's policy titled, Nutrition Policy, the facility failed to properly prepare pureed food and ensure nutritive value for eight of eight residents receiving a pureed diet. This failure had the potential to serve food at a lesser nutritive value that could cause weight loss.Findings include:Review of the facility's policy titled, Nutrition Policy effective 09/01/2024 revealed under Pureed- Dysphagia Level 1: The pureed consistency is planned according to the regular consistency, but the texture is modified to a smooth, pudding- like texture for all food items. This consistency follows the guidelines as set forth by the National Dysphagia (difficulty with swallowing) Task Force. Pureed recipes are needed for each item that requires addition of fluid and mechanical manipulation to achieve a pudding- like, smooth, lump free, puree consistency. Only nutritive fluids such as broth, gravy, juice and milk are designed for use in pureed recipes.Observation of the puree process on 02/17/2026 at 10:45 AM revealed Dietary Aide (DA) II loading a food processor with food product without measuring. No liquids were used to dilute/ liquify/ mechanically manipulate the substance to achieve the smooth, pudding- like texture, nor was a recipe followed. The processor was tilted back and forth then the substance transferred into a serving tray. DA II failed to assess the consistency before transferring the mixture.Interview on 02/17/2026 at 11:00 AM with DA II, she denied following a recipe and stated that she was not aware that she had to use any. DA II confirmed she was not trained on the proper technique of completing the puree process and stated that she had been doing it since she started working in the facility.During a second observation of the puree process on 02/19/2026 at 10:45 AM revealed DA JJ performing the puree process. She removed seven scoops of sweet potatoes from a baking tray that was removed from the oven and placed them into the food processor. She then added three scoops of the broth and blended the mixture. DA JJ tilted it back and forth before pouring the mixture into the serving tray. Interview on 02/17/2026 at 11:00 AM with DA JJ revealed she did not follow a recipe to prepare the meal nor used proper measurement documented in the recipe for the eight residents that were on a pureed diet. DA JJ revealed using the liquid from the baked potatoes instead of milk and not following the recipe though she had read it prior to starting. She stated that she completed the process based on how she was instructed by the Dietary Manager (DM). She stated that she had been working in the facility less than 30 days and had not been formally trained on puree meal preparation but stated, I know how to make puree because I used to do it for a family member. DA JJ revealed she was not aware of how many residents she was preparing for nor how many scoops of potatoes she had pureed.Review of the puree recipe book on 02/19/2026 at 11:00 AM revealed no recipe recommendations for hamburger helper preparation. The recipe provided revealed lasagna with no substation for hamburger helper. The recipe also called for eight ounces with 1 and1/4 cups of beef broth for ten servings. Further observation of the recipe book revealed that the sweet potato's recipe called for ten ounces of two percent milk and five cups of sweet potatoes for ten servings.Interview on 02/17/2026 at 11:10 AM with the DM, she stated that most of her staff were fairly new to the facility. She admitted to not training the staff on the puree process stating, they have watched other staff complete the puree process. The DM confirmed that the staff were not using the puree recipe book while preparing meals and revealed she verbally instructed them on what ingredients to use.

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: 115544	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2026
NAME OF PROVIDER OR SUPPLIER: Pine View Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 411 Pine Street Sylvania, GA 30467	

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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 policy titled, Food Safety and Sanitation, the facility failed to ensure that food was stored in a manner that prevented foodborne illness to the residents, failed to ensure the food was stored at the appropriate temperatures and failed to ensure that dishes and utensils were cleaned under proper sanitary conditions. The deficient practices had the potential to place all residents at risk of acquiring foodborne illnesses. There were 104 residents who received an oral diet from the kitchen.Findings include:Review of the undated facility's policy titled, Food Safety and Sanitation revealed in the initial paragraph, Having an established policies and procedures related to food safety and sanitation, along with ongoing training and monitoring is critical in preventing foodborne illness. From receiving until service, there are certain control points that must be closely monitored. Control point- a step in the flow of food where a potential hazard can be controlled. Critical control point- the last step to prevent a potential hazard prior to service. Receiving. Label foods with delivery date and discard by date.Freezer Storage: Freezer temperatures should be 0 (degrees) F (Fahrenheit) or below to ensure frozen foods remain frozen. Foods should be stored away from fans, vents, and pipes. Foods should be stored at least 6 inches off the ground. Sanitation: Maintain logs that include dishwasher temperatures and monitor chemical sanitizers on a regular basis. Keep maintenance records along with manufacturers specifications for proper use. Follow a regular written cleaning schedule and document cleaning.Dish Machine Temperatures. Low temperature dish machine (chemical sanitation): wash 120 F- final rinse 50 PPM (parts per million) chlorine. Manual washing (3 compartment sink): wash in hot water, at least 110 F and detergent. Rinse with water at least 110 F. Sanitize: hot water at least 171 F or chemical sanitizer in accordance with manufacturer specifications. No towel drying.Observations during the initial tour of the kitchen on 02/17/2026 at 8:50 AM with the Dietary Manager (DM) revealed a thick buildup of ice on the floor of the freezer with icicles hanging from boxes stored on the shelves. Several bags of frozen foods: French fries, hamburger patties, mixed vegetables and meats were observed in a box on a shelf with no expiration date nor opened/ used by date documented. An opened loaf of bread, a few slices of molded cheese, an opened box of pancakes and a staff member's personal medications were observed in the refrigerator. The three-compartment sink was observed with pots and pans with staff hand washing them using a bottle of bleach as sanitizer.Observation of the dishwasher on 02/17/2026 at 9:12 AM revealed the dishwasher was running, one staff member prewashing dishes, cups and utensils and another using a dish towel to hand dry them.Interview on 02/17/2026 at 9:17 AM with Dietary Aide (DA) II and the [NAME] revealed that the dishwasher was not working correctly. She also stated that the chemicals for the 3-compartment sink had been hooked up incorrectly. The [NAME] stated that the company was contacted about the issue and would be returning to correct it.Observation of the dishwasher temperatures and chemicals solution on 02/18/2026 at 9:30 AM revealed that the temperature gauge was not registering, and chemical testing strips did not give a reaction.Interview on 02/18/2026 at 9:43 AM with the DM confirmed that the staff had been hand washing the dishes prior to placing them into the dish washed and adding bleach to the machine to assist with sanitizing. She confirmed that the testing strips were not reading unless bleach was added and therefore no correct reading was obtained. She stated that the freezer was leaking the day before and caused the water to be leaking inside causing the icicles.Interview on 02/18/2026 at 4:36 PM with the Corporate Manager (CM) revealed that she was made aware of the issue only a few minutes prior and had instructed the staff to continue to use the bleach and do another cycle until the repairman comes in the morning. She denied having an alternate plan but stated she would contact her boss and communicate with the DM on formulating a different plan. CM revealed that the facility will purchase disposable plates, cups and utensils for use until the dish washer can be fixed.Interview on 02/19/2026 at 2:00 PM with the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pine View Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 411 Pine Street Sylvania, GA 30467	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administrator revealed her expectation was that all department heads would communicate issues and solutions to problems faced on a daily basis so they could be addressed in a timely manner.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, and staff interviews, the facility failed to maintain an effective Quality Assurance Performance Improvement (QAPI) program which systematically identified, reviewed, developed, and implemented plans to correct quality deficiencies. Specifically, the facility failed to Maintain and/or produce documentation that demonstrates evidence of its ongoing QAPI program. The deficient practice had the potential to affect resident care outcomes and quality of life for 109 residents.Findings include:A request to review the facility QAPI program documentation, including but not limited to meeting attendance revealed the facility could not produce any documentation for review.A request to review the QAPI policy revealed QAPI policy was not produced for review.Interview on 02/19/2026 at 5:30 PM with the Administrator revealed the facility does not maintain QAPI documentation. The Administrator stated documentation is not available because the facility has not been documented as required. She further stated the QAPI program is not effective. The Administrator confirmed there is currently no tracking and trending of data for trends. She stated most issues are addressed during the morning clinical meeting.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review, staff interviews, and review of the facility policy titled, Administering Medications, the facility failed to ensure that the medication error rate was less than five percent (%) for one of three residents (R) (R79) observed during medication administration. There were 26 opportunities observed for three residents with ten errors resulting in an error rate of 38.46 %.Findings include:Review of the facility policy titled, Administering Medications revised 06/06/2024 revealed in the policy statement that medications shall be administered in a safe and timely manner, and as prescribed. Under Policy Interpretation and Implementation: .3. Medications must be administered in accordance with the orders, including any required time frame.7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.Observation of medication administration on 02/18/2026 at 08:28 AM on the C Wing with Licensed Practical Nurse (LPN) KK. LPN KK administered multiple medications to R79. The following observations were made:Clopidogrel 75 mg (milligram) was administered by mouth.Divalproex sodium 250 mg Delayed Release Oral Tablet [Depakote] was administered by mouth.ACIDOPHILUS (lactobacillus) 1 capsule was administered by mouth.24 HR (hour) mirabegron 50 mg Extended-Release Oral Tablet was administered by mouth.Actos Oral Tablet 15 mg (pioglitazone HCl) was administered by mouth.Seroquel Oral Tablet 200 mg (quetiapine fumarate) was administered by mouth.Carvedilol 12.5 mg Oral Tablet was given by mouth.Gabapentin Capsule 300 mg was given by mouth.Buspirone HCl Oral Tablet 30 mg was given by mouth.Paroxetine HCl Oral Tablet 40 mg was given by mouth.Review of the February 2026 monthly Physician's orders in the electronic medical record EMR) of R79 revealed the following orders:Clopidogrel Bisulfate Oral Tablet 75 MG (clopidogrel bisulfate) Give 1 tablet via G-Tube (gastrostomy tube) one time a day for blood clot preventionDivalproex Sodium Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 1 tablet via G-Tube one time a day for headacheGabapentin Capsule 300 MG Give 1 capsule via G-Tube two times a day for painLactobacillus Capsule Give 1 capsule via G-Tube one time a day for anti-diarrheaMirabegron ER (extended release) Oral Tablet Extended Release 24 Hour 50 MG (Mirabegron) Give 1 tablet via G-Tube one time a day for bladder spasmsParoxetine HCl Oral Tablet 40 MG (paroxetine HCl) Give 1 tablet via G-Tube one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATESeroquel Oral Tablet 200 MG (Quetiapine Fumarate) Give 2 tablet via G-Tube two times a day for anxietyActos Oral Tablet 15 MG (pioglitazone HCl) Give 1 tablet via G-Tube one time a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONSBuspirone HCl (hydrochloride) Oral Tablet 30 MG (Buspirone HCl) Give 1 tablet via G-Tube two times a day for anxietyCarvedilol Oral Tablet 12.5 MG (carvedilol) Give 1 tablet via G-Tube two times a day related to ESSENTIAL (PRIMARY) HYPERTENSIONReview of the Medication Administration Record (MAR) for R79 confirmed these orders were correctly transcribed from the Physician's orders to the MAR.All medications were administered by mouth. The physician order notes that the medications were to be administered via G-Tube. Medications were given using the wrong route. Seroquel 200 mg was given; the order was for 400 mg. LPN KK administered the wrong dosage of Seroquel to R79.Interview on 02/18/2026 at 08:28 AM with LPN KK confirmed that the medication cards and physician orders for R79 were for G-tube administration and she had given the medications by mouth. When questioned why she had given the medications by mouth, LPN KK stated that the resident had been sneaking and eating and that the facility was trying to get R79 cleared to remove the G-tube. LPN KK stated that she should have followed the orders because the resident could have aspirated.Interview on 02/19/2026 at 10:50 AM with the Assistant Director of Nursing (ADON) revealed that she expected nurses to follow physician's orders when administering medications.Interview on 02/19/2026 at 05:10 pm with the Administrator revealed that she expected nurses to give medications as ordered and follow the rights of administration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility policy titled, Administering Medications, the facility failed to ensure that medication was administered according to physician's orders for one of three residents (R) (R79) observed during medication administration. Specifically, R79 received medications by mouth when she should have received the medication through her G-tube (gastrostomy tube). This deficiency had the potential to cause R79 to aspirate which could have led to physical harm or hospitalization.Findings include: Review of the facility policy titled Administering Medications revised 06/06/2024 revealed under Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation revealed: .3. Medications must be administered in accordance with the orders, including any required time frame.7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.Review of the electronic medical record (EMR) revealed R79 was readmitted to the facility on [DATE] with a G-tube and diagnoses including but not limited to chronic obstructive pulmonary disease with acute exacerbation, hyperlipidemia, dysphagia (difficulty swallowing), major depressive disorder, and altered mental status, Review of R79's significant change Minimum Data Set (MDS) assessment, with an assessment reference date of 2/10/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated R2 was cognitively intact. Section K revealed the resident had a feeding tube and received 51 percent or more of total calories and 501 cubic centimeters or more of fluid intake per day through the feeding tube.Review of R79's care plan indicated a problem: R79 alteration in nutrition related to tube feed with the potential for significant weight loss/gain/aspiration precaution, 5% (percent) WT (weight) loss for the month of FEB (February) 2026-12 lb (pound). Goal is R79 will be free from complications related to G-tube: aspiration, dehydration, abdominal distress/ SIG (significant) WT loss/gain. Interventions include R79 NPO (nothing by mouth) with Jevity 1.5 at 55ml/hr (milliliters per hour) with flush per MD (medical doctor) order, monitor abdomen for distention with aspiration precautions and HOB (head of bed) elevated with input/output Q (every) shift, monitor for placement and patency per policy.Review of the physician orders for R79 revealed an order dated 2/17/2026:Enteral Feed Order every 4 hours for Dysphagia, G-tube dependent Give 240 cc Jevity bolus with 60 cc water flush.Review of the physician orders for R79 included but not limited to:Clopidogrel Bisulfate Oral Tablet 75 MG (clopidogrel bisulfate) Give 1 tablet via G-Tube one time a day for blood clot preventionDivalproex Sodium Oral Tablet Delayed Release 250 MG (divalproex sodium) Give 1 tablet via G-Tube one time a day for headacheGabapentin Capsule 300 MG Give 1 capsule via G-Tube two times a day for painLactobacillus Capsule Give 1 capsule via G-Tube one time a day for anti-diarrheaMirabegron ER (extended release) Oral Tablet Extended Release 24 Hour 50 MG (Mirabegron) Give 1 tablet via G-Tube one time a day for bladder spasmsParoxetine HCl Oral Tablet 40 MG (paroxetine HCl) Give 1 tablet via G-Tube one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATESeroquel Oral Tablet 200 MG (quetiapine fumarate) Give 2 tablet via G-Tube two times a day for anxiety.Observation on 02/17/2026 at 12:30 PM of R79 revealed her sitting on her roommate's bed. She was receiving Jevity 1.5 at 55ml/hr with water flush at 40ml/hr through a G-tube.Observation on 02/18/2026 at 09:00 AM with R79 revealed her walking around in her room. She no longer had the continuous G-tube feedings. The order was changed to bolus (feeding given via syringe through the G-tube) feeding.Observation of medication administration on 02/18/2026 at 08:28 AM on the C with the Licensed Practical Nurse (LPN) KK revealed LPN KK administered all medications to R79 by mouth. Interview with LPN KK confirmed that the medication cards and physician orders were for G-tube administration and she had given the medications by mouth. When questioned why she had given the medications by mouth, LPN KK stated that R79 had been sneaking (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and eating and that the facility was trying to get R79 cleared to remove the G-tube. LPN KK stated that she should have followed the orders because the resident could have aspirated.Interview on 02/19/2026 at 10:43 AM with the Advanced Practice Registered Nurse (APRN) revealed that R79 should be receiving her medications via the G-tube as ordered.